Characteristics of effective teams: a literature review

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Abstract

Effective healthcare teams often elude consistent definition because of the complexity of teamwork. Systems theory offers a dynamic view of teamwork, in which input conditions are transformed via optimum throughput processes into maximal output. This article describes eighteen characteristics of effective teams across input conditions and teamwork processes, which have been identified from the literature.

Background

Research into team effectiveness has traditionally searched for characteristics of effective teams. Quantitative evaluations of specific interventions have largely been inconclusive and emphasised the need for further research (Schwartzmann 1986). The complexity of team functioning precludes reducing teams to their least number of components. Rather, a systems theory approach recognises the relationships and interdependence between and within teams. Given the importance of teamwork to delivering healthcare, a better understanding of how teams function effectively will be invaluable for educating and developing teams. This article will summarise and evaluate characteristics that create and maintain teams in healthcare environments.

Defining the context

There is broad consensus in the literature about the defining features of teams. Katzenbach and Smith (1993) stated that "... a team is a small number of people with complementary skills who are committed to a common purpose, performance goals, and approach for which they hold themselves mutually accountable" (p 45). In addition, regular communication, coordination, distinctive roles, interdependent tasks and shared norms are important features (Ducanis & Golin 1979; Brannick & Prince 1997).

Most commonly, teams are viewed as a three-stage system where they utilise resources (input), maintain internal processes (throughput) and produce specific products (output). Assuming this model, the necessary antecedent conditions (input) together with the processes (throughput) of maintaining teams define the characteristics of effective teams. Analysis of antecedent conditions and team processes often highlight issues for team development and training. In contrast, outcomes (output) are generally used to judge or evaluate team effectiveness.

The emphasis for this article is on defining the characteristics of effective teams across three different levels of organisational, team and individual function (Hackman 1990; West 1994; Brannick & Prince 1997). This tripartite analysis can be linked with the systems model of teamwork, where organisational structure and individual contributions refer to antecedent conditions (input) and team processes generally refer to throughput.

The literature abounds with empirical and anecdotal recommendations for creating effective teams. While there is broad consensus about the characteristics of effective teams, the literature will be critically evaluated for its contributions to healthcare environments. First, antecedent conditions will be described in terms of the structure of the organisational environment. Second, individual contributions to teams will be summarised as another antecedent condition. At the third level of analysis, team processes will be described in terms of their ability to maintain the functioning of the team. Table 1 offers an overview, preliminary to the following explanatory discussion.

Table 1: Characteristics of effective teamwork

Organisational structure	Individual contribution	Team processes
Clear purpose	Self knowledge	Coordination
Appropriate culture	Trust	Communication
Specified task	Commitment	Cohesion
Distinct roles	Flexibility	Decision making
Suitable leadership		Conflict management
Relevant members		Social relationships
Adequate resources		Performance feedback

Organisational structure

Many theorists offer recommendations about the structural characteristics of teamwork, by referring to relatively stable procedures of coordination and control. Seven of the most commonly described structural characteristics include a clear purpose, appropriate culture, specified task, distinct roles, suitable leadership, relevant members, and adequate resources. They will be described in turn below.

Clear purpose

Organisations are pervaded either explicitly through mission statements or by particular assumptions or behaviour. West (1994) emphasised the need for organisations to have a clear vision, which encompassed their underlying values. Mission statements communicated and synchronised these shared values across the organisation, thus engaging and motivating individuals (Beatty 1987; Headrick, Wilcock & Batalden 1998). Clear and measurable team goals could be derived from the mission statement. As team members participated in setting and prioritising goals, they better understood the task requirements and were more motivated to achieve them (Kirkman & Rosen 1999).

Goal agreement in healthcare is often achieved through a common commitment to patients' needs (Bassoff 1983; Headrick et al. 1998). Having a superordinate goal beyond professional goals motivates team members to emphasise their similarities without diluting unique professional contributions (Ivey, Brown, Teske & Silverman 1988; Loxley 1997). It follows that healthcare teams need to identify appropriate patient goals and link these with both team and professional goals, while upholding the organisation's mission (Maple 1987).

Appropriate culture

Teams should be recognised and integrated within their organisations (Pearce & Ravlin 1987). Organisations need to clearly define their expectations and mechanisms of accountability for all teams (Sundstrom, De Meuse & Futrell 1990). Organisational culture needs to transform shared values into behavioural norms (Brill 1976; Blechert, Christiansen & Kari 1987). For example, team success is fostered by a culture that incorporates shared experiences of success. In times of economic rationalism, there may be cultural conflict and inconsistency between norms of maintaining clinical standards and adhering to the healthcare organisation's mission (Firth-Cozens 1998). Team members with higher status also have less regard for team norms and may exacerbate internal conflict (Kane 1975).

Specified task

Teams require tasks that make a tangible contribution to the organisation and are consistent with the team's purpose, abilities and attitudes. Tasks need to be sufficiently motivating for team members to share responsibility and accountability for achievement (Sundstrom et al. 1990). Healthcare teams need to clearly define the specific aspect of complex and inter-related patient care which they address (Firth-Cozens 1998).

Distinct roles

Within a team, individual roles need to be clarified and understood by all. However, role construction can be influenced by personal expectations, and by organisational and interpersonal factors (Maple 1987). Therefore, roles need to be flexible enough to accommodate individual differences, personal development needs and membership changes (Blechert et al. 1987).

Ideally, individuals should be able to negotiate their roles to perform unique and meaningful tasks and team roles should be interchangeable (Brannick & Prince 1997). However, many healthcare team members are unable to choose with whom they work and professional specialisation limits the transferability of roles (Headrick et al. 1998). There is often inconsistency between a professional's role and the way others perceive it, due to differences in status, skills and social abilities (Kane 1975; Cott 1997). Although role conflict can be accentuated by different priorities between clinical and professional issues, it can be alleviated when healthcare professionals work across disciplinary boundaries in the best interests of the patient.

Suitable leadership

The more complex and dynamic the team's task, the more a leader is needed. Leadership should reflect the team's stage of development. Leaders need to maintain a strategic focus to support the organisation's vision, facilitate goal setting, educate, and evaluate achievements (Barczak 1996; Proctor-Childs, Freeman & Miller 1998). When leaders delegate responsibility appropriately, team members become more confident and autonomous in their work (Capko 1996).

Traditionally, doctors have been accorded and have assumed leadership of healthcare teams, regardless of their competence (Horwitz 1970). However, new roles for healthcare leaders are emerging that incorporate team development, in order to maintain clinical productivity and patient satisfaction (Carr 1995). Kane (1975) suggested that leadership be allocated to the team member with the most expertise, rather than being linked to professional groups.

Relevant members

Teams require the right number of members with the appropriate mix and diversity of task and interpersonal skills. A balance between homogeneity and heterogeneity of members' skills, interests and backgrounds is preferred (Hackman 1990). Homogenous teams are composed of similar individuals who complete tasks efficiently with minimal conflict. In contrast, heterogenous teams incorporate membership diversity and therefore facilitate innovation and problem solving (Pearce & Ravlin 1987). Healthcare teams are often large, due to norms of professional representation, regardless of contribution to patient care. Further, it is often unclear as to whether patients and their families are team members (Maple 1987).

Adequate resources

West (1994) emphasised that organisations need to provide teams with adequate financial resources, administrative and technical support and professional education. A safe physical environment where team members work in close proximity to each other can promote communication and cohesion (Sundstrom et al. 1990). The real costs of setting up and maintaining teamwork need to be formally recognised and sufficiently resourced (Loxley 1997).

In healthcare environments, there may be conflict between clinical responsibilities and training needs, and over issues of patient risk and privacy (Hackman 1990). Clinical care often takes precedence over professional education during economic scarcity. Healthcare professionals seldom prioritise training that is not directly related to their clinical setting, despite wanting to become skilled in teamwork (Loxley 1997).

Individual Contribution

The literature highlights different levels of individuals' experience and skills within teams. Although individual contributions are not normally considered antecedent conditions, they can be perceived as pre-requisite characteristics of effective teamwork. Establishing and managing relationships between individuals who have a variety of personalities and a range of professional and non-professional experiences is a critical component of teamwork (Brill 1976). At a minimum, individual participation in teams requires self-knowledge, trust, commitment and flexibility.

Self-knowledge

Each individual brings to the team a unique personality and position, which reciprocally affects team function (Maple 1987). Individuals need to be independent and self-aware before they can be satisfied, productive and respectful of others (Blechert et al. 1987). In healthcare environments, Horwitz (1970) described four images that each individual contributes to a team. These are a personal and professional self-image, professional expectations, an understanding of colleagues' skills and responsibilities, and a perception of colleagues' images of the individual. Of these four images, Maple (1987) suggested that the professional's self-image was the most influential in team members understanding and interacting with each other.

Trust

The ability to trust originates from self-knowledge and competence. Trust must be slowly built up across team members who have different competencies, assumptions and priorities, through developing confidence in each other's competence and reliability. Trusting individuals are willing to share their knowledge and skills without fear of being diminished or exploited. They often have an increased capacity for individual learning (Bassoff 1983). Incorporated with trust is respect for another's skills and expertise (Ivey et al. 1988; Loxley 1997). To develop respect, healthcare professionals need to discuss openly any similarities and differences in their professional values and standards. Trust develops as team members recognise and appreciate the unique skills and contributions of each other to coordinated patient care (Snyder 1981).

Commitment

Self-knowledge and an ability to trust others are the building blocks of commitment. Commitment to a unified set of team goals and values provides direction and motivation for individual members. Further, commitment is increased by and increases feelings of responsibility for and participation in the team's work (Pearce & Ravlin 1987). Goleman (1998) emphasised that committed individuals were willing to make short term personal sacrifices, believing that they could generate a greater good. In addition, high levels of commitment enabled individuals to thrive amongst challenges and pressures that may otherwise be perceived as stressful.

Healthcare teams generate commitment through a shared goal of comprehensive patient care and a common belief that the team is the best way to deliver this coordinated care (Proctor-Childs et al. 1998). Committed individuals are more willing to invest personally in the team, contribute to the decision making and respect the balance of interdependence and collaboration (Bassoff 1983).

Flexibility

Flexibility is the ability to maintain an open attitude, accommodate different personal values and be receptive to the ideas of others. Flexibility requires honesty, self-knowledge, reflection and regulation. Without understanding the diversity of personal and professional values, individuals risk judging others according to their own value systems. In healthcare teams, individuals need to accept role overlap and be supportive in assisting colleagues to meet patients' needs (Bassoff 1983). Further, professional values, identity and frames of reference often require renegotiation in response to policy and resource changes (Loxley 1997).

Team processes

Team processes describe subtle aspects of interaction and patterns of organising that transform input into output. For this article, team processes will be described in terms of seven characteristics; coordination, communication, cohesion, decision making, conflict management, social relationships and performance feedback.

Coordination

Coordination is described as the orderly interpersonal actions required to perform complex tasks (Pearce & Ravlin 1987). Teams need to harness the variety and minimise the differences of members, to ensure that expert skills and knowledge are well utilised. Throughout a team's development and evolution, its coordination needs will vary. However, a shared understanding of the team's purpose and culture facilitates coordination as team members accept the costs and recognise the benefits of teamwork (Loxley 1997).

Communication

Communication involves an observable interchange of information and subtle interactions of power, attitudes and values (Loxley 1997). Effective teams require reliable communication processes, with clearly defined responsibilities and appropriate delegation (Husting 1996). Individuals need to listen frequently to each other and collaborate in order to develop mutual knowledge, which enhances communication. Joint decision making and formal and informal interchanges can also enhance communication (Headrick et al. 1998). As a major form of communication, meetings need to have clear agendas, and be managed so that all members contribute (Loxley 1997). In addition, clear two-way communication channels across team boundaries and with the organisation ensures the relevance of the team's functioning (Firth-Cozens 1998).

Cohesion

Team cohesion acknowledges members' personal attraction to the team and the task. Members cooperate interdependently around the team's task in order to meet team goals (Pearce & Ravlin 1987). Socially, members feel as if they belong and want to remain with the team for future tasks. Cohesion can be fostered through small team sizes, similar attitudes and physical proximity. It also increases with accurate performance feedback, success in adversity, good communication and conformity to norms (Husting 1996).

Education about teamwork is strongly recommended for healthcare professionals to promote the interpersonal team processes of coordination, communication, and cohesion. Education needs to be offered consistently to all team members, to minimise the different attitudes to teamwork traditionally perpetuated through different professional models of practice (Snyder 1981; Beatty 1987; Ivey et al. 1988).

Decision making

A broad range of members' knowledge and skills usually contributes expanded information and generates more legitimate decisions. However, individual autonomy may decrease as decisions are shared and responsibility diffused to all team members (Kirkman & Rosen 1999). In addition, there are varying needs for different types of decision making processes depending on the nature of the team's purpose and its developmental stage. Democratic voting schemes reduced the decision making time and limited interpersonal conflict, at a cost of decreased participation and acceptance of the decisions made (Green & Taber 1980). In contrast, when team members were fully informed and participated in decisions, they were more committed and productive (Blechert et al. 1987).

Team decision making can be problematic in healthcare environments when doctors' opinions are rewarded very differently from those of other team members (Firth-Cozens 1998). Current medico-legal requirements also reinforce unequal responsibility for clinical decisions.

Conflict management

Team conflict can source both creativity and destruction. For teams to value creative contributions and promote effective problem solving, diversity needs careful management (Payne 1982). Destructive team conflict often has an interpersonal basis in work role or organisational factors. Conflict emerges in healthcare teams when the value and intention of other team members is perceived solely in terms of the professional's own frame of reference (Loxley 1997). Therefore, teams need mediation strategies to manage conflict and avoid its destructive interference (West 1994; Firth-Cozens 1998). In healthcare teams, professional assumptions and differences need to be openly acknowledged and negotiated around a patient focus to limit interpersonal conflict (Maple 1987).

Social relationships

Good social relationships maintain effective teams. Personally, team members who are empathic and supportive of their colleagues offer practical assistance, share information and collaboratively solve problems. Social networks within and beyond teams also enhance individuals' access to strategic information, facilitate a better understanding of team tasks and an increased belief in the team's effectiveness (Kirkman & Rosen 1999). A major risk in healthcare teams arises from caring for patients who have significant physical and emotional needs. This work is emotionally complex and taxing for all team members and needs careful management to prevent individual burnout and patient objectification (Hackman 1990).

Performance Feedback

Individuals, the team and the organisation all require accurate and timely feedback about the team's performance in order to maintain their effectiveness. Hackman (1990) recommended balancing the more traditional individual reward systems with team-based incentives that are contingent upon the whole team's performance, and emphasise co-operation rather than competition. Traditional individual feedback and reward systems in healthcare are very unequal, because of inherent status differences between professionals. Team based feedback, such as clinical audits, are an alternative method of determining team achievements (Firth-Cozens 1998).

Hierarchy of characteristic conditions

Having described eighteen characteristics of effective teams across the organisational structure, individual contributions and team processes, it is obvious that there are too many factors for most team training initiatives. Suggestions have been made about a hierarchy of factors, to identify the most potent point of intervention.

There is preliminary support for the primacy of the organisational structure. Dysfunctional teams respond better to organisational structure improvements, rather than process interventions (Hackman 1990). Similarly, Gladstein (1984) confirmed that organisational structure variables influenced team effectiveness via group processes. Appropriate team structures and processes can maximise individuals' contributions and limit the potential for interprofessional conflict (Loxley 1997).

In reality, teams are dynamic and there is often a degree of circularity between team structures and processes. Generally, appropriate team structures facilitate the development of team processes. Yet as teams evolve, team processes often shape the structures within which they function best. Therefore, there is a need to consider both team structures and processes equally when building effective teams.

Discussion

From the literature reviewed, teamwork is a complex phenomenon. Supportive organisational structures and optimal individual contributions set the scene for effective teamwork. Healthcare teams need a clear purpose that incorporates specific diagnostic groups and aspects of patient care. When teams have a clear purpose that is consistent with the organisation's mission, they can be more clearly integrated, supported and resourced. Further, strategic planning processes can clarify the alignment of multiple teams within healthcare organisations.

Leadership styles and patterns need to be explicit and appropriate to the team's developmental stage. Ideally, the team leader should be appropriately skilled and all team members need clearly delineated and necessary roles. Teams are more efficient with the minimum number of members to meet their purpose and membership should be regularly clarified in response to patient needs.

Team members must simultaneously recognise and value their contribution to the team. With sufficient self-knowledge, individuals can trust and respect the contributions of their colleagues. Regular formal and informal contact assists members to recognise their own and others' contributions to patient care. When individuals feel confident of the need for all team members, they understand the benefits of working as a team. Over time, commitment reinforces effective teamwork.

Once teams have developed clear structures, they need to maintain explicit processes through agreed and formal systems of communication and co-ordination. Consistent education and support for team building and development should be accessible for all healthcare workers. When all team members are cohesive, make decisions jointly and manage conflict, the team is more effective. Both individuals and the team need regular feedback and recognition of their progress towards the team's goals.

Finally, there is a need to build and maintain effective teams to maximise the specialist skills of healthcare professionals in meeting complex patient needs. Team development and performance can be promoted through education if there is knowledge of the most important characteristics of teamwork in healthcare settings. Patient care will ultimately be enhanced through the co-ordinated efforts of effective healthcare teams.

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