Ian Anderson Continuing Education Program in End-of-Life Care

Module 11

COLLABORATION

A Joint Project of Continuing Education and the Joint Centre for Bioethics, University of Toronto
and The Temmy Latner Centre For Palliative Care, Mount Sinai Hospital

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Barbara Bark, a 65-year-old woman with advanced metastatic breast cancer, is admitted to the hospital with uncontrolled bone pain. She has four daughters, all of whom have taken time off work to care for her. Both Barbara and her daughters want her to die at home. Unfortunately her pain has been unbearable and she became confused on regular oral morphine (see the Pain Management module). In the hospital, she was switched to subcutaneous morphine. Her confusion subsequently resolved and after a few dose adjustments, she achieved good pain control. Her pain is currently being controlled by subcutaneous injections of morphine administered through a butterfly needle every four hours with occasional q1hour breakthrough doses. Her daughters are afraid of giving her the morphine – having fears of needles themselves. Furthermore, they are worried about overdosing her or not giving her enough morphine to alleviate her pain. However, both Mrs. Bark and her daughters continue to express a desire to return home. The physicians spent time with the daughters and explained some of the basics of pain management. They asked the nurses to teach the daughters how to administer the subcutaneous injections in order for her to be discharged home in the next couple of days. The family and Mrs. Bark eagerly anticipate the discharge and start to plan a small get-together of friends and family members to celebrate.

On the day before the planned discharge, the daughters are quite upset. They tell you their mother can't leave the hospital since they have not been taught how to give the morphine. Furious at having your instructions disobeyed, you leave her room and stalk to the nursing station. Seeing her nurse there you demand to know: "Just WHY Mrs. Bark's daughters have not been taught sc injections".

Introduction

Collaboration or teamwork in medicine is the foundation of medicine. Different healthcare providers have different skills, knowledge and perspectives, all of which are crucial to maximizing the patients' and families' quality of life. In end-of-life care, the need for collaboration is crucial in any strategies to improve the quality of care provided. Surprisingly in view of the fact that all medical care is approached as a multidisciplinary or interdisciplinary team effort, no courses actually teach healthcare providers how to work as a team. Such abilities are yet another example of the skills that we are expected to acquire naturally by osmosis. With any role modeling approach to teaching such as this, we witness a "hit or miss" learning opportunity – those of us fortunate enough to have good role models have a better chance of being able to work as effective team members. However, the lack of education about the skills needed to form and function as a team means that we cannot easily correct problems as they arise. These problems may become so significant that the teams can no longer function and no longer provide the care required by vulnerable people who are dependent upon them.

In end-of-life care, collaboration is a necessity since the demands of caring for dying patients and their families cannot be met by one person alone. Typically this requires the skills of several health professionals and often needs the skills of chaplainry, social work, nursing and medicine to alleviate pain and suffering and provide emotional psychological support. In the community, some teams caring for dying patients and their families are more community-based in nature in that they may seldom have opportunities to work face to face. Collaboration and efforts to improve teamwork can thus be especially challenging. Consideration of how all teams form and function, and strategies to overcome the ubiquitous difficulties in collaborative work will lead to improved treatment effectiveness and improve quality of end-of-life care.

Currently, research has revealed, not surprisingly, that physicians and nurses do not communicate about the goals of care for their patients. There is a lack of understanding of each other's roles and responsibilities and the rigidity of the traditional hierarchical system often results in some members lacking a voice in decision-making and care-plan development. For example, the literature has shown us that in many cases, nurses are the ones meeting patients' and families' emotional and psychological needs yet often their thoughts and knowledge about a particular patient or ideas about management of issues are ignored. These collaboration difficulties are unfortunate because research clearly demonstrates that effective collaboration 1) can help prepare the patients and families for bad news, 2) can prompt the sharing of information and facilitate asking questions, 3) can support and reinforce messages and 4) avoid miscommunication and misunderstanding. Furthermore, workplace frustration and disempowerment are a frequent cause of staff "burnout" and having one's thoughts and ideas recognized and valued may enhance and support retention of well-trained staff who may otherwise leave an

uncollaborative workplace and even their professions.

Just putting people together in a room, on a ward or in a community does not result in the formation of a team or produce effective teamwork. Few resources are available for those who seek to improve their collaboration. This module will provide some tools and strategies for dealing with the challenges that commonly arise.

Objectives

By the end of this module, participants should be able to

1. Describe the importance of collaboration in the provision of quality end-of-life care
2. Describe the stages of team formation and development
3. Describe different types and styles of leadership and effects on team function
4. Reflect upon how own personal character, values and beliefs affect ability to work on a team
5. Describe and recognize issues that may arise when two teams converge to provide patient care
6. Demonstrate skill in resolving difficulties in team function

Teams and Collaboration – A Definition

The tools described in the subsequent sections of this module were developed by:
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A team is a group of people with different skills and backgrounds who work together to achieve common goals and resolve common problems. Members of a team share an organized division of labour. On a medical team, each member uses his/her own tools, abilities, knowledge and skill to improve the quality of care for a given patient and family. Without the contributions of individual team members, the problems could not be solved, the goals could not be achieved. Effective collaboration (teamwork) is a process of continuous communication, examination of and demonstration of respect for each other's work resulting in all of the team members assuming responsibility for the final outcome

Over the years, medical teams have undergone many changes. From the initial doctor-patient model, teams have evolved to incorporate interdisciplinary members. Teams in health care have great diversity. They are always in a constant dynamic state of forming and re-forming around the needs of particular patients and families. Membership on the team will vary depending on these patient and family needs from the time when illness is first suspected to when it is clear that the end of life is near. They will have diverse disciplinary mixes. Their work is in diverse locales. They may be standing teams with fixed mandates or ad hoc teams convened to solve emergent problems then be disbanded. They might be therapy, teaching, or

task teams. Their duration might be fixed or open-ended and of various sizes. As well, these days, health professionals working in networks might find themselves on distributed or community-based teams. Inevitably, the functional ability of these work groups will vary widely.

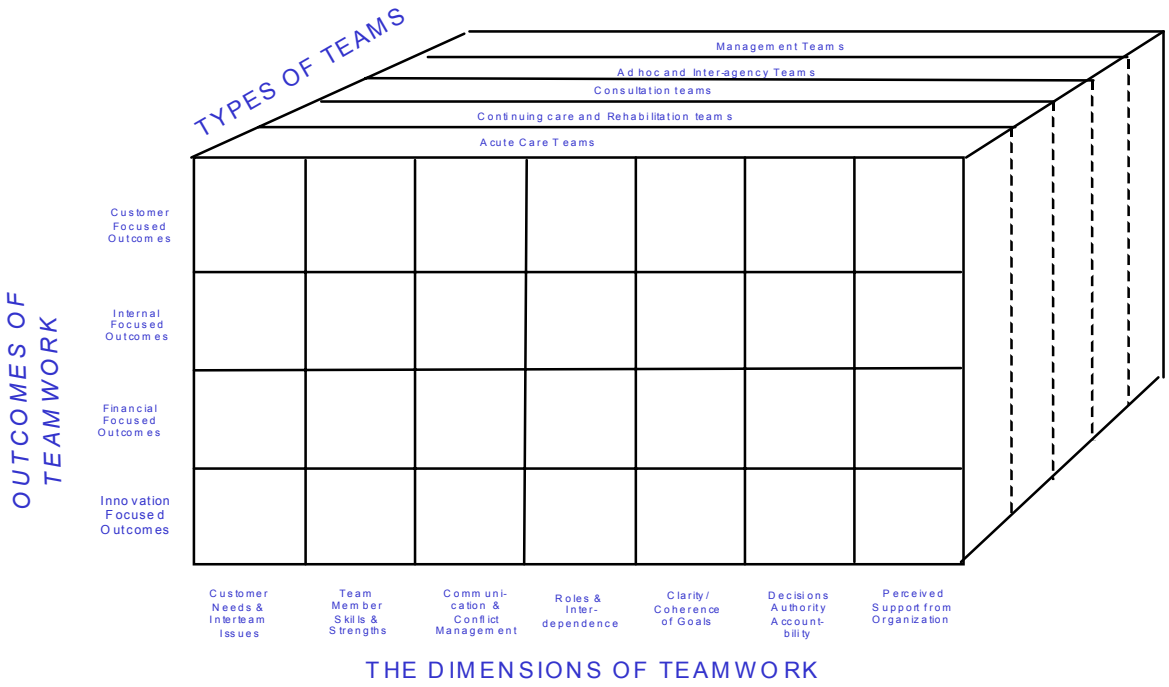
Given this complexity it is always important to formally review teamwork and collaboration. Simply putting people together to work does not necessarily produce effective teamwork. Teams usually need a little help but there are few resources available to them. Here we outline several relatively simple tools to enhance collaboration and teamwork.

Simply Understanding the Style of Teamwork is Helpful

In complex medical care such as that required at the end of life, several types of team structure can be seen. In **sequential teamwork**, an attending physician requests the assistance of other professionals who communicate by writing reports and with informal conversation. On **multidisciplinary teams**, members practice independently of one another, each member being guided by his/her own professional standards. Leadership is determined a profession hierarchy. Each member reports to the team leader (usually the staff physician). Typically rigid role boundaries exist. Conflicts are attributed to individuals. Members of the team not involved in the conflict look the other way, avoid the warring members and make no attempt to help resolve the issues. Though all professionals meet formally to discuss their work, little attention is paid to team process. On **inter-professional teams**, members practice interdependently. Each member is guided by professional practice standards and also by the team's practice standards. Leadership is determined by the problems and issues that arise in the patients' and families' care and role boundaries are flexible. All members take responsibility for managing conflict and team conflict is managed and resolved and team process is routinely examined. Across the structural continuum from sequential to multi-disciplinary and inter-professional teamwork, teams also vary in the extent to which they allow patients to guide their practice.

Most teams are multidisciplinary in nature. A hierarchical structure still dominates medical thinking. It is only by increasing our understanding of and respect for the abilities of all team members that interdisciplinary teamwork can evolve to improve the efficiency and quality of the care we provide.

Below is a framework for considering different types of teams, dimensions of teamwork and outcomes.



A framework for examining teamwork and a balanced set of outcomes

Understanding the Sources of Your Team's Cohesion

Group cohesion determines a team's performance and has three primary sources: interpersonal attraction, group pride, and task commitment. Of these, interpersonal attraction is the least stable form of cohesion and team cohesion based on attraction will lower performance. Group pride and commitment, on the other hand, enhance performance. Achieving set outcomes is the best predictor of pride.

Myths About Teamwork

- If we work together we will eventually become an effective team
- There are no leaders on teams, everyone is equal
- Everyone is accountable for everything on teams
- Teams take a long time to get up and running
- All decisions must be made by consensus
- Conflict must be worked out for a team to be productive
- On the best of teams everyone likes everyone else
- The most important work of the team takes place at its meetings
- Confrontation means conflict

Stages of Team Development

Over the last 40 years, models of teamwork have developed which characterize team development as a progression through several phases or stages. Although research has been unable to confirm that these phases of development are necessarily sequential or even universal, still, practice has shown that recognition of these characteristics of team functioning is helpful in understanding what is happening in a team, why, and what to do next. A model of team development is outlined in Table 1.

In this model five stages of team development are described: **forming, storming, norming, performing, and reforming**. Team development is a continuously changing and recursive process. Often, no sooner, has a team begun to function efficiently in stage four than something will happen requiring it to **reform** and, even if only in part, recapitulate its development. This cyclical process of change is inevitable; a highly functioning team might loose one member, for example, and go back to a much earlier stage of development.

Sometimes teams can pass mercurially from one phase to another. More often, however, teams fail to progress and do not maximize their potential (consider the Leafs). Perhaps this is not surprising. In health care for example, few teams have access to team development expertise, few health professionals have training outside their particular discipline, and many are uncomfortable and resistant to the blurring of boundary functions characteristic of mature inter-professional teams. When consulting to teams it is always wise to think about their stage of development.

Each stage of team development has its own characteristics with distinct forms of team leadership and team member behaviour, emotional climate and rituals, and style of team humour. These characteristics are outlined in the following table. What may be funny on one team is a lead balloon on the next and without understanding the context of team development the consultant might easily misunderstand the barbed humour of a **storming** team or feel lost when a **norming** team fails to explain its particular style of humour. Similarly a **norming** team may appear preoccupied with details and be frustrating to you and to its members if it doesn't think that perhaps its preoccupation is a necessary and temporary element of team development. To assist in orienting oneself to the stage of a team's development the following table provides a useful tool. Using the framework for discussion can be a simple, yet powerful, team development intervention which can help a team move beyond an obstacle to growth.

Table 1. An Integration of Team and Group Development Theory

Stage of Team Development	Leader Behaviour and Informal Style	Team Member Behaviour and Informal Roles	Emotional Climate and Team Ritual	The Team's Style of Humour
Stage 1: Forming	The leader seeks to control and direct. Styles which might emerge include: the "tyrant", "superwoman" "party host", or "reluctant candidate".	Dependency seeking characterizes team member behaviour. "Scapegoat" and "Helper" roles may emerge.	The ritual of bringing refresh-ments often emerges to reduce tension arising from the feeling of anxiety and uncertainty.	The leader uses jokes to soften orders or gibes and put-downs to assert control. Members joke about the leader and the team often makes jokes about patients. Black humour prevails.
Stage 2: Storming	The leader tries to convince the team and may use "salesman" and "nice guy" styles often struggling to be a socio-emotional leader.	Team members resist. Scapegoating often persists and new roles may emerge: e.g. Hatchetman" vents resistance or the "clown reduces tension.	Conflict and revolt frequently emerge, often in response to minor issues which take on broader symbolic meanings.	Humour is often barbed and personal, interspersed with the clown's buffoonery.
Stage 3: Norming	Leadership exercised by coalitions of members based on earlier demonstrated competence.	Members are colleagues who are able to defer to each other's relevant experience.	Team members are mutually supportive and a party to express solidarity often marks this stage. Team symbols (e.g. a nickname) often develop.	The team can share humour which often deprecates the team. Members make self-disparaging jokes. Humour emphasizes membership and may exclude non-members
Stage 4: Performing	Authority exercised by a coalition of colleagues. When earlier styles (e.g. tyrant, host, etc.) emerge they are they are quickly recognized and dismissed.	Team members are Interdependent. When earlier roles (e.g. scapegoat, clown, etc.) emerge they are quickly recognized and dismissed.	Members have pride in accomplishments of the team. Team meetings become constructive and enjoyable. Team legends emerge and team anniversaries celebrated.	The team laughs at itself but explains its in-jokes to new or non-members. It enjoys its own funny stories and myths. Humour typically at the expense of the team but without loss of task orientation.

Adapted from Bennis & Sheppard (1956), Tuckman & Jenson (1977), Farrell, Heinemann & Schmitt (1986), and Drinka (1991).

Leadership and Power

Styles of leadership (Adapted from Hersen & Blanchard)

Level of Leader Support	Level of Leader Direction: High	Level of Leader Direction: Low
High	**Leader as coach** Directs decision making but involves others and solicits input. Explains desired outcomes and prompts and cues behavior. Recognizes suggestions and following directions	**Leader as supporter** Gives decision making power to others buts engages in a process of inquiry to help people analyze and think through issues Recognizes and supports decisions but helps to guide evaluation and development
Low	**Leader as director** Takes responsibility for all decisions and tells others what how and why to do things. Recognizes following directions	**Leader as delegater** Gives responsibility to others to identify issues and implement solutions. Gives briefings and updates Recognizes acceptance of responsibility

One style of leadership is not necessarily better than the other. Indeed, leadership style should be flexible as teams form and re-form around various issues/focuses (see below). Effective leadership means knowing and respecting the skill and commitment of team members and will vary according to the skill and commitment of these members. The relationship between leadership style, skill and commitment is outlined in the following table.

Leadership style, staff skill and commitment

Staff Skill and Commitment		Leaders Style	
Skill	**Commitment**	**Direction**	**Support**
Low	Low	High	High
Low	High	High	High
Moderate	Low	High	High
Moderate	High	High	High
High	Low	Low	High
High	High	Low	Low

Team members often struggle for recognition of their individual talents, successes and merits. Such quests for recognition often manifest themselves as power struggles and there are several sources of power on teams.

Sources of power and influence on teams:

- Legitimate Power
- Coercion
- Reward
- Personal or Referent Power
- Expert
- Information
- Network

Legitimate power arises from members recognizing the knowledge, skills and talents of an individual member that renders him/her crucial to the successful attainment of the team's goal(s). Coercive power arises when one member is able to pressure individual team members or the team itself into granting him/her responsibility or roles which he/she may desire but would be better filled by another member based on knowledge and/or skills. Power arising from the ability to distribute rewards and recognition is powerful. And team members will try to gain his/her favour. Some team members may have achieved recognition in another arena, may be perceived by colleagues and peers as experts and /or may have a network of acquaintances/peers/friends that would help the team achieve its goals. When these sources of power are distributed amongst team members, as is usually the case, struggles for team leadership often emerge which can compromise team performance.

TAKE HOME POINT

Recognition of the sources of distributed power on a team and using these sources of power effectively is often an important step in resolving destructive leadership struggles.

On mature teams, leadership is a shared responsibility, something seen as necessary and even onerous, which team members may have to shoulder from time to time as their skills and knowledge become essential to an element of the team's work.

TAKE HOME POINT

When strong leadership is required, and leadership challenges compromise teamwork, it is often necessary to practice effective confrontation. Remember that the confrontation works best if it emerges by common agreement, describes behavior and ones feelings about it rather than passes judgment, and offers a collaborative search for solutions. e.g.: "I need to something with you that's troubling me. Lately I've been finding that we have been disagreeing with each other more often than usual. I'd like to talk with you to understand this better and find a way to be more collaborative."

Below is a tool for facilitating teamwork that may be useful if and when difficulties arise.

Tools for Facilitating Health Care Teamwork

Just putting people together to work does not necessarily produce effective teamwork. Teams usually need a little help but there are few resources available to them. Here we outline one relatively simple process to help understand and develop health care teamwork.

Even if your team is more community-based in nature in that you work in the community and rarely have the opportunity to work together physically, you are still a team collaborating to meet the needs of the dying patient and his/her family. As you search for strategies to improve the quality of end-of-life care in your community, you may find that meeting and using these tools becomes an important part of your efforts.

The Analysis of Informal Roles in Work Groups

The analysis of informal roles provides another useful tool for understanding team process. There are three broad sets of informal roles: 1) **Task roles** that are necessary for accomplishing the teams task, 2) **Maintenance roles** which help the team function as a team, and 3) **Individual roles** in which a team member attempts to satisfy individual rather than team goals. A team is most productive when all three sets are managed simultaneously.

The three broad sets of these roles comprise 16 specific role functions:

Task Roles		
1. Initiating/energizing	2. Information/opinion giving	
3.Information/opinion seeking	4. Reality testing	
5. Coordinating	6. Orienting	
7. Technician		
Maintenance Roles		
8. Harmonizing	9. Gatekeeping	10. Encouraging
11. Following	12. Climatizing	
Individual Roles		
13. Blocking/Aggressing	14. Out of field	15. Digressing
16. Recognition seeking		

In an effective team, all **task** and **maintenance** roles are being played and this characteristic is called **role distribution.** As well, on effective teams, team members are able to identify gaps in role performance and take on these roles when they are needed so that over time each team member will have an opportunity to play every role. This is called **role flexibility**. By observing **role distribution and role flexibility,** an important source of team strength or weakness can be readily identified. Helping a team see and discuss this element of team functioning can be a powerful impetus for team development.

Definitions of Task Roles	
Initiating/energizing	Defines goals and problems of team. Suggests procedures and stimulates.
Information/opinion seeking	Seeks clarification of goals, problems, procedures. Asks for opinions on topic.
Information/opinion giving	Gives facts and general information. States opinions relevant to discussion.
Reality testing	Provides critical analysis and judgement of ideas, checks practicality.
Coordinating	Tries to link ideas and issues, summarizes, pulls things together.
Orienting	Questions whether team is on track, points out deviations from purpose.
Technician	Doing things for the team, e.g. keeping records, getting supplies, arranging seats
Definitions of Maintenance or Group Building Roles	
Harmonizing	Mediates conflict, reduces tension, explores differences of opinion.
Gatekeeping	Facilitates participation, ensures ideas, questions, opinions are expressed.
Encouraging	Provides friendly and warm response and praise for comments and ideas
Following	Goes along with team process and provides accepting audience.
Climatizing	Follows team's emotional climate and reflects on team climate.
Definitions of Individual Roles	
Blocking/aggressing	Persistent attack, argument, resistance, returning to "dead" issues.
Out of field	Withdraws from discussion, daydreams, fiddles, flirts, and whispers to others.
Digressing	Goes off topic, makes brief statements into long nebulous speeches.
Recognition seeking	Attention seeking by boasting, seeking sympathy, being loud or acting unusual.

Observing a team function using a simple Informal Roles Checklist like the one found below is usually of great interest. The process reveals that on many teams, even ones that have been together for some time, very few roles are played and/or they are played by the same people over and over again. Exploring the team's informal roles by using the checklist can be an important way of ensuring quality of care.

Example 1

Consider the following example. A team on a palliative care unit was troubled by an agitated, combative gentleman who was striking staff and other patients. Searching for ways to improve the clinical treatment of this man and others like him, the team thought of exploring its functioning by using the informal roles checklist. When the checklist was completed during a subsequent team meeting it was noted that few maintenance roles were being played by team members. If differences appeared no one **harmonized** them, if someone waited to say something the group would often move on without paying attention because no one was attending to the **gatekeeping** function. It was clear that someone had something to say. Few words of **encouragement** were evident and as the meeting drew tiredly to an end no one commented on how everyone was feeling – the **climatizing** function.

But not only were few maintenance roles evident, **task roles** were largely limited to people **opinion giving.** In this context the opinions revolved around why the patient was doing what he was doing. It became evident that there were many opinions about this. Seldom were opinions **reality tested** and there was no **coordination** of these opinions into a progressive care-plan.

As a result, back on the ward, the agitated patient was being treated differently by team members depending upon their opinion regarding why he was doing what he was doing. There was no consistent approach or communication from shift to shift. In this confusing context it was likely the case that the team was contributing to the agitation that they wanted to eliminate.

A discussion of role distribution and flexibility during the team meeting led to an agreement to make a list of the hypotheses on why the patient was doing what he was doing. Each opinion was reality tested and an appropriate care plan developed for the opinions that remained. The team agreed to work with one opinion and care plan at a time until they could find the one that worked best.

Example 2

Like most teams this one spent little time examining its own process. As a result team difficulties smouldered beneath the surface. Did you know that hidden conflict on care teams can provoke patient distress and agitation?

One day, an evening nurse had not entered the team physician's written order for a patient. As usual the physician's writing was illegible but no one ever said anything about this. The next day at the team meeting, the day nurse apologized that her colleague had missed the order, whereupon the physician lost his cool and berated the nurse who broke into tears. The rest of the team looked off in other directions. After the meeting anger seethed through the team and the physician felt awful because she had

blown her cool.

In this instance attention to informal role distribution and flexibility on the team would have revealed that, as is typical, the team focused almost entirely on its task functions. The member who usually played the peacekeeping role was not working and her **harmonizing** function was unavailable and while many afterwards said that they had felt like saying something, no one played the **gatekeeping** function – noticing that people were about to say something and encouraging them to speak up.

Review and discussion of team roles on this team helped to resolve the conflict and the team agreed to periodically review its process using the checklist and be guided by its principles of **role distribution and flexibility.**

The following **Checklist and Summary** of the informal roles in teams may be a helpful tool to deal with the challenges of working as a team. Please photocopy it and bring it to your next meeting. Distribute it to all members of your team and ask them to complete it. Create a safe environment, allowing everyone to share their thoughts. Be non-accusatory and avoid any perception of assigning blame. Use the discussion to explore your team process and develop strategies for improvement.

A CHECKLIST OF INFORMAL ROLES IN TEAMS

Put each members initials at the top of column

Task Roles											
Initiating/energizing											
Info/opinion seeking											
Info/opinion giving											
Reality testing											
Coordinating											
Orienting											
Technician											
Maintenance or Group Building Roles											
Harmonizing											
Gatekeeping											
Encouraging											
Following											
Climatizing											
Individual Roles											
Blocking/aggressing											
Out of field											
Digressing											
Recognition seeking											

SUMMARY PAGE FOR TEAM MEMBER ROLES EXERCISE

For each team or study group enter the number of members playing each role at the top of each square and the frequency of occurrence of each role at the bottom.

Task Roles	1	2	3	4	5	6	7	8	9	10
Initiating/energizing										
Info/opinion seeking										
Info/opinion giving										
Reality testing										
Coordinating										
Orienting										
Technician										
Maintenance or Group Building Roles										
Harmonizing										
Gatekeeping										
Encouraging										
Following										
Climatizing										
Individual Roles										
Blocking/aggressing										
Out of field										
Digressing										
Recognition seeking										

When Problems Arise Due to Individual Roles…

Individual roles are often counterproductive to team effectiveness. However, we are only human and many of us may display this behaviour on occasion. Recall the definitions of individual roles in the following table.

Definitions of Individual Roles	
Blocking/aggressing	Persistent attack, argument, resistance, returning to "dead" issues.
Out of field	Withdraws from discussion, daydreams, fiddles, flirts, and whispers to others.
Digressing	Goes off topic, makes brief statements into long nebulous speeches.
Recognition seeking	Attention seeking by boasting, seeking sympathy, being loud or acting unusual.

Team members demonstrating individual role behaviour are usually doing so in a search for personal power or recognition and if prolonged, inevitably undermine the team's function. Members searching for personal power may either

1. lack confidence in their own knowledge, skills and talents,
2. have been made to feel undervalued by the leader/other team members
3. have a need to be perceived as the most powerful member
4. be frustrated over a lack of voice, or responsibility or
5. lack challenge in the roles/responsibilities assigned to him/her

Members who engage in individual role behaviour to achieve personal power or recognition may disagree either

1. with the goals or
2. the process the team is using to achieve them

TAKE HOME POINT

Resolution of this disruptive behaviour sometimes requires open and frank discussion but teams will find that if they routinely attend to role distribution and role flexibility, consider the distribution of power and empowerment, and recognize the stages of development of their team, difficulties arising from the need for personal power and recognition can often be prevented.

Understanding One Another Better Can Often Help to Sustain Team Development

Sometimes, it seems like a team just cannot move forward towards achieving its goals. Some team members just want to leap ahead and are impatient with any delays, while some want more data, some are concerned about "toes being stepped on" and others want a concrete well developed plan. The words "Red Tape"/ Resistance/ Barriers are on everyone's mind and it may seem that nothing will ever be accomplished. This next section will describe a tool that may help teams overcome these problems and attain its goals by helping us understand our behaviour and that of the people we work with.

THE "SO SIMPLE YOU CAN'T MAKE A MISTAKE AND IF YOU DO ITS NO BIG DEAL" GUIDE TO UNDERSTANDING ONE ANOTHER IN ALL SORTS OF SITUATIONS.

Individual differences in our behaviour, thinking, emotional life and relationships moderate our reactions to life experiences. These experiences might be teaching and learning experiences, coping with illness experiences, managing life's inevitable transitions, or managerial and leadership experiences.

To better understand individual differences, there are many validated and reliable measures of personal style including the Kolb Learning Style Inventory or the Myers-Briggs Inventory. Like these devices, most validated inventories are quite lengthy and take at least a moderate amount of time to complete and score. The "So Simple" Guide that I have adapted and developed is a very simple tool. It has but two items and is useful in time-limited workshop settings. And, while without extensive psychometric validation, when combined with a contextually appropriate process of inquiry, the "So Simple" Guide helps users to think systematically about individual differences in a wide variety of settings and facilitate learning.

The "So Simple" Guide is based on two dimensions of temperament and individual differences emerging from several decades of research: 1) Style of expressing emotion and 2) Response to Novel Stimuli. The guide has two items. The first item asks participants to rate whether they "let their emotions show easily and often" or "stay cool, calm and collected no matter what the situation". The second item asks participants to rate whether they like to "jump into new things quickly and are impatient waiting" or whether they "like to wait, watch and listen to all sides before jumping into new things." The items were written so that the poles of each rating scale are value-free (i.e. it's not better to be "emotional" versus "cool", "jumping in" versus "waiting and seeing all sides".

Where Can the Guide Be Used?

The Guide has been used by opinion leaders to think about reaching "hard to reach docs.", clinical supervisors to understand difficult interns, by teachers to understand "students from hell", by managers to facilitate managerial problem solving, and by all of the above to understand themselves.

The "So Simple" Guide has been used by health care teams to explore patient learning styles in teaching programs on osteoporosis, diabetes and disability and in learning about having dementia.

The Guide has been used with individuals in performance appraisal situations, in small groups during workshops and for as many as 250 people in a conference setting.

Because it is an active process it is often helpful right after a lunch when people might otherwise feel inclined to snooze.

How to Administer the Guide

The "So Short" guide is easy to use. First, each user is given the "so short" rating sheet and is asked to rate themselves on the two dimensions: handling emotion and reacting to change. Typically they are then asked to rate someone else. Usually someone they "have difficulty with", find "frustrating to teach or show anything", etc. depending upon the situation. It is usually helpful to focus the rating to specific situations such as "when you are at work", "when you are teaching", "when you go to the doctor" and etc.

Most often the exercise is implemented by marking out the two scales with masking tape on a large tabletop, on the classroom floor or in a large conference hall. When participants have finished rating themselves on the rating sheet everyone gets up and “lines themselves” up along one of the marked scales, then along the second so that everyone finds themselves more or less in one of four quadrants. If there is enough room, participants can then get chairs and sit in the quadrant in which they find themselves.

If the grid is marked out on a floor, each quadrant can have a flip chart. If the grid is marked on a table, each quadrant has a page facing down at the intersection of the two ratings. When everyone is seated in their quadrant the pages of the flip chart or the face down pages are flipped over to reveal capsule summaries of each of the four “personal styles” as indicated in the figure below: "Drivers", "Enthusiasts", "Analysts", and "Harmonists".

Each of the four styles are reviewed and discussed and extra effort is given to explaining that one style is not better than another, and that a team needs people in every quadrant. The analogy of a raft is often used. “If everyone is on one side, the raft will sink." After reviewing each style people are asked if they think they belong in

another quadrant and if they do they are encouraged to move there. Inevitably someone says “this isn’t scientific” or “I’m different in different situations” and of course this is true. Amusingly, it is usually “Analysts" who raise this point.

Usually users are encouraged not to take their ratings too seriously. That is why the exercise has the silly title. If, once the ratings are completed and described, people would like to change their rating they are encouraged to do so. Interestingly though, most people say that the styles describe them fairly well. And, usually people seem to feel pretty comfortable with their self-description.

Once everyone is settled in their quadrant the ratings of someone you don’t get along with are reviewed. This is usually done by having people think about their rating of the other person and where they would be placed on the grid. Inevitably, someone says that they couldn't think of anyone they didn’t get along with. Interestingly, these people have usually described themselves as “Harmonists”.

Then a show of hands is requested. First ask how many placed the person "who is frustrating to teach" (or whatever the question was) across the diagonal from them. Usually, 60 to 70% of participants do this. "Harmonists" are less likely to get along with "Drivers", while "Analysts" are less likely to get along with "Enthusiasts" (both vice versa's obtain). This makes sense when you think about it. People across the diagonal share neither of the rated dimensions

The facilitator can then review the fact that though we generally tend to think that people we don’t get along with are unpleasant people who don’t do things right, the exercise lends itself to the realisation that individual difference can be the basis of disharmony.

A second small group of users will have rated someone in the adjacent square. Then discussion might focus on whether the similar or dissimilar dimension is the focus of disagreement. The smallest group are those who rate someone as being the same as them. This is usually not a focus of discussion but typically handled with a passing "tongue in cheek" comment; though the possibility of rich learning is evident in this situation it might not be comfortable in a group situation.

The Query Process

Then the groups get down to business asking questions about the topic at hand. This can be done with the group as a whole or in four groups comprising those participants in each quadrant of the grid. The latter would require a report back to the group as a whole and is often very amusing and insightful.

Suppose, for example, that the group has formed to **discuss an educational initiative**, then the questions might be:

How would people in each quadrant differ in their preferred teaching style?

How would people in each quadrant differ in the way they like to learn?
What might be the special needs of learners in each quadrant?
Thinking about resistant learners what might people in each quadrant resist and how might they do it?

In **discussing coping with giving or receiving a palliative diagnosis** or a dementia diagnosis, participants might be asked:

How might individuals in each quadrant react to this diagnosis?
How might physicians with each style prefer to give the bad news?
How might differences in physician/patient style best be managed?

The query process can be adapted to the **learning situation**. For example, a series of workshops for nursing unit managers who were preparing their staff for impending mergers and re-engineering were asked:

How might people in each quadrant react to news of downsizing?
Are there special needs unique to each style?
How would you like others to behave if you were told you were laid off?
If you were a manager and the next day had to tell your unit it was closing what would you do the night before? Who would you like to have with you? What would be your biggest fear?

In workshops during organizational **mergers and reconstruction**, questions might include:

What do you think about the changes and how are you coping with them?
Would the people in each quadrant feel differently about having to bump someone?
How are managers with each style likely to be perceived by receiving team members?
What are each style's special needs?
How can we refine the orientation of new staff to meet their special needs?
If teams need people with all styles can the grid help to guide recruiting?
Think about how the organization's executive team allocates the executive to the grid?

Some Experiences with the "So-Short" Guide

With Health Professionals

With physicians we used the exercise to gain insight on physician preferences for CME approaches.

Understanding/Planning CME:

- "**Drivers**" wanted an agenda, a plan and clear goals that they could get on with.
- "**Enthusiasts**" did most of their learning before the CME event and were frustrated by the wait and avoided lectures. They also avoided group work because others slowed them down.
- **"Analysts"** wanted the facts and figures and preferred lectures, while
- "**Harmonizers"** much preferred group and highly interactive learning.

With other physicians we have explored physician/patient relationships and patterns of adherence to medical advice.

Originally developed to help hospital staff cope with downsizing and restructuring, it was used in helping managers cope. The day before one "So Short" workshop a group of managers had been told that their units would be closed. Still, they came to the workshop and we used the framework to process the experience. One manager who described herself as a **"Driver"** had gone home and made lists of the things she needed to do when telling her staff. Her greatest fear was being unable to manage the strong emotional part of it all. Interestingly, she rated a "**Harmonizer**" as a person with whom she had the most difficulty under normal circumstances but in this situation she saw that a **"Harmonizer**" was what she needed in order to help the team with their emotions through the process. Similarly, a "**Harmonizer**" was afraid that she would not be able to stick to the scripted message when giving the news to her staff. She realized that she needed a "**Driver**" to help her staff through the process, even though she had earlier seen "**Drivers**" as the people she could least get along with.

During the downsizing, a husband and wife team who had retained separate names were put in a tricky predicament. Human Resources had unknowingly put the wife in the position of having to "bump" her husband. She, a "**Harmonize**r", was unable to act because of the depth of her feelings. Her husband, on the other hand, who described himself as an "**Enthusiast**", was optimistic about the future and ready to move on but couldn't get his wife to believe him. Surfacing their differences in personal style helped them to gain insight into their dilemma and move through it.

We have used the guide to problem solve what was considered to be racial differences on care teams, the relationships between clinical students and their supervisors, patient adherence to medical advice and patient education programs, even people with a dementing illness and their caregivers.

With Disease Support Groups

In a workshop for 120 people attending a Diabetes Association support group, participants rated themselves then their primary support person, spouse, physician and diabetes nurse. The overflow crowd prevented us from using the grid format.

Instead, people were simply asked to raise their hands if they fell into a quadrant and then whether the description fit and in what way did they see it. People gained insight and the discussion quickly flowed and was a source of both insight and laughter. When the “other person” was added the drama increased. One couple described themselves as **"harmonists"** and was quickly able to identify one reason for their frustration with their visits to the doctor. They were too concerned with pleasing him to let him think that they didn't understand a word that they were being told. One woman came to me and said that finally her husband understood why she did what she did. It had taken 45 years of marriage. Another couple, a **"driver**" and a **"harmonist"**, came to understand the difficulty they had coping with the diabetes when one just wanted to get on with it while the other wanted to talk and express their feelings.

In a workshop focusing on talking about having dementia, it became clear that responses to the possibility of having dementia were diverse but, in some respects at least, reactions could be predicted by the "So Simple" guide. **"Harmonists"** were most concerned with how the family might feel. **"Enthusiasts"** want to try any promising cure and at any price, often without telling the doctor. **"Drivers"** are frustrated with the length of the time it took to make the diagnosis and would begin to make plans, while **"Analysts** " would deny the difficulties and demand the proof more strongly than others and especially in the context of driving difficulties**.**

With a Conference on Diversity

Finally, 250 people in a conference on diversity used the guide to explore the reality that within group diversity is always much greater than between group differences.

Summary

The "So Simple" guide is hardly a replacement for other, longer, better-validated approaches to understanding individual differences but it does have a useful purpose. It fits effectively into many teaching contexts and its highly interactive and reflection supporting qualities work well with adult learners. In addition though, it often prompts quite important learning. Everyone is needed on the raft is one learning. Disagreement is often due to difference and not to wilfulness is another. Resistance to learning may be that teachers are not teaching in the way that a student prefers to learn is a third. While we are most likely to have difficulty with people who share fewer of our characteristics it is often these characteristics that we need when the going really gets tough are among the insights routinely surfaced by the exercised. Another is more profound, nothing less than the rewriting of a commandment. The golden rule needs to be rewritten was the conclusion of one student: Rather than “doing . . . as you would have done to yourself” she argued we might better “do unto others as they would have done unto themselves”. And the "So Short" guide can help you to do it.

The exercise is simple to use and simple to interpret. People can do it for themselves. Please feel free to use the exercise in your work wherever you see that it fits. And remember, it's so simple you can't make a mistake and if you do its no big deal.

Figure 1.

"So simple you can't make a mistake and if you do it's no big deal" A guide to understanding one another in all sorts of situations

Use the ratings to plot **your** place on the So Simple grid and mark it with a triangle. Then plot the **other person** you rated. The results can be insightful and amusing. Remember, we are not rating whether someone is good or bad. We need all kinds of people. We are trying to understand each other's reaction to events.

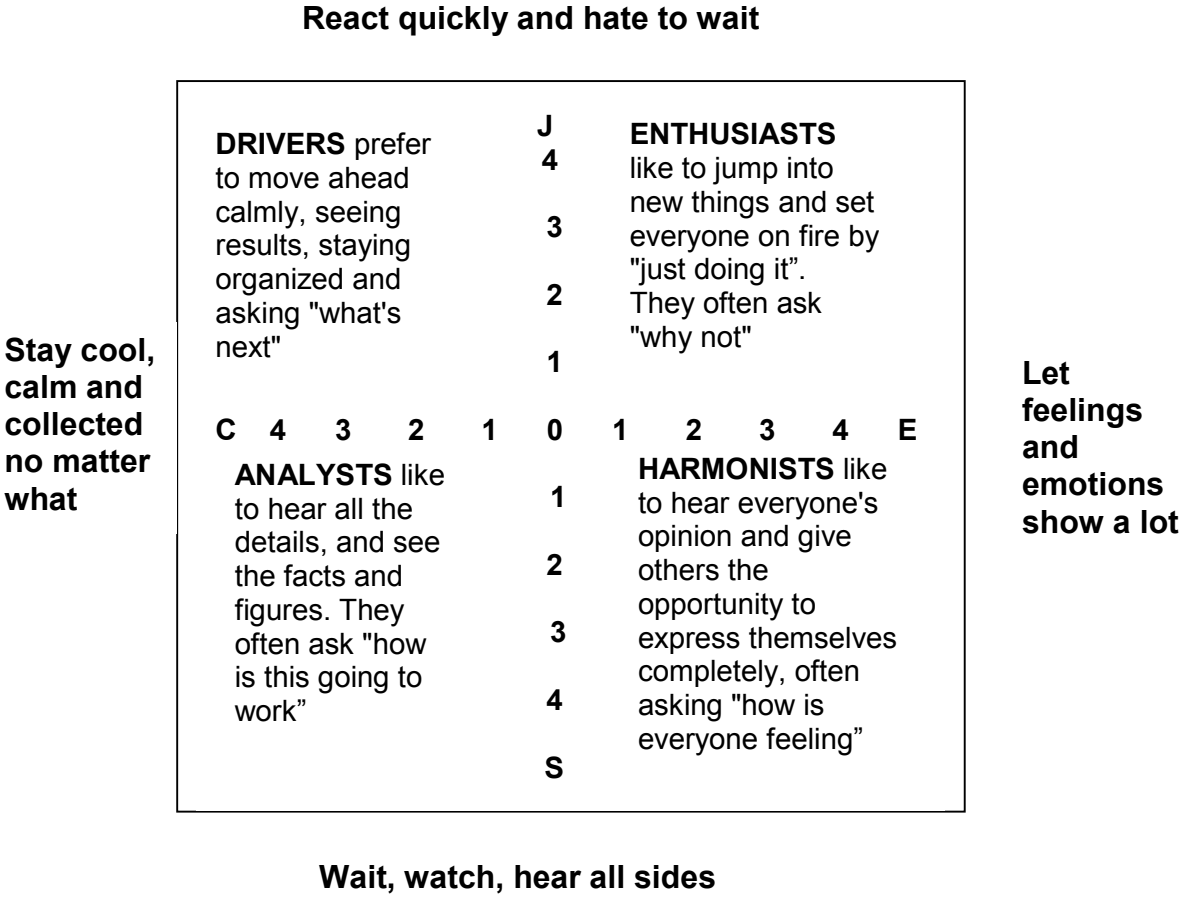
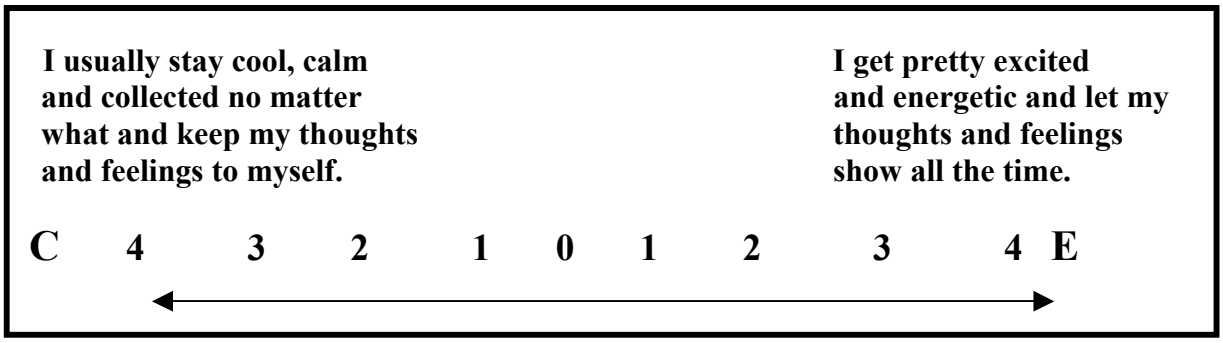


Figure 2

"So simple you can't make a mistake and if you do it's no big deal" A guide to understanding one another in all sorts of situations

Think about yourself on the following two scales. Give yourself one rating on each scale by circling a number which reflects "the way you see yourself".

Remember that in this guide there are no right or wrong ways to be, so be as open as you can and try not to sit on the fence (i.e. do not circle 0).



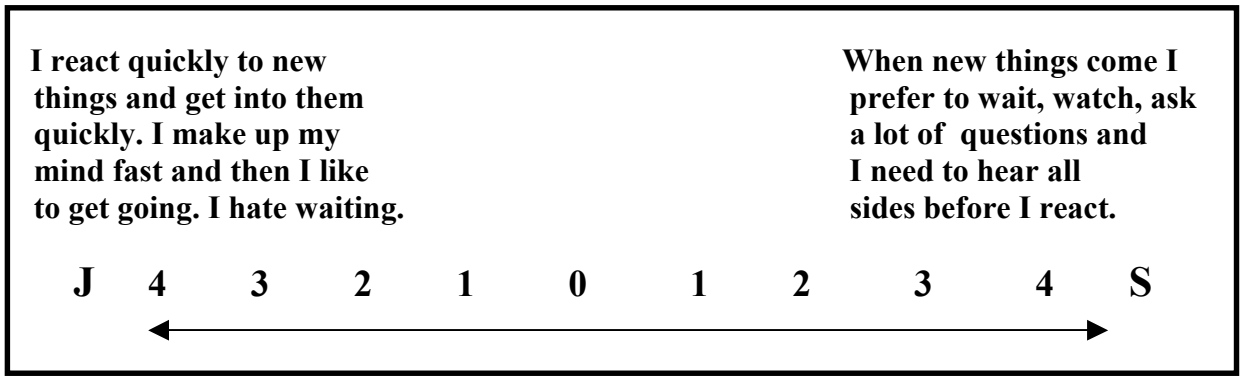
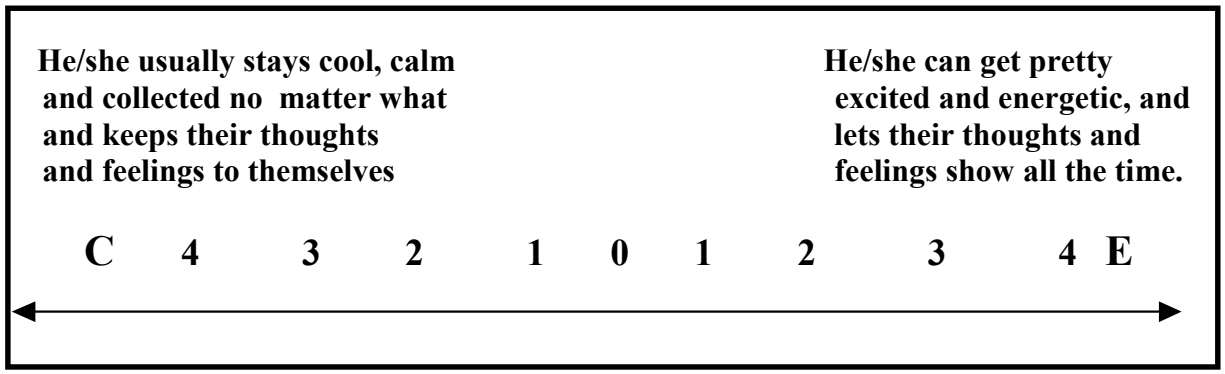


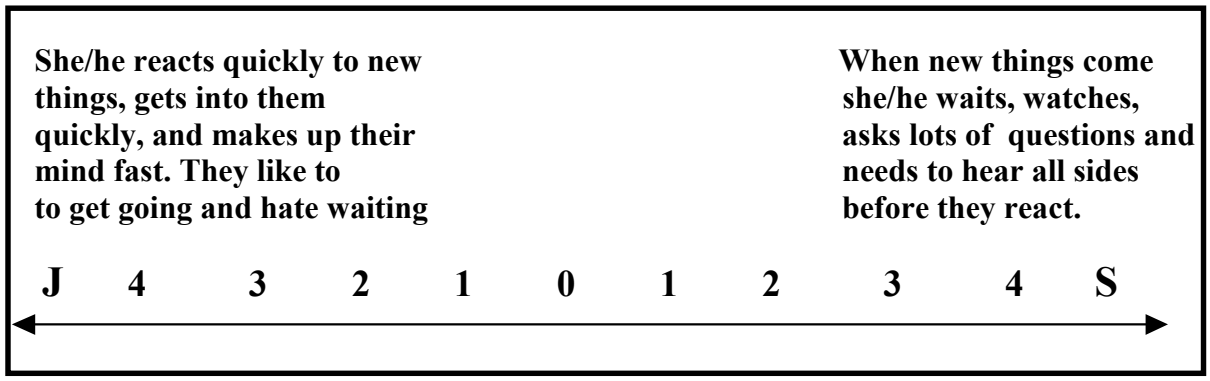
Figure 3

"So simple you can't make a mistake and if you do it's no big deal" A guide to understanding one another in all sorts of situations

Think about a (You can add whatever you like e.g. a colleague, a physician, a student, a teacher etc.) whom you found difficult to work with (teach, guide, treat, talk to etc.) and rate that person on the following two scales.

Remember that in this guide there are no right or wrong ways to be so try not to sit on the fence (i.e. do not circle 0).





Team Culture and Inter-Team Collaboration

Teams have their own characteristic individual culture – sets of norms, beliefs, values, traditions and behaviours. In general, such culture can mean teams can be divided into:

- Power focused teams
- Role focused
- Task focused
- Person focused
- Customer focused

In medicine teams may have more than one focus. For example a team may be focused on treating patients with a certain illness and yet may really value and attempt to increase its power within the institution in order to further its ability to provide excellent patient care. Power focused teams may however strive to achieve its individual members' personal agendas, satisfying their egos and the quest for power and influence within the hospital at every opportunity. In medicine, the main goal of every team should be to meet the needs of patients and families and to provide top quality patient care. To achieve this goal, the team's focus may need to shift periodically. Having more than one focus is not necessarily detrimental to the team's provision of health care as long as the improvement of patient care, or the provision of the best possible care, remains the goal.

Problems may arise when teams with different cultures must interact to meet the needs of patients and families. A team that is power focused – even if the reason for the focus on power is its striving for recognition of its importance to patient care – may find it more difficult to work with others. Multidisciplinary teams with established hierarchies may also find it difficult to work with other teams especially if both have hierarchies that have to merge in some way. Multidisciplinary team and interdisciplinary teams may also find it difficult to work together: the established hierarchy of one may seem antiquated to the one, while the lack of a constant leader may leave the other with a sense of anarchy. One team cannot force the other one to change its approach – nor should this be the expectation. These differences need to be explored, understood and respected.

TIPS FOR COLLABORATION BETWEEN TEAMS

When two medical teams come together to provide patient care, they should explore their individual processes and approaches to functioning AT THE START of their collaboration before problems develop. Differences should be explored and respected. Questions such as:

"We would deal with an issue similar to this one by … How would you approach it?"
"We always consult our Social Worker and Homecare on admission, what is your approach?"
"We would never page our attending physicians directly about an issue like this; we wait for him/her to appear. Would you page him/her?"

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Detailed Case Scenario

Barbara Bark, a 65-year-old woman with advanced metastatic breast cancer, is admitted to the hospital with uncontrolled bone pain. She was first diagnosed in 1992, had a mastectomy and underwent chemotherapy and radiation. She initially responded well and was felt to be in remission until eight months ago when she presented with back pain. Subsequent investigations revealed widespread bony metastasis and liver mets. Initially devastated by the diagnosis, Mrs. Bark decided that she was going to make the most of "the time she had left" and "enjoy life".

Mrs. Bark is widowed; her husband died five years ago of a myocardial infarction. She has four daughters – "the lights of her life" – all of whom have taken time off work, on a rotating basis initially, to care for her. Now that it is clear that she does not have much longer to live, all of the daughters have taken "sick leave" from their employment.

Both Barbara and her daughters want her to die at home. Unfortunately, four days ago she had a fall while getting out of bed to go to the bathroom and since then her back pain has been unbearable. You have increased her doses of long acting morphine; however, much to everyone's distress, she became confused and started having horrible hallucinations. She remained in significant pain to the point of having a very difficult time with turns and is unable to get to the bathroom. Even using a bedpan is difficult.

In view of her uncontrolled pain, you and her daughters decide to admit her to the hospital. In the hospital, she is switched to subcutaneous morphine. Her confusion subsequently resolved, and after a few dose adjustments, she achieved good pain control. Her pain is currently being controlled by subcutaneous injections of morphine administered through a butterfly needle every four hours with occasional q1hour breakthrough doses. Her daughters are afraid of giving her the morphine – having fears of needles themselves. Furthermore, they are worried about overdosing her or not giving her enough morphine to alleviate her pain. However, both Mrs. Bark and her daughters continue to express a desire to return home. The physicians spent time with the daughters and explained some of the basics of pain management. They asked the nurses to teach the daughters how to administer the subcutaneous injections in order for her to be discharged home in the next couple of days. The family and Mrs. Bark eagerly anticipate the discharge and start to plan a small get-together of friends and family members to celebrate.

On the day before the planned discharge, the daughters are quite upset. They tell you their mother can't leave the hospital since they have not been taught how to give the morphine. Furious at having your instructions disobeyed, you leave her room and stalk to the nursing station. Seeing her nurse there you demand to know: "Just WHY Mrs. Bark's daughters have not been taught sc injections'.

Teaching Instructions for Opinion Leaders

Directions for Opinion Leaders:

1. Distribute the case scenario. Allow participants a couple of minutes to read the information or have one of the participants read the scenario.

2. Ask participants what issues in team collaboration are raised in this case scenario and what learning issues they would identify. Write these down on a flip chart, overhead or blackboard.

3. The participants might identify a number of issues including:

   - Importance of identifying the patient's goals, values and beliefs, perception of quality of life in determining the goals of care
   - The role and responsibility of the family and loved ones in caring for a dying person
   - The importance of discussing goals and plan of treatment with the team
   - The role and responsibilities of team members in meeting the needs of patients and families when providing end-of-life care
   - Definition of a team
   - Membership on a team
   - Team formation and development – what are the stages?
   - Processes team uses to improve its function and achieve its goals
   - Challenges that arise when working on a team
   - The effect of personal and individual character, values and beliefs on ability to collaborate with others
   - Strategies to improve team collaboration to meet the needs of patients and families
   - Distinguishing palliative care from euthanasia/assisted suicide
   - Addressing concerns of euthanasia/assisted suicide when administering sedatives and narcotics at the end of life

4. Participants should move on to request more background information about Mrs. Bark's illness, values and her family.

5. Move on to ask how participants would resolve the problem of Mrs. Bark's and her daughters' desire for her to be discharged despite their lack of comfort/knowledge in administering her opioids.

TIP: An effective teaching intervention is to ask participants to divide into groups of two or three, assume the roles of the physician and nurse and role-play the collaboration and end-of-life decision-making process

Ask participants to complete the **So Simple Guide** and reflect on how their own style might affect their approach to resolving the issue arising in question five.

TIP: It may be difficult to get participants to discuss situations in which they felt uncomfortable either with their role/responsibility, the lack of recognition for their efforts or their lack of agreement with the team process or its goals. Normalizing these experiences and sharing your own personal experiences may help facilitate these discussions. Or, if you have done the So Short exercise, you might know who will be most likely to lead the conversation.

7. Ask participants to reflect on their past experiences in working as a team.

   What challenges have they faced?
   Do they need to pay more attention to process/roles?
   What situations did they find difficult? What made these situations hard? What did they do to overcome these difficulties?

8. If participants are a functioning team, or if they have worked together in the workshop to begin to work as a team, they can practice use of the **Informal Roles Checklist.**

   Are there any roles on their team that are not being fulfilled?
   How can they resolve this problem?
   Do any members engage in individual role behaviour?
   What are some of the reasons for this and how can this behaviour be changed into something productive for the team as a whole?

9. Review the take home points arising from these exercises.