To the Graduate Council:

I am submitting herewith a dissertation written by David Michael McDonald entitled "Collective Responsibility and Health Care Teams." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Philosophy.

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COLLECTIVE RESPONSIBILITY AND HEALTH CARE TEAMS

A Dissertation

Presented for the

Doctor of Philosophy

Degree

The University of Tennessee, Knoxville

David Michael McDonald

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ABSTRACT

Society is developing a heightened awareness of the importance of treating the whole patient and is seeking a treatment mode which satisfies this need. Health care treatment teams (especially interdisciplinary) are receiving new consideration as possible solutions to this problem. The possibility of expanded team treatment raises important philosophical questions concerning collective and individual responsibility; issues of the moral relationships of teams, patients, and medical institutions. In this research the belief is defended that individual team members, and not teams, must always be held responsible for their activities in both technical and moral senses.

The primary methods for data collection included studying current literature of philosophy, medicine, sociology, and psychology. I also obtained recent medical codes of ethics for assessment. Many of the facts and observations in this study were drawn from personal clinical experiences.

To answer the thesis question required that other issues related to health care teams first be studied. These included defining "health care team," considering whether the concept of team practice has been accepted by the medical community, studying how medical education fosters student attitudes toward team treatment, providing a basic symbology to explore different types of team structures and functions, and reflecting on basic philosophical issues underlying problems of collective responsibility and health teams.

One chapter considered Thomas Kuhn's ideas of paradigms and incommensurability applied to health teams to present reasons for the inability of members to understand the limits of personal responsibility. One chapter examines whether current medical codes of ethics fail to address issues of interdisciplinary cooperation for health teams.

Current findings suggest that whether treatment teams can be cost effective or superior to traditional treatment forms is unknown, that responsibility attribution for teams is relative to each one's functional structure, that current research data is lacking to help medical workers and students understand why answers to questions about team responsibility are so vague, that no member of a treatment team can claim to be an expert decision-maker during moral dilemmas, and that medical bureaucracies foster ways for individuals to avoid personal responsibility in teams.

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INTRODUCTION

As a graduate student at The University of Tennessee, Knoxville I attended a class on Advanced Topics in Medical Ethics taught by Professors Glenn Graber and David Thomasma. During that time I received my inspiration for this research after reading A Philosophical Basis of Medical Practice written by E. D. Pellegrino and David Thomasma. One of the most captivating sentences stated "that no fully developed ethical theory exists to define the obligations of a group of individuals (a team) making decisions that effect the well-being of the patient."[1] With this idea I began to write my dissertation.

This same book presented another idea which I used in this study: that professional medical codes of ethics say little or nothing about the responsibilities, duties, and obligations of workers in health teams to work cooperatively and promote the patient's welfare.

With these two primary ideas in mind, I decided to accept the task of researching treatment teams from both a philosophical and sociological perspective in order to study team responsibility. This led to questions such as What is a team?, What are the diverse types of teams?, What are the values and disvalues of team treatment?, How have teams dealt with responsibility in the past?, and How are they

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[1] E. D. Pellegrino and D. C. Thomasma, A Philosophical Basis of Medical Practice (New York: Oxford University Press, 1981), p. 10.

dealing with it at present? Answers to these and many other questions led to the belief that individual team members must ultimately be responsible for decisions in both technical matters of skill application as well as in decision-making when moral dilemmas arise during team interactions.

There has been a trend appearing in philosophical, psychological, and sociological literature which exempts individuals from responsibility when they act within a group or team. In this study I attempt to point the finger of responsibility back to individuals by suggesting that ideas such as group agency are fallacious when not grounded in the concrete activities of individuals within groups.

The primary emphases of this study are two-fold: to undercut concepts of group agency while refocusing on individuals as responsible agents, and to develop a decision-making methodology for treatment teams which expresses a modern and, I believe, workable approach for treatment teams on issues of collective responsibility.

Chapter I presents reasons for the modern appeal of health care teams, and attempts to put them in perspective concerning the psychological needs of society. Also, health care teams are defined and contrasted with other collectivities.

Chapter II discusses reasons for a renewed enthusiasm among health care professionals concerning the reexamination and utilization of the concept of team practice. It also includes criticisms from, and appraisals by, sceptics on the usefulness of such teams. This

chapter closes with considerations about why research on treatment teams is progressing slowly and suggests ways to increase such research.

Chapter III considers how education processes for medical students shape their conceptual frameworks and how such processes determine whether students are adequately prepared to be efficient members of health care teams. Also included is a brief discussion of several past and present interdisciplinary education and treatment projects which are reflective of cooperative treatment about whether modern medical codes of ethics do or do not reflect the new trend toward cooperative efforts among treatment team members—and especially for interdisciplinary teams. Finally, a model code for interdisciplinary health care teams is suggested, parts of which could easily be altered and incorporated into existing codes.

Chapter IV has a dual focus: that of analyzing the sociological relationships of health care teams to society and medical institutions and of examining the different types of treatment teams. This latter task is accomplished through the creation of a new symbology. In this chapter I lay the foundation for understanding how the differing team structures determine how collective responsibility is understood in medical settings.

Chapter V examines important theoretical issues which lie at the root of understanding responsibility in collectivities of any type. Such issues as particular-universal and whole-part dilemmas will be discussed and considered in terms of treatment teams. Also

included is a section on how such problems are carried over into modern discussions of these same issues by methodological individualists and methodological holists.

Chapter VI first examines different types of individual and collective responsibility from both theoretical and historical standpoints. Second, Alfred North Whitehead's famous Fallacy of Misplaced Concreteness will be presented for its usefulness when considering theories which suggest that groups are moral agents. Third, extensive reasons are presented why treatment teams cannot be considered moral agents. Fourth, I consider how the power structures of medical settings continually place health care workers in decision-making dilemmas and how such dilemmas affect the functions of treatment teams.

Chapter VII discusses Thomas Kuhn's concept of paradigm shifts which he outlines in The Structure of Scientific Revolutions, and it will explain how these can be useful for understanding how health teams function in terms of the conceptual frameworks and assumptions of each team member. In addition, the implications of paradigm differences in relationship to personal and team responsibility will be discussed.

Chapter VIII is an attempt to summarize the previous chapters, suggest limitations of the project, and explore its possible practical applications.

It is my hope that the reader will find the study informative and will have a better understanding of issues of collective responsibility and treatment teams after being exposed to this material.

CHAPTER I

THE PHENOMENON OF HEALTH CARE TEAMS

Health Care Teams as a Social Phenomenon

The twentieth century is unique due to its rapid evolution of technology which has spurred an accompanying set of ethical dilemmas in medicine. Every day such dilemmas are evident in health care settings as patients voluntarily place their trust in medical professionals, leaving themselves physically and psychologically vulnerable. Such vulnerability is often a necessary part of treatment, for patients often lack the expertise to diagnose and prescribe care, and therefore they place their trust in experts. In such relationships, physicians have traditionally been the principal helpers, with their powers being vested in them by society. History reveals, however, that other auxiliary helpers, particularly nurses, have had primary responsibility for patient care and contact before and after physicians have made diagnoses. The idealistic and somewhat mythical belief that physicians alone have the ability to guide patients back to health dies slowly, and it is still evident in most health care settings. Not only do most patients continue to place the primary decision-making power in physicians, but many physicians are unwilling to relinquish this assigned role or part of it to other medical workers. Physicians thus feel threatened as other health care workers assume some of their traditional professional activities.

Changing roles within the medical community are reflecting part of the evolution of medicine as a whole. As roles change, so do the methods, styles and forms of communication among medical personnel.

Not only are the roles of professional health care workers changing, but patients are taking a more active role in their own treatment. There is a new concern in modern life about the unquestioned acceptance of medical decisions. More patients are taking time to acquire knowledge about their own health care through reading and preventive medical education programs; and they are coming into medical settings better prepared with questions, information, and thoughts. This is considerably different from an old image of passively accepting patients with little concern or personal initiative for their own health care. Patients are now showing a strong desire to participate in their own care by relying less on professional medical advice. It would be presumptuous, however, to assume that a majority of the population fits this descritpion of the self-helping patient; but it is safe to assume that the modern emphasis on preventive medicine is a reaction both to past forms of health care and rising costs.

Such reactions by patients have met with counter-reactions from the medical community. With the new wave of preventive medicine has also come continuing criticisms from medical personnel that patients regularly fail to follow health care advice. As a result, health workers are sceptical concerning patients' abilities to act responsibly by following treatment programs and practice preventive health care.

Such criticisms are supported by patients who do not listen to and follow medical advice such as: stop smoking, get more exercise, stop drinking, take this medicine, etc.

Another reason that medical workers are sceptical about patients' abilities to help themselves in health matters is that patients regularly relate to the professional helper with a fix-it mentality. By this I mean that many patients treat their bodies like their automobiles and only bring them in for repair when they break down. Thus, the automobile repairman, like the physician, becomes a crisis worker only and is expected to "fix" anything we break—no matter how we broke it. This patient attitude vexes medical personnel, for even with their greatest educational efforts patients often ignore advice and abuse their bodies. Such scenarios have justifiably led to medical scepticism about patients' abilities at self help.

The aforementioned tensions between patients and medical professionals have created ongoing problems. Because ours is a society which attempts to promote maximal personal freedom concerning how individuals handle their own health care, a majority of the public believes that individuals have a right to care for or destroy their own bodies as they choose. Such beliefs get expressed in the interactions of patients and medical personnel. On the one hand most citizens would agree with John Stuart Mill that

> each is the proper guardian of his own health, whether bodily or mental and spiritual. Mankind are better gainers by

> suffering each other to live as seems good to themselves than by compelling each to live as seems good to the rest.[1]

This is one passage from On Liberty. In it Mill attempts to emphasize the importance of absolute freedom of individual consciousness, tastes, and pursuits, plus the need to allow each person to form his or her life's plans without hindrance from others—unless he acts in ways harmful to others. In spite of Mill's consistent emphasis on individual autonomy, in a later passage he states that "it is impossible for a person to do anything seriously or permanently hurtful to himself without mischief reaching at least to their connections, and often far beyond."[2] Here he is suggesting that all persons live within a complex web of social relationships and that damage to any one member presents a strong possibility for directly harming others physically or psychologically.

The two quotations above exemplify the dilemma of modern health practitioners and of health care teams when treating patients. On the one hand, patients are viewed as free agents to harm or heal themselves as they please. On the other hand, patients are expected to be responsible social beings because their actions affect others as well as themselves. Medical personnel regularly see patients who are continual abusers of themselves and others, which places such personnel in psychological dilemmas concerning care and treatment of

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[1] John Stuart Mill, On Liberty (New York: The Bobbs-Merrill Company, Inc., 1956), p. 17.

[2] Ibid., p. 97.

such patients. Medical workers have been trained to feel obligated to uphold the ideals of professional medical practice by attempting to help all ill or injured persons. At the same time, they are frustrated by having to treat persons who do not respect their bodies and take few measures to help themselves. Even with the modern emphasis on preventive medicine, the excessive numbers of public health abusers places a sceptical cloud over the public's abilities in general to help themselves—in the opinions of most medical personnel. Thus, the continuing tensions between freedom in a democratic society versus respect and abuse of such freedom is daily enacted within medical setting in various ways. These tensions affect not only the common dyadic patient-physician relations but also the ways health care teams relate to patients. The problems do not dissolve just because a team of individuals treats a patient, but some patients and health care workers continue to believe that the advantages of team treatment will outweigh disadvantages.

Another important social change which has fostered the advance of health care teams in medicine concerns the increase in specialization. Many patients have had the experience of being referred to several medical specialists for diagnosis and treatment and recognize the frustrations of cost, uncertainty about coordination of information, and the unanswered questions about the necessity of multiple specialists. Because of society's general increase in medical information and technology, such specialization has been understood as requisite for the availability of the best and latest information on

medical topics. In fact, specialization is based in part on the assumption that no one individual can possibly keep up with the burgeoning information base in medicine. Hence, there are hundreds of medical specialties.

With this increased emphasis on specialization has come a new type of patient dissatisfaction. Many patients continue to want the personalization of a dyadic relationship with a health worker while at the same time seek a more holistic approach to health care.[3-5] Patients are also tired of shuffling among medical specialists. Consequently, they desire more unified and localized health care units. These needs express both psychological as well as practical reasons for changes in the current medical system.

One possible psychological reason why persons are today seeking a more unified health care mode concerns what has been called the "modern value crisis." Because we live in a pluralistic society, persons' beliefs are regularly being challenged; and they must continually integrate, reject, and revise values in order to create a psychological pattern they can live with as they meet daily social needs. They must continually seek unity or wholeness amidst change

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[3]Susan McKay, "Wholistic Health Care: Challenge to Health Providers," Journal of Allied Health 9 (August 1980):194-201.

[4]Rebecca Bergman, "Understanding the Patient in All His Needs," Journal of Advanced Nursing 8 (1983):185-190.

[5]Kevin M. Sherin, "Toward an Added Dimension of Medical Practice," Postgraduate Medicine 73 (April 1983):73-74.

and insecurity. Such seeking is not isolated but affects every part of life, including medicine. With the advent of new knowledge, increased specialization, and the modern thrust on self-care, persons have been given the basic foundation for expecting such emphases to be reflected in the way they are treated by medical personnel. This means that patients are expecting medical care to address more of their social and psychological needs as well as their physical problems. Whether this is asking too much of medicine is a topic of continual debate, but even medicine recognizes the complexity of the human organism and admits the close relatedness of other aspects of patients' lives to their physical well-being. Hence, most medical institutions now employ social workers, psychologists, chaplains, nutritionists, and many other auxiliary employees to address particular patient needs beside just those requiring physical diagnosis and treatment.

Many medical institutions have experimented with various associations of medical and nonmedical personnel in an attempt to meet society's demand for a more holistic treatment approach. Such associations have traditionally been called "health care teams." Although teams of medical personnel have worked together for hundreds of years, never have so many different specialties, each with a large body of diverse information, been brought together to treat patients. This is a phenomenon arising out of twentieth-century medical, technological, and social progressions.

As such teams have formed, new problems accompany the interrelations of the personnel. As stated earlier, roles are changing in medicine, and this has had a profound effect on the way medical personnel relate. Furthermore, specialization has fostered a type of territorialism among specialists who feel that intrusions by others into their particular domains is forbidden, or is at least to be discouraged. Another problem for teams is the solving of moral dilemmas which accompany the interactions of specialists, patients and modern technology.

This study will address (in later chapters) issues related to decision-making in health care teams, especially interdisciplinary teams, and will suggest that decision-making processes on moral matters must be updated. By this I mean that decision-making processes for health teams cannot proceed with efficiency unless they too are changed to meet alterations within medical institutions concerning roles and technological advances. As teams are formed to treat patients a tremendous body of potential information becomes available for diagnosis. The very fact that many persons treat a patient changes the interrelations of patient to medical personnel. No longer is there one physician and one patient, but a new patient-team relationship develops. In the past one physicial was solely responsible for a patient's treatment, but during team treatment this hardly seems correct. Typically, however, treatment teams continue to function in a dyadic manner with multiple personnel. The physician is still deemed ultimately responsible for patient care, and he or

she is understood as the primary decision-maker. But this does not seem correct in an interdisciplinary team where each member has a particular body of knowledge not available to other team members which can be brought to bear on patient treatment. But if a technical or moral error occurs during a team treatment function, which was not the fault of the physician but of another member, the physician still gets the primary blame. It would seem more just for health care teams if the individual making the error is blamed and takes full responsibility for the action himself instead of blaming the leader, who is usually the physician. This suggests that the concepts of blame and praise for treatment teams must be changed to reflect the changed character of the relationships of patients and teams. Serious questions must be asked about how teams relate to patients, especially on moral matters. When a technical or moral error occurs, who should patients blame when a team has been treating them? Should they blame the whole team, or only one member?

If the very idea of a team treatment effort suggests that members work cooperatively together, does this imply shared blame for the results of group decision-making? Answers to such questions concerning technical expertise may seem obvious, but when matters of moral concern arise during team operations, solutions to decision-making processes involving responsibility are unclear. In Chapters VI through VIII I suggest that our understanding of decision-making for teams during moral crises needs to be updated to reflect changes in

team treatment and that the present decision-making processes are inadequate for such matters.

In this chapter I have considered several of the ongoing problems facing medical personnel as they attempt to meet public demands for more holistic forms of treatment. I also suggested that changes such as altering medical roles, technological developments, and medical specializations have, by necessity, required that treatment teams change in the way they handle decision-making, especially concerning moral dilemmas.

To this point I have not defined "treatment team" but have left the reader to surmise what is meant. In the next section I address this issue and develop a personal definition of treatment team.

Defining the Health Care Team

Before embarking on other discussions about treatment terms it is essential to define how the word "team" will be used throughout this study. In this section the term "team" will be discussed in relation to, and compared with, other commonly used words denoting collectives such as "mob, aggregate, crowd," and "group." It is a common error for these words to be considered synonymous, but distinctions must be made among them for conceptual clarity.

In the last part of this section I present several current definitions for health care teams as well as a stipulative definition which will be used in this research.

Group. According to Webster's New Twentieth Century Dictionary, a group is "a close gathering together of objects or persons to form a recognizable unit; cluster, aggregation,"[6] or may mean persons classified together due to a number of common characteristics or community of interests.[7] Scholars should be cautious of dictionary definitions because they tend to attempt to capture, in broad and vague terms, every possible meaning for them. Hence, they often fail to make important distinctions and are usually too vague for analytic purposes. It is usually best to seek scholarly sources for these distinctions.

Typically groups are defined in terms of numbers of persons in relations of varying types. John DeLamater suggests that it is possible to develop a comprehensive definition of group:

> A comprehensive definition of "group" can be formulated in terms of the following properties: interaction between individuals, perceptions of other members and the development of shared perceptions, and development of affective ties, and the development of interdependence of roles.[8]

This definition is functional because "group" is being defined in terms of what it does. Some authors believe that this is the only viable way to define groups because of extreme variations among group types. This idea is expressed by Weigert when he states that "a

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[6]Noah Webster, Webster's New Twentieth Century Dictionary of the English Language, 2nd ed., revised by the staff under the supervision of Jean L. McKechnie (United States of America: William Collins + Word Publishing, Inc., 1978), p. 805.

[7]Ibid., p. 805.

[8]J. DeLamater, "A Definition of 'Group,'" Small Group Behavior, 5(1) (1974):39.

group is a new and irreducible social reality; to use a traditional term it is an 'emergent reality' that cannot be exhaustively understood merely by scrutinizing its parts."[9] Such functional ideas do not, however, fix the parameters of groups to particular sizes; and they tend to see groups as highly variable in their activities as well as numbers of participants. Hollander suggests that groups may be subcultures or categories that describe members of society in multitudes of possible face-to-face interactions directed at common goals.[10]

Not all have shared in these views, with some authors denying that groups even exist. Allport believes that "groups only exist in the minds of people; they are no more than shared sets of value ideas, thoughts, and habits that existed simultaneously in the heads of several persons."[11] In making such a statement he is heading into old issues of the relationships of ideas to objective realities. I do accept his belief that groups are ideas in minds, but this does not seem to be the only way concepts can be interpreted. They also refer to external realities. When Allport suggests that "groups" are shared sets of values he is stating the basis for definitions of

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[9]Andrew J. Weigert, Social Psychology, A Sociological Approach Through Interpretive Understanding (Indiana: Notre Dame Press, 1983), p. 29.

[10]Edwin P. Hollander, Principles and Methods of Social Psychology, 3rd ed. (New York: Oxford University Press, 1976), p. 376.

[11]Floyd H. Allport, Social Psychology (Massachusetts: Riverside Press, 1924), p. 553.

group types. Hence, groups are typically defined functionally, normatively, statistically, and psychologically, but these attempts are suggested in the search for standardization. Standard definitions evoke ideas and present values, but they are descriptions of objective activities of human beings in particular relationships. Hence, Allport's negative idea that groups are merely mental is weak and will be addressed in a later chapter. For my purposes, it will be assumed that groups do in fact exist in the world, and that definitions and research are attempts to specify the status of these realities.

It is interesting that both DeLamater and Allport seem to agree that groups are defined in part with psychological criteria.. But such criteria alone seem inadequate. Typically theorists seek the number of persons necessary for a group to exist. Such searches often end in frustration because of the diversity of group types. However, a considerable body of professional literature usually draws the lower limit of groups as "two or more individuals."[12] The upper limit for discerning when a group becomes another type of collectivity, such as a crowd, has never been adequately standardized.

Aggregates. Groups are also typically characterized by some common goal or goals of associated persons which help distinguish them from other types of collectivities such as aggregates.

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[12]Benjamin B. Wolman, ed., Dictionary of Behavioral Science (New York: Van Nostrand Reinhold Co., 1973), p. 163.

Researchers who study groups regularly do statistical studies with them while considering given-sized sample of individuals from some population with particular characteristics. But such groups are considered aggregates when psychological properties that are resultant of personal interactions are disregarded.[13] To be an aggregate, then, is to have a number of persons in close proximity with one another but who lack goals for orientation. The Dictionary of Behavioral Sciences defines an aggregate as "a mass of distinct units; a group of objects, thoughts, persons, etc., that are brought together but remain separate entities."[14] In this way an aggregate can be a group if it is understood that what is being signified is merely objects of persons together.

Aggregates of persons do not have common goals, but they can be created by situations. If an aggregate forms on an elevator or at a bus station, this togetherness should not be called a goal because it is not verbally or consciously shared. Such sharing was deemed essential for groups in earlier definitions. The Encyclopedia of Psychology suggests that relationships between people riding a bus or on an elevator are intermittent and accidental with no observable or persistent goals available.[15] It seems important to make the

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[13]David L. Sills, International Encyclopedia of Social Sciences, Vol. 6 (New York: The Free Press, 1968), p. 27.

[14]Wolman, Dictionary of Behavioral Sciences, p. 15.

[15]H. J. Eysenck, W. Arnold, and R. Meili, Encyclopedia of Psychology (New York: The Continuum Publishing Company, 1982), p. 30.

distinctions between accidental purpose for aggregates and verbally shared and planned goals for groups.

Crowd. Another type of collectivity of persons is called a crowd. It is distinguished from groups or aggregates by a number of formal characteristics which are said to account for its unique psychological character. Crowds are not organized groups even if some organization initiated the crowd formation. Also, a crowd is a temporary structure in distinction from a group which may meet repeatedly with the same personnel in an organized fashion. As a changeling, crowds are continuously in process, and it is difficult to note stability in numbers and activities. Lastly, crowds must have enough people to exhibit the forementioned characteristics. Concerning the necessary number of persons for crowds to exist, Kurt and Gladys Lang believe that three does not make a crowd.[16]

Team. The word "team" has been used to suggest "a number of persons associated in some joint action."[17] "Teamwork" is also described as

> a special form of direct cooperation where every member of the group is a specialist but has constantly to rely on coordination and communication with the others, and where success cannot be achieved by anyone alone.[18]

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[16]Kurt Lang and Gladys Lang, Collective Dynamics (New York: Thomas Y. Crowell Company, 1961), p. 112.

[17]William Little, H. W. Fowler, and Jessie Goulson, Shorter Oxford English Dictionary, 3rd ed. (England: Oxford at Clarendon Press, 1973), p.

[18]Eysenck, Arnold, Meili, Encyclopedia of Psychology, p. 1090.

It is not uncommon for the terms "team" and "group" to be used synonymously since both imply that the collectivities have goals and that members work cooperatively to achieve them. This suggests that discussions about groups or team activities regularly utilize a cluster of words and descriptive concepts which are the same. In this study both words will be used synonymously.

But if such a close identification is made between the concept "team" and "group," is there any difference in the numerical constitution of both? As stated earlier this debate will be avoided here, but I tend to agree with a statement made in the Encyclopedic Dictionary of Psychology; that "there is a vague boundary between a group and larger social entities such as mobs, crowds, masses, and collectivities . . ."[19]

Traditional definition. In order to arrive at a useful and meaningful definition of "team" for this study it is helpful to understand how other scholars have defined "team." As will become clear, definitions and uses of the term are as ambiguous as "group," but several common characteristics are usually stated.

Davis suggests that a team is "any organizational element whose members have a common supervisor."[20] This definition seems inadequate, for it suggests the possibility that the United States Government is

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[19]Rom Harre and Roger Lamb, eds., The Encyclopedic Dictionary of Psychology (Massachusetts: MIT Press, 1983), p. 259.

[20]A. Davis, "Building More Effective Teams," Innovation 15 (1970):52.

a team. It could be argued that the President is the supervisor of the government just as a coach directs a basketball team. If a government is an authoritative system with a leader, then why do we not usually call it a team? Part of this problem with Davis's definition is that it is too broad and does not state more specific qualities of teams.

Robin, Plovnik, and Fry suggest another definition of "team" that considers group activities as significant:

> If the basic job or mission requires that you and others must work together and coordinate your activities with each other, then you are a "team," even though you may not formally call yourselves a team.[21]

This definition is again nonspecific and broad. Their criteria of coordination can easily be questioned. For example, if one author is working cooperatively with two others to produce a textbook but each lives in a different city, we might hesitate to call them a team. Clearly they coordinate their activities by mail and over the phone, but usually when one thinks of team close proximity of the members is an important consideration. This tighter sense is the one I choose to use in this study; it places special emphasis on face-to-face interactions of the members on a regular basis. What constitutes a regular basis of interaction is debatable; but when considering health care teams, daily interaction is usually a standard criterion for "team."

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[21] I. M. Robin, M. E. Plovnick, and R. E. Fry, "Improving the Coordination of Care, A Program for Health Development" (Massachusetts: Ballinger Publishing Co., 1976).

Although the preceding definitions of "team" were inadequate, the following one by Bloom and Parad is better:

> A team is a group of people each of whom possesses particular expertise; each of whom is responsible for making individual decision; who together hold a common purpose; who meet together to communicate, collaborate, and consolidate knowledge from which plans are made, actions determined, and future decisions influenced.[22]

Although this definition is still expansive, it provides more precise parameters for determining the characteristics and activities of a team. This definition is clearly functional in intent. Positive points presented by it are individual responsibility and decision-making, collaboration, and communication of expertise.

In later chapters interdisciplinary health care teams are discussed, and therefore it is important to understand how they are commonly defined. Luszki defines an interdisciplinary team as

> a group of persons who are trained in the uses of different tools and concepts, among whom there is an organized division of labor around a common problem with each member using his own tools, with continuous intercommunication and re-examination of postulates in terms of the limitations provided by the activities of the other members and often with group responsibility for the final product.[23]

Actually, this definition of a team differs little from the previous one except that it places more emphasis on the division of labor and the idea of taking responsibility for group activities.

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[22]B. L. Bloom and H. J. Parad, "Interdisciplinary Training and Interdisciplinary Functioning. A Survey of Attitudes and Practices in Community Mental Health," American Journal of Orthopsychiatry 46(4) (Oct. 1976):669.

[23]Margaret Luszki, Interdisciplinary Team Research Methods and Problems (New York: National Training Laboratories, 1958).

In light of the previously mentioned definitions of "team," a list of common descriptive characteristics and activities distinguish teams from other types of collectivities. Teams members usually (1) cooperate to accomplish some single result, (2) have members whose functions are specialized to assist others in obtaining a specific result, (3) meet regularly to communicate, pool knowledge, and make plans of action, (4) take action to obtain a goal, and (5) have some method of praising and sanctioning members' activities.

The definition of team to be used in this study will include these five criteria. Because my interests are specifically in health care teams. I add a sixth qualification. A health care team must care for a common group of patients. These qualifications are those which I consider to be essential for any health care team to exist. It is my belief, however, that good health care teams should include an additional three normative criteria. They must:

1. meet when possible to practice interaction and communication skills,
2. keep current on professional trends and thoughts regarding the general operations of treatment teams, and
3. be involved in the creation of the form of the team's organization in order to determine how it will function, especially in terms of responsibility attribution.

These criteria are controversial, for some medical personnel see no need to practice communication skills, suggesting that on-the-job training excludes any benefits from such activities. This

negative belief, however, is antithetical to an idea of personal progress because it suggests that one does not need formal training in communication skills beyond daily work experiences. I suggest that this is false, for the rapidly changing face of medicine which affects the operations of teams in hospitals makes continuing education desirable. Such education needs to include new methods and ideas concerning the way hospital personnel communicate, which is vital for fully operational treatment teams. Not only will improved communication skills assist medical personnel, but patients will benefit as a result of improved interactional skills.

The second criterion suggests that team members should keep current on new discoveries and trends regarding how other teams function in order to evaluate, utilize, or reject such information in relationship to their own teams. This of course implies that medical personnel have an interest in such topics, have some time to pursue them, and are encouraged to do so by the institution. Unfortunately, this does not always occur. A typical complaint of medical staffs is that there is not enough time to perform daily required tasks, let alone add new ones. This is an organization problem of many medical institutions today, but such institutions need to seriously consider continuing education mentioned in the first and second criteria above as vital to the growth of staff members and operational efficiency of the institution.

The third criterion suggests that teams are composed of personnel who should have some input concerning the type of

decision-making structure the team chooses to follow. This means that different types of health care teams require differing structures for functional efficiency. It is usually the case, however, that team members are told how the team will function by a superior and have no option concerning their participation if they desire to work. It does not seem unreasonable, however, given the mass of available current information about group functioning, that each team member should participate in its formation. Such participation could instill a sense of belonging. Those choosing a particular structure must abide by its operational methods, but these would include facts about how praise and blame will function in relationship to the team's activities. More will be said about this subject in a later chapter.

In this chapter I have suggested several qualities and activities which teams must possess in order to function efficiently. Furthermore, teams have been contrasted and compared to several other types of collectivities in order to show how treatment teams are considered unique in the way they operate and in their activities. Not all scholars believe that the concept of a treatment team suggested in this study is viable for treatment purposes. This is the topic to be addressed in the next chapter.

CHAPTER II

AN EVALUATION OF THE CRITICISMS OF HEALTH CARE TEAMS

Many persons believe that treatment teams are an accepted form of patient care for a majority of the medical community, and that few questions need to be raised about their efficacy. These ideas are unfounded, however, and many functional, theoretical, definitional, and philosophical questions are being raised in a considerable body of professional publications which question the value of medical treatment teams.

Brian Henderson asserts that "anyone who reads medical or allied health publications must assume that the health care delivery team exists. After all, it is mentioned so frequently. The plain truth is that it doesn't. It never did."[1] Similarly, Rae-Grant and Marcuse believe that the treatment team concept "holds a sacred position in American Mythology, somewhat uncomfortably situated alongside rugged individualism."[2]

Henderson explains that the idea of health care teams is supported by the medical community because they signify a search for unity in a disunified society, and help to bolster the medical

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[1]Brian Henderson, "The Health Care Delivery Team: A Plan That Needs A Push," Canadian Medical Association Journal 124 (1981):83.

[2]Q. A. F. Grant and D. J. Marcuse, "The Hazards of Teamwork," American Journal of Orthopsychiatry 38 (January 1968):4.

profession's image. In actuality, he suggests, health care teams are not unified associations of medical personnel interested in treating patients, but are "fragmented agglomerations of health care professions."[3] His primary point is that the image and ideal of health teams does not fit the reality of modern medical practice. Also, it is a condemnation of the abilities of health workers to become a unified body for treating patients. If he expects a health care team to be made of perfect individuals who have no personal and often selfish concerns, such as power, money acquisition, or status, then he is correct—no such teams exist. If, however, a collection of health workers cooperate, and attempt to meet the qualifications for team members set down in the last chapter, then they are a team even if they fall considerably short of the ideal. The term "treatment team" implies the notion of struggle and imperfection as well as some concept of the ideally functioning team. The fact that treatment teams fail in their attempts to function efficiently, or at all, is not necessarily a condemnation of the possibility of successful treatment teams, but condemns the system of health care itself. One reason why treatment teams fail is that persons in them have no skills for inter- or intradisciplinary communication. Another reason is that a typical medical curriculum for many health professionals includes little, or no training about how to utilize the health care skills of workers in other disciplines.

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[3]Brian Henderson, "The Health Care Delivery Team: A Plan That Needs A Push," Canadian Medical Association Journal 124 (1981):83.

Henderson's criticisms seem quite premature in light of the lack of research data, professional studies, and institutional experiments using team treatment methods.

A Definitional Criticism

In the last chapter the term "team" was criticized for its ambiguity, and even considered worthless. It is true that definitional clarification is needed, but to call it worthless is unjustified. Consider the fact that many other terms are regularly employed by professionals and nonprofessionals alike that lack clarity, but they are not considered useless. Several of these are "autonomy," "medicine," "health," "normalcy," "rights," "pleasure," "pain," "happiness," and "virtue." The supposed vagueness of these does not suggest abandonment, but clarification through research, and agreement about how to use them in different contexts.

Philosophical Considerations

Rosalie A. Kane points out that one of the hidden assumptions of treatment teams is that the democratic ideal is the best model to follow for cooperative efforts among members, and that each member is one among a community of equals.[4] These ideals suggest that each member has an equal vote in team affairs, and helps to minimize differences inter- and intraprofessionally. Even if this ideal

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[4]Rosalie Kane, "The Intraprofessional Team as a Small Group," Social Work in Health Care 1(1) (Fall 1975):24.

initially reigns in the formation of a new team, members, and even patients soon learn where the power actually lies, and see the obvious shortcomings by observing the members in action.[5] Factors such as power, status differences, personal desires, and differences in educational backgrounds cloud the democratic ideal.

It is a fact that many group therapists have and still do maintain the assumption that all persons are equal when they teach group dynamics, but this has been shown to be detrimental. Such therapists have made health personnel skeptical about the value of efforts to harmonize the team based on the democratic assumption of personal equality. It is clear that the "town meeting" approach is unworkable given the bureaucratic structure of most medical institutions. In fact, the idea of harmonization for teams has been shown to be detrimental, because teams require conflict and struggle over matters of power and control if they are to evolve into teams where members respect one another's uniqueness.

Kane suggests that "the inaccuracy of the term 'democracy' as applied to the interprofessional team complicates clear, open communication from the outset; probably the term should be abandoned."[6]

Peter Kong-Ming New also attacks the democratic ideal of equality, because he believes that the titles and symbols of medical

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[5]David Kaplan, "The Continuous Workshop: A Forum of Interdisciplinary Research," Social Work (May 1960):79.

[6]Rosalie Kane, The Intraprofessional Team as a Small Group," Social Work In Health Care 1(1) (Fall 1975):24.

status in modern institutions are constant reminders that persons harbor self-perceptions that others are more or less equal, no matter whether the ideal of equality is verbalized or not. He states that

> in our attempts to be too equal, we have done a disservice to ourselves by failing to recognize that certain situations could only end in a deadlock if provisions are not made to allow a full expression of inequality . . . competence, by itself, implies a certain idea of inequality; that indeed, some persons are more capable than others.[7]

Both Kane and New acknowledge a need for the abandonment of the myth that democracy is always best, and suggest a realistic approach of facing the facts that humans are not equal in terms of status, power, educational background, financial supports, etc. Concerning these criticisms, I find them to be for the most part correct, and believe that democratic ideals applied to treatment teams can never completely work since, by the very social structure in which we exist, some team members are held in higher esteem than others. The democratic ideal of an equal vote in teams is appealing, however, if we consider the fact that many decisions teams make have no one member who is an expert at solving them in their entirety. Moral decisions commonly fall into this category.

Another philosophical problem concerns the concept of autonomy for treatment teams. It is no secret that our society values the freedom of the individual actor, but this idea must in part be abandoned if a professional is to be a team member, for the notion

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[7]Peter Kong-Ming New, "An Analysis of the Concept of Teamwork," Community Mental Health Journal (4) (1968):327.

"I'll do my thing, you do yours, and never the twain shall meet" is unworkable. The earlier definition of a team discussed the subordination of the individual member's goals and desires to those of the group. But a serious problem arises when we attempt to find the demarcation between the free-thinking individual on the team who openly expresses his or her views, and the limitation of that freedom for the sake of the team. Generally, personal freedom in teams becomes of secondary importance to the overall team goals, while at the same time the team needs to create an atmosphere where the members are not afraid to speak their opinions. This is a complex problem with no easy answer.

Autonomy is also a concern for professions. Historically physicians have enjoyed a position of authority and power unchallenged by other health workers. In the past two decades that power has been severely challenged, especially by nurse-practitioners. Now that they, too, are seeking more autonomy in practice, new role conflicts are occurring. Other allied health workers are also attempting to expand their roles, thus creating further friction. These conflicts are having effects on the functions of treatment teams, and must be considered as one element of possible discord as professions struggle to shift power and status. Mark L. Phippin suggests that autonomy is a myth, and that the sooner nurses, physicians, and administrators face the fact, the sooner "frustrations will cease, interrelationships will strengthen, and intraorganizational communication will improve."[8]

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[8]Mark L. Phippin, "Winning Through Communication," AORN Journal 34(6) (December 1981):1044.

The problem of autonomy is also a problem of role perceptions, for it is a serious matter whether or not practitioners will recognize the competency of others. If ways cannot be found to bridge these recognition barriers, then the team concept of health care treatment may be a bankrupt idea. A recent study on the perceptions of different occupations in the medical profession by these same professionals indicates that different groups tend to place high value on the status of their own group, especially when they find themselves in role competition.[9] In-group favoritism continues to be a tendency of health care workers who are insecure with their own roles. This study indicates a serious problem for the function of health teams. It may be possible to partially eliminate this problem by fostering clearer recognition of roles among team members, and by educating medical personnel about the parameters of their own and other's profession's roles.

Some new experiments in collaboration among health care professionals suggest that clarification of roles can lead to better communication and patient treatment. A project of The National Joint Practice Commission studied the relationships among nurses and physicians, and attempted to broaden the nurse's roles. Nurses in several hospitals rewrote their practice policies and expanded the scope of practice to include "more independent judgments, permission

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[9]Adrian Furnham, David Pendleton, and Charles Manicom, "The Perception of Different Occupations Within the Medical Profession," Social Science & Medicine 151 (1981):289.

to initiate care based on those judgments, and use of assessment skills."[10] Although physicians were nervous about nurses expanding their roles, acceptance of them occurred.

The NJPC summarizes the experiment by stating that

> in view of their growing interdependence, it becomes increasingly evident that successful delivery of health care cannot be achieved through unilateral determination of functions by either medicine or nursing.[11]

Strauss is not very optimistic about solving these problems, and blames improper educational programs for fostering them. Medical schools continue, he believes, to function as professional-oriented rather than patient-oriented institutions that stress lateral perspectives and treatment values. He further indicates

> that professionalism complicates the task of developing teamwork between occupations. Each profession tends to develop a parochial specialized point of view. As a result, jurisdictional disputes become common and the over-all system starts to break down into a number of semi-autonomous departments.[12]

Other critics are skeptical about the abilities of the varying health professionals to coordinate their views of treatment with other practitioners. Each profession develops a specialized vocabulary and language for intraprofessional communication, operates within its own

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[10]Pamela McNutt Devereux, "Essential Elements of Nurse-Physician Collaboration," Journal of Nursing Administration (May 1981):21.

[11]National Joint Practice Commission—Statements 1-5, 1974-1977.

[12]George Strauss, "Tactics of Lateral Relationships: The Purchasing Agent," The Administrative Science Quarterly 7(9) (September 1962):267.

concept of human nature, and builds in assumptions about how professionals conduct themselves and treat patients. We might say that each professional group converts a problem into the kind of formulation it is accustomed to work with, and ignores what lies outside its concerns and conceptions.[13] If professional health workers are in fact stultified with ideological trappings, than there is serious concern whether such barriers can be overcome for taking the ambiguity out of medical communication.

Functional Considerations for Teams

It is often difficult to separate philosophical issues from functional considerations, for often the former precedes the latter. Several considerations will be mentioned that must be resolved to the satisfaction of team members if a team is to function efficiently.

One critic believes that the concept of shared responsibility in teams "may mask the fact that no one fully accepts responsibility or feels himself to be ultimately accountable for what happens."[14] Such a criticism is just, and in fact makes some bureaucratic structures appealing just for this reason. It is my contention, however, that the terms "shared responsibility" should not indicate a hiding, but a willingness among team members to accept more responsibility for being knowledgeable about the contributions, knowledge

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[13]Lawrence K. Frank, "Interprofessional Communication," The American Journal of Public Health 51(12) (December 1961):1800.

[14]Q. A. F. Rae-Grant and Donald J. Marcuse, "The Hazards of Teamwork," American Journal of Orthopsychiatry 38 (January 1968):4.

bases, and general activities of the other members. This is not a reality in many practicing teams today due in part to a lack of knowledge about how teams function and about the assumptions of various professions, but could become a reality as educational emphases change. How responsibility is meted out to the various team members will be a consideration addressed in Chapters VI, VII, and VIII.

A common criticism about health care teams concerns their maintenance and initial work-up time. To develop an efficient team takes considerable time, for extensive planning, meetings, and discussion must occur prior to its experimental functioning. Even if a team is initially successful, it takes continual work by participants to make sure that it does not become an arena for personal concerns which have nothing to do with patient care; it must not become a preoccupation rather than an occupation.

How does one measure something as abstract as team success to determine if it is a success? This is one of the greatest obstacles to further team utilization, for we enter the hazy area of quality of care rendered, cost-effectiveness, and manpower utilization. The available information in these areas is not only questionable but also conflicting, and I, like the critics of team concepts, await further research data before rendering any final verdict.

Not only have teams been viewed as places to hide from responsibility, but team workers have been accused of emotionally hiding from their patients in the team structure. Rae-Grant and Marcuse suggest that the team may mask the insecurities of its members concerning the issues of facing their own and the patient's feelings.

> There is a great deal profoundly wrong with colleagues agreeing mutually to utilize each other to avoid coping honestly with the feelings their patients engender in them. That is a cheap defensive trick which short changes all concerned and which most helpers would strongly discourage in those they were trying to help.[15]

This criticism is pointed, but I think that it holds little weight. As with responsibility, teams can be used for hiding from many things one might be insecure about. The team can also be a support group in which members express their true feelings to one another about patient-related issues and share alternatives for treatment. It is an unrealistic picture of the daily lives of most health workers to assume that they continually work with a team, except for surgical, emergency, and intensive care units. Most personnel are involved both with teams and individual work throughout the day, thus making it impossible to avoid one-to-one encounters with patients. Even if health workers act individually during a day, there is no guarantee that they will cope with their feelings any better than if they were in a team. Many instances of the personal insensitivity by individual medical professionals occur daily, and one need only talk to friends and listen to stories of health care workers themselves about the actions of colleagues to understand the extent of the problem. The perception of apparent insensitivity to patients is not always the health worker's fault, however, for patients regularly do not express their feelings or ask questions. Thus, teams hold no special monopoly on sensitivity or insensitivity, but will develop their own peculiar emotional

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[15]Ibid., p. 6.

character according to the abilities of those who compose them to want to make teams a positive experience for creative sharing and support.

Some critics believe that treatment terms deemphasize "the potential capabilities of the individual therapist and of the therapeutic possibilities of intimate and confidential, one-to-one clinical work."[16] Such a criticism is weak, for the very nature of medicine as an organization of specialists is necessitating that practitioners be more creative in order not to underutilize the capabilities of others on the team. This criticism may be more psychologically based because patients have regularly complained about the impersonal nature of medical care, but such complaints indicate that many physician-patient encounters are less than intimate, and that they do not exemplify the potential capabilities of the individual therapist. There is no hard evidence to suggest that one-to-one clinical work with patients insures more intimate or therapeutic contacts with them, and no evidence to suggest that treatment teams will be less effective than individuals. Also, the days of the solo-practice family doctor are passing away, and most patients are having to face the assistance of many medical helpers and specialists, and are attempting to find ways to adjust to these changes. Now fragmented team efforts might bring coordination.

Concerning the loss of confidentiality through the utilization of treatment teams, I find that this is a justifiable criticism.

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[16]Ibid., p. 7.

Clearly more persons have access to a patient's chart if a team is utilized, and squabbles can occur between team members about what information to share. Consider, though, how many persons have access to patient records even in private practice. Usually several nurses, aides, and secretaries can read the records. Also, physicians regularly refer patients to other specialists, and the records are released to them and their medical helpers. Thus, the idea of confidentiality as less of a problem with a private practice physician is unfounded, and carries little weight for degarding the treatment team as more likely to violate patient trust.

Treatment teams may fall into the same trap as individual practitioners and overdiagnose. There are many legal and medical precedents that cause this to occur, but there is concern that the increasing number of specialists leads to overdiagnosis. In 1979 there were approximately 665 occupation titles in the health care industry,[17] with each one stressing the autonomy of its own professional organization. In teams there is a tendency between members to overdiagnose as a means for protecting professional territories. When this occurs, the model of an integrated and harmonious team strays from its primary purpose, which is the treatment of patients.[18] Such problems occur due to the hidden agendas of the members, and, if

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[17] R. W. Rhein, Jr., "Nurses: Colleagues or Competition?" Medical World News 20 (1974):67.

[18] Saad Z. Nagi, "Health Care in the U.S.A.: A Sociological Perspective," Milbank Memorial Fund (Winter 1975):85.

not considered in the open, can lead to ill feelings and lack of cooperation between them.

Reasons for the Continued Utilization of Health Care Teams

Very few positive observations can be made about health care teams without someone finding faults or weakness supported by contrasting data. Brief consideration will be given to some positive roles health care teams might assume, and why the concept is not useless or dead. Again, I give critics a voice in this section.

If one reads professional medical literature the discovery will be made that on the whole writers about treatment teams tend to be optimistic concerning future team applications, but generally temper their words with suggestions for improving education, group processes, or for calls for further research. Few articles, however, are totally against the team concept. The following discoveries, although tempered, provide reasons to be optimistic about further team utilization.

Briggs, Hickok, and Rassier assert that by improving the utilization of health care personnel, rising costs can be controlled and productivity increased.[19] Through personal studies and experiments, they suggest that cost may be reduced through collaborative teams if a manpower shift can be made which utilizes other medical personnel who will accept lower salaries, and who can do many of the services once done by physicians. The physician is one example of an over-extended role. Recent research shows that physicians are

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[19] R. M. Briggs, D. E. Hickok, and D. S. Rassier, "Midlevel Personnel in Obstetrics and Gynecology Practices," Western Journal of Medicine 132 (1980):466.

allocating too much time to nonmedical tasks.[20] The purpose of utilizing other medical workers in traditional roles held by physicians is not to take away territory from physicians and diminish his or her powers, but to assist them:

> Under the team approach, the physician's critical skills are still recognized but deployed more cost efficiently in the types of medical treatment he/she delivers. Under the team methodology, the physician is used for referral, consultation, supervision, and treatment of urgent consideration.[21]

The nurse-practitioner, or nurse-midwife, would take on such functions as deliveries, record taking, preliminary examination, and in some cases might diagnose. Furthermore, they could counsel in prenatal care or teach seminars in preventive medicine.

During the Fourth Annual Symposium on Medical Education, Rabkin stated that at the Beth Israel Ambulatory Care Center more than half of the patients in the walk-in clinic could accurately be diagnosed and treated by the nurses alone. He draws this conclusion from studies about patients concerns and complaints over a number of years. After the program had been in place for a considerable period of time, and after interviewing patients, he found "no difference in either the clinical outcome of patients as they were followed

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[20] A. Yankauer, S. Tripp, and P. Andrews, "The Outcomes and Service Impact of a Pediatric Nurse Practitioner Training Program and Nurse-Practitioner Training Criterion," American Journal of Public Health 62 (1972):347.

[21] R. Clay Burchell, Howard L. Smith, Waneta C. Tutle, and Debra A. Thomas, "Collaborative Practice in Obstetrics/Gynecology: Implications for Cost, Quality, and Productivity," American Journal of Obstetrics and Gynecology 144(6) (November 1982):622.

subsequently or in the reported satisfaction of the patient."[22] Recent studies by B. C. Flynn suggest the same results, and that in "many instances patients actually believed that care increased because medical personnel could act solely in the roles for which they were trained."[23] This trend may be positive because it can help sharpen the role definitions of team members and alleviate much unnecessary conflict over territorial claims and roles.

It has also been suggested that by substituting nursing time for physician time costs can be cut. Ancilliary services of treatment could also be cut by using team processes, for many of the activities physicians traditionally undertake, such as contraception counselling and health education, could be made available through other members in the team. Hence, needless duplication could be avoided, and physicians freed for issues other than rudimentary education.

The optimistic note that costs can be reduced is quickly tempered by opposing views. C. M. Godfrey, a psychiatrist at Wellesly Hospital, suggests that we are still awaiting a "real study of whether there is a cost-saving in replacing the physician with new groups of

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[22]J. Lowry Mills, Eleanor C. Lamberstein, Mitchell T. Tabkin, Joseph G. Benton, and Bella Strauss, "The Contributions of Other Members of the Health Care Team to the Solution of Medical Manpower Problems," Bulletin of the New York Academy of Medicine 15(9) (November 1976):1153.

[23]B. C. Flynn, "The Effectiveness of Nurse Clinician's Service Delivery," American Journal of Public Health 64 (1974):604.

over-trained allied health care workers."[24] He further contends that health care teams purported to reduce costs are doing just the opposite because team members "won't play." Multiple patient assessments, he believes, are a waste of time and actually increase costs:

> To recommend a greater proliferation of health care delivery teams before a proper assessment can be made of their effectiveness and cost efficiency is to ignore what we already know from 25 years of honest endeavor to make the team concept work.[25]

It is unclear from his article what would constitute a "proper assessment" of team effectiveness before he would be satisfied that they are or are not effective. It is through the process of failures, reevaluations, and new attempts that we discover new and often effective ways to correct past errors. His reference to 25 years of assured failure is unjustified, since the team concept and educational system of today are radically different than past ones and are continually changing. Godfrey's bitter attitude may be the result of his own experiences with treatment teams, but his experiences do not justify the implication of the failure of the team concept.

When health care personnel are not properly educated for interdisciplinary work, nor work in teams with others who desire to make them work, then they are bound to fail. These facts in themselves

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[24] C. M. Godfrey, "Health Care Delivery Teams," Canadian Medical Association Journal 124 (May 1981):1258.

[25] Ibid., p. 1258.

are not indictments of the team concept, but of the way our current medical system functions and educates its practitioners.

Godfrey is not alone, however, when it comes to a skeptical attitude about health teams. A recent study by Bloom and Parad suggests that a significant number of mental health workers involved in treatment teams disagreed with a survey statement that fiscal demands and administrative burdens would decrease when interdisciplinary training programs were developed.[26] In fact, almost all of 1464 respondents believed that such programs would cause management costs to increase.

Although most of these respondents were skeptical about costs, a majority still believed that interdisciplinary training should be a part of one's professional education. This same study also indicated that interdisciplinary interactions are very common in community mental health centers, and that such activity is not an exception, but commonplace.

One reason for optimism about health care teams is that our society is continuing to expand its concept of health, and hence also the activities encompassed with the medical domain.[27] As a result,

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[26] Bernard L. Bloom and Howard J. Parad, "Interdisciplinary Training and Interdisciplinary Functioning: A Survey of Attitudes and Practices in Community Mental Health," American Journal of Orthopsychiatry 46(4) (October 1976):675.

[27] Saad Z. Nagi, "Teamwork in Health Care in the U.S.A.: A Sociological Perspective," Milbank Memorial Fund Quarterly (Winter 1975):76.

diverse health care activities are by necessity being pulled together in institutions in order to be coordinated for a higher quality patient treatment.

Medical schools are also slowly beginning to incorporate elective courses in the third and fourth years of medical education which emphasize interdisciplinary activities. Although these courses are not usually required, their purpose offers reason for hope in the changes such emphases might bring.

Also the need for medical care in this country has not diminished, but increased, while the number of physicians has decreased.[28] As a result, many allied medical workers are expanding their roles in order to fill this void, with usually lower costs to patients, which again is important for understanding how the roles are changing in treatment teams.

Finally, both health care professionals[29] as well as patients are increasingly concerned with what they perceive to be fragmented and impersonal care, and hence are putting pressure on medical institutions and organizations to find a better approach to patient treatment.

In this brief excursis into reasons for being both optimistic and pessimistic concerning treatment teams, it is clear that neither the optimists nor the pessimists are the victors, but that serious

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[28] C. M. Godfrey, "Health Care Delivery Teams," Journal of the Canadian Medical Association 124 (May 1981):1251.

[29] Edmund Pellegrino, "What's Wrong With Nurse-Physician Relationships in Today's Hospitals?" Hospitals 40 (December 1966):72.

research concerning treatment teams must continue in this infant period of serious focus on treatment team utilization. Such research is faced with innumerable theoretical difficulties, some of which will be considered.

Current Difficulties in Researching Health Care Treatment Teams

An important question to consider is "What is the state of health care team research, and what are some of the difficulties in such research?" Serious studies of health care teams are few, although much research has been done on group processes. In current medical literature one can find comments about research problems. Recently the Committee on Professional Organization and Control of the Medical Sociological Association concluded that after twenty years of research in health care institutions little is actually known about "the effects of variations in health care organizations (including financial arrangements) of physicians and the work setting on the technical and social quality of medical care provided."[30] They further conclude that little is known about the distinctions of power among professionals in health care teams.

Another pragmatic consideration was studied by Birk, Dalton, and Word. Their research concludes that variables such as cohesion, communication, and patterns of decision-making are variable and are

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[30]M. E. W. Goss, R. M. Battistella, J. Colombotos, E. Friedson, and D. C. Riedel, "Social Organization and Control in Medical Work: A Call for Research," Medical Care 15 (1977):3.

extremely difficult to measure.[31] They suggest that a lack of measuring instruments, which actually inform us of something significant, is causing part of this dilemma.

Not only are measuring devices a problem, but medical personnel are resistent to many studies which could provide vital information. They feel threatened by the presence of an evaluator, even when informed that none of the information will be seen by superiors or co-workers.[32]

Researchers also face the practice-orientation of medicine, meaning that it tends to be teleological and pragmatic due to focuses on outcomes rather than on process measures. Estimates of quality of patient care is often based on results achieved rather than on the effort expended.[33] This can have serious consequences for teamwork and patient care because process analyses are scarce which describe in detail efficient ways to deal effectively with presenting problems in teams. Some studies do exist which are abstract analyses about group processes, but they do little to help team members with interdisciplinary problems by providing methodologies that work. On the other hand, there are some training programs to help teams work together more efficiently, but they are so oversimplified and unrealistic that

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[31]Peter Birk, Cynthia Dalton, and Thomas Word, "Problem Oriented Analysis of Medical Care Episodes—A New Evaluative Model," 99th Annual Meeting, American Public Health Association, 1971.

[32]Ibid., p.

[33]Ann Barry Flood and W. Richard Scott, "Professional Power and Professional Effectiveness: The Power of the Surgical Staff and the Quality of Surgical Care in Hospitals," Journal of Health and Social Behavior 19 (1978):240.

their usefulness is minimal. Thus, the team is caught between methodologies for team decision-making that are too simple, and complicated research that is difficult to translate into pragmatic team applications.

A recent nursing journal suggested that most health care team projects fail because they do not properly consider long-range plans with precise evaluation techniques. Most team efforts are random, and incidental, partly due to the lack of standardization methodologies and research information that tells how to best implement a team and maintain it.[34,35] This is further complicated by the vagueness of terms used to describe teams, plus the fact that a majority of health care professionals are not employing health team research.[36]

It would be overly optimistic to believe that these problems can be solved soon. Many of them can be traced to the lack of coordination among teaching institutions concerning standardization of terminology and training techniques. Some of these problems, however, are due to resistance of the interdisciplinary team concept by organizations and persons desiring to remain autonomous. The extreme complexity of these matters could lead one to be a pessimist, but

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[34] Avedis Donabedian, "Evaluating the Quality of Medical Care," Milbank Memorial Fund Quarterly 44 (July 1966):166-206.

[35] Carol S. Weisman, Cheryl S. Alexander, and Laura L. Morlock, "Hospital Decision Making: What Is Nursing's Role?" Journal of Nursing Administration (September 1981):35.

[36] Phillip Woollcott, "Interdisciplinarity," Bulletin of the Meninger Clinic 43(2) (1979):163.

pessimism usually gives way to optimism in those who do not give into criticisms, but rather see them as a challenge, and continue in their endeavors.

Throughout the last three chapters I have mentioned that medical education is a primary reason for many of the problems facing the use and implementation of health care teams today. It is to this consideration that we now turn.

CHAPTER III

MEDICAL EDUCATION: THE PRECURSOR OF CONCEPTUALIZATION

Medical education is a process of conceptual building, in which students learn to perceive their worlds through perspectives unknown to exist prior to professionalization. The content of the materials used, teaching methodologies, symbols (such as white coats), stethoscopes, various medical instruments, and value-laden comments influence students throughout their education. Also the medical institutions they enter have a set of intricate assumptions carefully woven into the institutional fabric which suggest the "correct" and "proper" way to practice medicine. Such rules are designed to help students orient their lives in order to exemplify the roles they will assume as students and potential professionals. How these influences and assumptions affect their behavior in interdisciplinary settings and relationships is unclear, for research is meager on this topic. However, if meaningful progress is to be made for developing interdisciplinary teams, it must begin in educational institutions and filter through the entire medical complex.

This chapter will discuss first, the implications of the various conceptual frameworks for interdisciplinary communication, and second, will consider what trends are underway in medical institutions to introduce interdisciplinary skills to medical students.

Conceptualization as Perspective

Close observation of medical personnel in institutional settings will reveal that each person has a different way of understanding what constitutes patient care, and how he or she should relate to personnel from different disciplines and backgrounds. Clearly there are "cluster perspectives," meaning that persons educated with the same conceptual and assumption-laden bases will in general recognize the same forms of treatment and techniques as those similarly trained; they "see" the same things when viewing patients. This use of "see" does not mean visual perception, but conceptualization as a result of education and experience. Persons educated in the same general manner are insiders to these perceptions, while those from differing backgrounds are external viewers of their activities, and are often puzzled by what they see and hear.

Treatment teams are no different, except for the fact that the members must regularly assemble and attempt to interrelate their conceptions. This is a difficult task, but such undertakings are becoming more common, and are in part the result of increased specialization. Teamwork has, as Nagi believes, an "operation assumption" that cooperative efforts by many will not only broaden the perspectives of the team members, but also the patient.[1] Whether this assumption is useful is unknown, for the value of interdisciplinary interactions is sketchy.

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[1]Saad Z. Nagi, "Teamwork in Health Care in the U.S.A.: A Sociological Perspective," Milbank Memorial Fund Quarterly (Winter 1976):76.

It is clear, however, that each team member brings a peculiar set of images to the assemblage.[2] First, each has a particular self-image and usually identifies with one dominant method of practice. If the individual believes he or she must act within a restricted conceptual framework, then whenever a problem is presented to the team, he or she will evoke a set of mental assumptions, questions, and answers for solving it. The social worker may evoke a set of thoughts about family practices, living environments, and emotional concerns about the patient, while the physician primarily focuses on patients' physical appearances and symptoms while drawing upon complicated thoughts about disease courses, causes, and cures. While the social worker sees him or herself as a warm and caring person who attempts to empathize with the patient (as opposed to the social worker's perceived coldness of the physician), the physician may view the social worker as a rather ineffective member of the team who contributes nothing tangible, believing his/her efforts are the most important. Each team member is subject to the consideration of self-image, and each has a set of beliefs about the images and tasks of others.

A second factor in conceptualization concerns self-definition of role expectations. Each member has a general idea about the parameters of their expertise, but often they find that they are asked to perform tasks which they were not trained for, nor that they

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[2]John J. Horwitz, "Dimensions of Rehabilitation Teamwork," Rehabilitation Record (March-April 1969):37.

desire to do. Unless role clarifications are attained members may feel used or bitter toward others, and hence cause dysfunction in the team.

Team members also bring to the medical setting an understanding, or lack of understanding, of the skills which others possess. Unless individual members clarify exactly what they can do for the patient and team, then the parameters of their skill bases will be vague, which also can set up conflicts.

Although the subject rarely gets discussed, each member of the team has an ego—some more, and some less than others. Given the nature of the importance of self-image for proper functioning in society, it seems important that team members receive support from their associates in order to keep a stabilized image which can serve the team. This does not mean praising persons for poor work, but it does mean recognizing them when they do well, which sets the precedent for high-quality work. Insecure team members with poor self-images are a disservice to patients, themselves, and co-workers.

Also, team members must share their conceptions of the patient, for how they view him or her will determine the problems they do or do not see, as well as the types of diagnoses and treatments suggested. Such conceptions may be of a variety of levels and types, for one worker may see the patient as an undernourished body requiring an adequate diet, while another may see a depressed woman with emotional problems.

The language that professionals use is also important. The terms "health, healing, autonomy, and cure" may receive different meanings from the various members, and such definitions may be assumed. If these definitions are not expressed either directly or indirectly, and are merely understood by other members, then discord may result with no one being able to pinpoint the reason or reasons for it. There are no guarantees that a more efficient team would result. But such understandings would probably raise the level of appreciation among members for the differing beliefs of others, even if they do not agree with the forms of treatment which other disciplines utilize.

A recent study by Furnham, Pendleton, and Manicom focused on interprofessional perceptions in order to understand how personal perceptions may affect team communication. The study explored the idea that

> health care professionals might be expected negatively to evaluate professionals who seek to appropriate a field of knowledge, style of operation or particular client group that is under their control and jurisdiction.[3]

The study included questions about skills in caring, knowledge bases, and status of general practitioners, nurses, health visitors, and occupational therapists. It was discovered that each professional group tended to see other groups negatively when they felt in competition with them, and this was especially true of general

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[3]Adrian Furnham, David Pendleton, and Charles Manicom, "The Perceptions of Different Occupations Within the Medical Profession," Social Science and Medicine 151 (1981):292.

practitioners and social workers. This study is one of the latest projects which show that perceptions of medical workers clearly affect the interactions of team members.

A new methodology has recently been developed by Ducanis and Golin for measuring interprofessional perceptions. The Interprofessional Perception Scale was created as a result of work done by Laing, Lee, and Phillipson,[4] which investigated perspectives in dyadic relationships in health centers. Laing's primary contribution is his identification of several levels of personal perspective:

> Level 1. perspective, i.e., what I say,
> Level 2. perspective, i.e., how I say you would answer the same question, and
> Level 3. perspective, i.e., what I say you would say that I said.[5]

Three three levels of analysis are commonly used as tools for ethical analysis. Ducanis and Golin created a scale to measure these levels in order to understand how health care workers view persons in other medical disciplines. After unsatisfactory results from a small pilot test, a new revised scale, the IRS, was developed. The results of the IRS indicate significant relations between the subject's view of the other professions (Level 1) and the subjects' perception of how the professions viewed themselves (Level 2). Allied health personnel perceived that physicians and nurses failed to understand

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[4]Alex J. Ducanis and Anne K. Golin, The Interdisciplinary Health Care Team (Maryland: Aspens Systems Corp., 1979), p. 33.

[5]Ibid., p. 34.

the capabilities of other professionals, encroached on professional territory, were defensive about professional preogatives, and did not fully utilize the capabilities of other professions.[6] This study also indicated that allied health personnel believed that their perspectives of health care treatment were not understood by physicians or nurses.

In another study using this same test 115 health professionals, including nurses, physical therapists, rehabilitation counsellors, and other allied workers, were tested. Most respondents believed that professional health care workers are generally competent in their own specialties. However, one question about professional ethics showed that 25 percent of the sample viewed the professions of nursing, physicians, and social workers as highly unethical.[7]

Concerning territorial encroachments, 70 percent of the physicians felt threatened, while less than 20 percent of the other's questioned said that physicians would answer this way.

As Ducanis and Golin noted, much more research needs to be done with measurement scales similar to theirs, and they suggest that these can be valuable for educating health professionals so that knowledge about interdisciplinary perceptions can be shared, and hence understanding maximized to lessen conflicts.

Rubin and Beckhard (who have done considerable research on treatment teams) suggest that many common assumptions are brought to

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[6]Ibid., p. 41.

[7]Ibid., p. 51.

treatment teams by the individual members, with most of them being the result of medical training and acculturation. They are:

1. "In making a decision silence means consent";
2. "Doctors are more important than other team members"; "We don't disagree with them"; "We wait for them to lead";
3. Conflict is dangerous; avoid conflicts and interpersonal disagreements; "it's best to leave sleeping dogs lie";
4. Positive feelings, praise, support are not to be shared; we're all professionals here to do a job.
5. The precision and exactness demanded by our task negate the opportunity to be flexible with regards to our own internal group processes.[8]

The importance of disarming these assumptions for creative group communication cannot be underestimated. From conversations with medical personnel and due to observations, it is clear that these assumptions are still widely held. Disarming many of these ideas requires considerable risks which many are not willing to take.

Frank suggests that teams might benefit from seminars where each member gives "an initial exposition of his concepts and especially the often formulated assumptions."[9] Problems can arise if each worker does not recognize his/her assumptions, or is not cognizant of his/her conceptual framework and how it functions to guide one's activities. Similarly, they may not be able to understand the same assumptions of others, which leads to further misunderstandings.

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[8]R. M. Irwin and Richard Beckhard, "Factors in Influencing the Effectiveness of Health Teams," Milbank Memorial Fund Quarterly I(3) (1972):327.

[9]Lawrence K. Frank, "Interprofessional Communication," American Journal of Public Health 51(2) (February 1982):28.

The Problems and Promises of Interdisciplinarianism in Medical Education

As an ideal the concept of an efficiently functioning health care team appears sound. Several reasons have already been discussed that put a cloud over this belief, such as lack of cooperation among members, inadequate research, lack of interest, etc. But what is the climate for interdisciplinary work in medical institutions?

Students today are asking serious questions about the demanding nature of their work, and whether what they have been practicing adequately prepares them to deal with the realities of future practice. Turnbull believes that the medical student population today is older, and is bringing in new and diverse ideas to medical settings.[10] Also, these same students question their roles in light of an awareness of changing public perception that show increased dissatisfaction with traditional medical care. Furthermore, students are specifically asking for more training in the skills they see as necessary for professional survival—the ability to live with conflict, the art of negotiation, the use of power, and the development of self-knowledge. Unfortunately, most medical schools do not offer these skills.[11]

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[10]Eleanor N. Turnbull, "Interdisciplinarianism: Problems and Promises," Journal of Nursing Education 21(2) (February 1982):28.

[11]R. De Tornay, "Changing Student Relationships, Roles and Responsibilities," Nursing Outlook 25(3) (March 1977):189.

Today's medical market requires that students need an ongoing dialogue with persons from other disciplines throughout their education, which includes some exposure to the assumptions and conceptual thought processes of other health professionals.

Many national organizations are also stressing changes in medical education. In 1978 the National Institute of Medicine of the National Academy of Sciences stressed that persons training health care students need to teach health care delivery by teams.[12] They further stressed that medical students need new skills such as those mentioned above. This suggestion appears to align itself with the general trend toward holistic health which the public is requesting.

A recent study by Snyder at the University of Wisconsin indicated that medical students believed knowledge concerning other health care professionals would have facilitated more effective interactions during clinical experiences.[13]

The University of Connecticut has implemented a program with a four to eight week elective clerkship during the third or fourth year in family medicine, where students spend half of the week participating in the regular family practice curriculum, and the rest of the week with an interdisciplinary team. Students work closely

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[12]National Academy of Sciences; Manpower Policy For Primary Health Care (Washington: Institute of Medicine, 1978), p. 81.

[13]C. Meisenheimer, "The Adjunct Appointment Can Provide Realistic Experience for Leadership Students," Nursing Administration Quarterly 3(3) (1979):41-49.

with those from other health care schools—social work, nursing, physical therapy, and pharmacy; as well as participate in community out-reach programs.[14] Several goals of the program include an understanding of the cultural and anthrophogenic determinants of the community. This allowed students to act as facilitators for utilizing community services, to develop communication skills with colleagues, and to be aware of the social needs of patients. This was a bold attempt to develop a new curriculum, but the results of it are still questionable because such programs appear to have had minimal effect on present treatment delivery. It still seems premature to make any judgments about such programs due to their newness and the slow acculturation of the team concept into medical institutions.

Many faculties at nursing schools are also beginning to recognize that present curriculums do not adequately facilitate interdisciplinary skills. In a recent study of three nursing schools offering diverse degrees, the majority of the faculty members filled out a questionnaire after participating in an observation and analysis program of students involved in interdisciplinary activities. Most teachers stated that they favored teaching strategies which promoted interprofessional cooperation.[15]

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[14]C. M. Godfrey and D. Ripley, "Health, Society, and the Medical Student: A Team Education Program in Primary Care," Psychosomatics 22(10) (October 1981):896.

[15]Mariah Snyder, "Preparation of Nursing Students for Health Care Teams," International Journal of Nursing Students 18(21) (1981): 115.

Although new programs are being designed to foster interdisciplinary skills in medical schools, there is considerable concern that practitioners who already hold jobs may not have these skills. Kelly suggests that the best persons for interdisciplinary health care training are individuals who are emotionally mature, have had considerable professional experience, are stable with their own personal identity, and enjoy being involved in new and unexplored territories.[16] Many mature practitioners with considerable practical experience have probably developed a set of skills which they have been using for many years, but new educational experiences should be a regular part of continuing education for all medical personnel, regardless of age or experience. Medical institutions do a disservice if they do not form programs to continually educate workers in new skills being introduced into medical curriculums—especially interdisciplinary ones. On a practical note, whether current practitioners would take advantage of new skill-developing programs is uncertain due to time constraints, an unwillingness to change, the vision that such skills are worthless, or an institution's promotion of current educational discoveries. Mary Challela suggests that "unless medical personnel recognize that a "socialization process is necessary in order to develop different attitudes and approaches"[17] change will

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[16] J. Kelly, Community Psychology in Transition, 1976.

[17] Mary Challela, "The Interdisciplinary Team: A Role For Nursing," Image 11(1) (February 1979):13.

not be forthcoming. One reason for resistance in the medical community is because the team approach has not been conclusively shown to be superior to private practice, nor that the combined efforts of many professionals are superior to those of one practitioner.

Diverse Projects in Experimental Health Care Collaboration

Though it is not my intent in this study to thoroughly research past and recent collaborative efforts in health care, it is important to provide a brief description of some projects which any serious researcher would want to review in order to understand their failures and successes, and hopefully use to plan superior programs. The following list provides a mixture of collaborative efforts both in medical institutions and medical schools:

1948 Montefiore Hospital provided home health care for institutionalized early persons and the chronically ill. Teams were composed of a public health nurse, an internist, social worker, physical therapist, and automobile driver. The primary contact was the nurse.[18]

1950-1958 Montefiore Hospital. George Silver developed a team composed of a social worker, a public health nurse, an internist, and pediatrician. Psychiatrists and psychologists were available on request. This project was carried out in patients' homes, and focused on the comprehensive care of 150 middle-income families, with special emphasis on preventive medicine.[19]

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[18]M. Cherkasky, "The Montefiore Hospital Home Care Program," American Journal of Public Health 39 (1949):29-30.

[19]G. A. Silver, Family Medical Care, A Report on the Family Demonstration Program (Massachusetts: Harvard University Press, 1963).

Early 1960's — University of Florida. An attempt was made to unify nursing education and service by appointing one administrator to supervise these efforts. This was an attempt to bridge perceived gaps in educational theory and application.[20]

1966 — Martin Luther King, Jr. Health Center. This project attempted to provide primary care to poor urban areas in New York when a shortage of physicians occurred. Primary care teams were formed, but the experiment was considered a failure because communication skills were lacking.[21]

1966 — Case Western Reserve University. The school of nursing and University Hospitals collaborated in a five year program to unify the academic and clinical nursing programs. The outcome was positive, for faculty and clinical personnel were able to collaborate to achieve effective integration. The nurse specialist was evolved as a result of this work.[22]

1972 — Beth Israel Hospital Ambulatory Care Center in Boston, Mass. The University hospital reorganized its teaching-hospital clinics, eliminated general medical, obstetric-gynecology, and pediatric clinics, and replaced them with primary health care delivery. Ten full-time physicians replaced voluntary physicians. Teams consisted of a nurse, physician, social worker, secretary, and aid. Nurses were allowed to expand their roles and do some of the tasks traditionally assigned to physicians.[23]

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[20]D. M. Smith, "Education and Service Under One Administration," Nursing Outlook 13(2) (1965):64-66.

[21]Wise, The Primary Care Health Team, p. 438.

[22]R. M. Schlotfeldt and J. MacPhail, "An Experiment in Nursing: Rationale and Characteristics," American Journal of Nursing 69(5) (1969):1018-1023.

[23]Mitchell T. Rabkin, "Bringing the Individuals Together to Form a Team," Bulletin of the New York Academy of Medicine 52(8) (November 1976).

1972 Rush-Presbyterian-St. Luke's Medical Center. They established a program to combine nursing services and education, with one individual holding the dual position of vice-president for nursing affairs and dean of the college of nursing. This was an attempt to use a holistic matrix model.[24]

1975 University of Illinois. A new role for a nurse practitioner was developed in which she accepted a joint appointment in education and service in order to serve as both classroom teacher and clinical preceptor. The new title was Faculty Nurse Preceptor. This was a project which involved the departments of public health nursing in the college, the department of ambulatory care in the hospital, and the section of primary care in the department of medicine.[25]

1977 National Joint Practice Commission's Hospital project which attempted to insure nurse/physician collaboration in order to establish more appropriate nursing roles in hospitals. Four hospitals in California, Oklahoma, Maine, and New York participated. All hospitals rewrote policies of nursing practice to expand his or her roles. Questions about cost saving and team efficiency were not resolved, but overall the project was considered a success.[26,27,28]

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[24]L. Christman, "The Practitioner-Teacher," Nurse Educator 4(2) (1979):8-11.

[25]Michele Regetz Helmuth and Thomasine D. Guberski, "Preparation for Preceptor Role," Nursing Outlook (January 1980):36-39.

[26]Pamela McNutt Devereux, "Essential Elements of Nurse-Physician Collaboration," Journal of Nursing Administration (May 1981).

[27]Pamela McNutt Devereux, "Does Joint Practice Work?", Journal of Nursing Administration (June 1981).

[28]Pamela McNutt Devereux, "Nurse/Physician Collaboration: Nursing Practice Considerations," Journal of Nursing Administration (September 1981):37-39.

1979 University of Texas. This was a project of collaboration among nursing services, nursing education, and the health department in order to establish a nursing center. The center was an experiment to work with the ever increasing older adult population while broadening the parameters of the traditional nurse's role as a nurse practitioner.[29]

These experiments are just a few of the many which have been studied, but certainly many others have been attempted but not pubblished. Future efforts at team experimentation should take into account these attempts at collaboration and profit from them.

A Summary of Assumptions

It seems appropriate to conclude this section with a summation of the often unexamined assumptions made by medical personnel attempting to utilize or research treatment teams. This list is both a warning against premature conclusions and presents possibilities for future research projects, for it permeates all medical institutions and educational endeavors attempting to undertake interdisciplinary efforts. Some of these, such as 11, 12, 15, 18, and 21 appear to be true, but even these require more study for verification.

1. The concept of a "treatment team" is unambiguous.
2. Health care teams are accepted by a majority of medical personnel as superior to the dyadic relationship of patient and physician.

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[29]J. S. Rokosky, "Faculty Observations In An Interim Joint Appointment Role," Nursing Administration Quarterly 3(3) (1979): 32-38.

3. Health care teams are accepted by a majority of society as superior to the dyadic relationship of patient and physician.
4. Health care teams can adequately meet the needs of individual patients seeking a more holistic approach to treatment.
5. Health care teams will replace the general practitioner.
6. Health care teams reduce costs.
7. The collaboration of several professionals in a health care team assures a higher quality of patient care.
8. Health care teams can eliminate overlapping services, and hence conserve time and money.
9. Health care teams can adapt to the new role changes of their members, and thus clarify roles for more harmonious interactions.
10. Health care teams do not destroy the personal relationship many patients claim to enjoy in the traditional doctor-patient relationship.
11. It is possible for health professionals from various disciplines to work together cooperatively and understand, as well as respect and appreciate the activities of team efforts.
12. It is possible for team members to find constructive ways to vocalize any objection to other members' thought or activities in order to maintain team harmony.

13. Health care teams provide an atmosphere of democratic idealism, where members feel like equals in decision-making processes.
14. The ideals of democracy are the best ones for treatment teams to follow.
15. Medical students can be trained to effectively work in interdisciplinary teams.
16. Courses in medical curriculums stressing interdisciplinary theory and practice will assure the success of treatment teams in medical institutions.
17. Intraprofessional barriers can be broken so that professional medical associations and societies will see the benefits of interdisciplinary activities, and recognize the value of the work of other medical professionals.
18. Medical personnel presently in practice would benefit from continuing education in interdisciplinary skill building.
19. Health care members with traditionally powerful roles are willing to share some of their power.
20. The rise in specialization in this country necessitates the formation of treatment teams.
21. It is possible to find adequate research methods for understanding how the assumptions and conceptual frameworks of team members affect their interactions, and to develop practical methodologies for utilizing this information.

Although this list is extensive, it only begins to cover a few of the many assumptions often unconsciously made by researchers, medical practitioners, citizens, and educators.

Interdisciplinary Cooperation and Medical Codes of Ethics

As mentioned earlier, medical education has a tremendous influence on students and determines how they will or will not be able to work cooperatively with other medical workers on health teams. It is important, therefore, to consider whether current medical codes of ethics from varying health-related disciplines address topics of interdisciplinary cooperation, and whether this issue is being seriously considered on the professional level by practicing medical workers.

Professional codes of ethics are the written ideals of organizations exemplifying rules of conduct which are to be used as references for members. With monotonous regularity one hears the disenchantments from medical professionals and the general public about the inabilities of professional organizations to enforce codes as well as their nonobservance. Both criticisms are interlocked in the sense that some professionals will not utilize any code unless there is a strong enforcement mechanism, while others follow only parts convenient to their purposes. Furthermore, because such codes are vague, many types of practices become justified as part of "broad" interpretations which other professionals might deem unethical. Also, it is no secret that medical organizations like to

down-play violations of such codes in order to preserve the profession's image; an image regularly coupled with what is perceived by most observers to be noneffective punishments for offenders.

Most codes of ethics say something to the effect that "The Ethics Committee encourages members to use the code in a positive manner, recognizing the high motivation and professional responsibility of our membership"[30] while at the same time containing statements similar to this: "The Code of Ethics is not law."[31] Hence, there is an inherent tension in all codes between what the organization mandates, and what it can enforce. Most health care professionals are more interested in what the law says about their activities with little or no thought about professional codes of ethics. In many discussions with medical personnel I discovered that although codes of ethics exist for their particular professions, they did not know so, or, when they did, could not state its principles.

Another serious problem with codes of ethics is standardization inter- and intraprofessionally. Within each major division of medical practice there are many subspecialties, each with a particular group of ethical concerns. Thus, in order to encompass these differences general codes are created such as the American Medical Association

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[30]The American Dietetic Association, "Philosophy Statement To Accompany The Standards of Professional Responsibility," November 1983.

[31]American Society of Radiologic Technologists Code of Ethics, Preamble, 1982.

Code of Ethics, whose broad applications are questionable as value guides.[32]

It is also difficult to find standardization for interfacing both medical and nonmedical codes when considering the activities of interdisciplinary health teams or personnel. For example, an interdisciplinary team might consist of a physician, social worker, medical student, nurse, and nutritionist. Given the diversities of treatment models and ideologies of each member, how is it possible to create a code that addresses them all but which does not become mediocre? This is an unsolved problem, for no formal code exists to specifically address the ethics of interdisciplinary teams. There is a need, I suggest, for the development of one, for it is important that teams have standardization for conduct when treating patients and interacting with other members. Such a code would also let patients know how the team views its relationship to them.

The need for such a code may seem unnecessary because each professional represented in the team has one, whether the AMA or another. This is correct. These codes, however, usually are so broad in focus and vague in language that it is difficult to see how they could address the special interests of health care teams. This does not mean that parts of other codes could not be used for the development of a more detailed code for teams, but only that their structure renders them ineffective for team interests.

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[32] American Medical Association Principles of Medical Ethics, Preamble, 1982.

Existing Statements About Interdisciplinary Concerns

Most medical codes of ethics contain references to preservation of patient dignity, confidentiality of all information, the reporting of unethical behavior through proper channels, keeping current on the latest technical materials of one's field, guarding against conflicts of personal interest, to have social obligations that promote the general welfare, nonprejudicial treatment, and exortations about not extending oneself beyond one's professional abilities.

A few codes contain broad and varied statements about working with personnel from other disciplines in order to treat patients. For example, "The Ethical Principles of Psychologists" states that the effectiveness of the individual professional "depends in part upon their ability to maintain effective interpersonal relations,[33] and that aberations on their part may interface with their abilities. Also,

> A psychologist acts with due respect to the needs, special competencies and obligations of their colleagues in psychology, and other professionals. Psychologists respect the prerogatives and obligations of the institutions or organization with which they are associated.[34]

Last, the same code states that "psychologists take into account the tradition and practice of their professional group with which they work and cooperate fully as a member of such groups."[35]

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[33] Ethical Principles of Psychologists, Principle 2e, January 1981.

[34] Ibid., Principle 7.

[35] Ibid., Principle 7b.

Another code, "The American Medical Technologists Code of Ethics," states that members should

> participate in the interchange of knowledge with other competent practitioners of Medical Technology and/or other para-Medical Arts and Sciences that our joint knowledge shall benefit the profession and my practice.[36]

In the American Nurses' Association Code we read:

> The complexity of the delivery of health care service demands an interdisciplinary approach to delivery of health services as well as strong support from allied health occupations. The nurse should actively seek to promote collaboration needed for ensuring the quality of health services to all persons.[37]

Finally, the American College of Hospital Administrators states in their code that "health care institutions should maintain organizational relationships, policies, and systems that produce an environment that is conducive to human and individualized care for those being servied."[38]

Each of these statements expresses important elements necessary for the proper functioning of an interdisciplinary health care team. Such factors as recognition of the importance of other allied professionals, active cooperation with them, and respect for the backgrounds and views of others are important first-steps in bridging gaps in interdisciplinary teams. These elements are nonexistent in many codes. Although most medical personnel would probably say that

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[36] American Medical Technologists Code of Ethics, December 1983.

[37] American Nurses' Association, Code for Nurses, 11.3, 1976.

[38] American College of Hospital Administrators Code of Ethics, I, 4, August 29, 1973.

they agree with the above ideas, I think it is significant that their professional organization excludes some or all of them. Because health care ethics have traditionally been considered an intra-professional concern, little is usually said about respecting the views, ideologies, and roles of other professionals to foster inter-disciplinary efforts.

The American Medical Association Code of Ethics states that medical personnel should "utilize the talents of other health care professionals when indicated."[39] Although there have been many interpretations about what this means, it is significant that no mention is included about respecting the ideas, opinions, roles, or ideological backgrounds of other allied professionals, nor about the importance of interdisciplinary work and cooperation. Clearly medical personnel do cooperate with others to varying degrees and attempt to live by high ethical standards, but such activities are not reflected in ethics codes. Such an important omission in a prestigious code such as the AMA cannot be taken lightly.

Although some codes attempt to stress the importance of consultation with other professionals, they do not address these concerns to the types of consultation or work. One code states that "a physician should not hesitate to seek consultation when he himself

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[39] American Medical Association Principles of Medical Ethics, V, 1980.

believes it advisable,"[40] but this says nothing about whether this is consultation with other individual workers, work with treatment teams, or what. Furthermore, the word "consultation" is vague, and no idea is presented in this code about what activities accompany it.

Other codes make sweeping generalizations about patient welfare, and the reader is left to guess what this means. Some of these statements are: "provide services with consideration of human dignity and the uniqueness of their patient,"[41] "share responsibility with associated professionals in meeting the health needs of the public,"[42] "keep patients from harm and injustice,"[43] "function with discretion and integrity,"[44] and "cooperate with other health care professionals and participate in activities to promote community and national efforts to meet the health needs of the public."[45] It is quite puzzling whether these statements mean that patients should be directly or indirectly served by the individual professional

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[40] American Osteopathic Association Code of Ethics, Statement 13, November 28, 1983.

[41] American Society of Radiological Technologists, Principle 2, December 1981.

[42] Code of Professional Practice for Members of American Dietetic Association, October 1970.

[43] Principles of Occupational Therapy; Ethics, V, August 1973.

[44] American Association of Respiratory Therapy Code of Ethics, December 1983.

[45] The Hippocratic Oath.

efforts, through efforts in cooperation with other medical workers, or at all. Again, unclarified terms and meanings hamper adequate interpretation.

What is important is that these statements are representative of those found in up-to-date codes. It is also significant that most codes do not contain a statement about being responsible for the activities of other professionals outside of one's own field. Friedson points out that most health care workers are not concerned with other workers unless such work has direct bearing on theirs.[46] With the many types of treatment teams in existence and inter-disciplinary experiments under way, it is curious that professional organizations do not place more emphasis on the belief that all team members are responsible both to the patient and each other. This suggests that team members need to keep an eye on the activities of the other members to assure an optimum functioning team. Thus, some acknowledgement of these facts should be built into codes of ethics.

The fact that most codes contain a statement about general ethical competency is inadequate for interdisciplinary team concerns. I strongly suspect that protectionist attitudes about roles help foster such omissions.

Just as there are many different professional medical groups, so there are many types of treatment teams. Some form of codified statements needs to encompass the unique activities of teams and the

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[46]Eliot Friedson, Profession of Medicine: A Study of the Sociology of Applied Knowledge (New York: Harper & Row, Publishers, 1970), p. 182.

relationships of their members; for how members view these relationships can have an effect on the way patients are treated. Clearly the relationship of one medical professional to a patient is not the same as that of a team and patient.

An objection might be made that even if such a code existed, it would be as weak and ineffective as others. This may be true to some extent, depending on its enforceability, but this does not negate the necessity for one. If a need is seen for an interdisciplinary code, this indicates that health care organizations recognize the importance of acknowledging the changing roles of medical personnel, that team treatment creates a different relationship with the patient, and that promotion of interdisciplinary activities are requisite given changing social forces which stress a more holistic type of patient care.

The model code is an attempt to construct an interdisciplinary health care code which addresses interdisciplinary teams in general. The reader may find all or parts of it useful for potential inclusion in existing codes. It expresses interdisciplinary respect in health teams, recognition of the uniqueness of each team type and their abilities to create a chosen decision-making system for responsibility attribution, and the importance of inclusion of the patient as part of health teams. One part of the code suggests that the patient may request unconventional medical treatment and participants as part of the health team. Certainly this idea will meet with some resistance, but there are qualifications for its observance which should satisfy both patients and medical personnel.

In conclusion, it is true that no code of ethics can possibly encompass all the varied aspects of professional and moral life which is required for caring for and treating patients. The American College of Osteopathic Surgeons expresses this sentiment:

> No code or set of rules can be framed which will particularize all ethical responsibilities of the physician in the various phases of professional life. The enumeration of obligations in the Code of Ethics is not exhaustive and does not constitute a demand of the existence of other obligations, equally important, though not specifically mentioned.[47]

When obtaining the codes of ethics for this study, one physician stated that he knew his organization was "in accord with the Hippocratic Oath, the Ten Commandments, the American Medical Association Code of Ethics, and Golden Rule."[48] This was a noble attempt to cover all ethical bases, but few organizations ever obtain such lofty heights.

Model Code of Ethics for Interdisciplinary Health Care Teams

The _____ (Association, College, Professional Organization) recognizes that interdisciplinary health care teams are important parts of patient treatment. Their creation has been brought about by social and professional needs which address treatment of the whole individual, thus requiring the recognition for comprehensive treatment forms for patients. Such treatment often necessitates care

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[47] American Osteopathic Association Code of Ethics, Section 6, November 1983.

[48] Author wished to remain anonymous.

by various types of health care personnel who work cooperatively in teams.

To be a professional working in a health team requires that respect be given to the varying health care ideologies of each member. Such ideologies should be respected, for the underlying assumption of interdisciplinary teams is that no one individual has the complete knowledge to analyze, care for, and treat the many facets of patient needs.

Because of the great number of treatment teams which have evolved to treat patients, it is recognized that each team has a unique decision-making structure which allows for varying degrees of participation by the members. It is suggested that each team must bear responsibility for the creation of its own operational and decision-making mechanisms designed to create cooperation and efficiency of the team. To do this means allowing each team member to participate in the design process, thus making the created team a reflection of democratic processes. When possible, the team design should be symbiotic with the host institution for efficient functioning. When this is not possible, the team member must decide whether to attempt to change the institution through internal change, accept the "status quo," or disband. Whatever team forms or activities evolve as a result of the members' interactions, these should reflect and promote high moral standards.

It is further recognized that well-functioning interdisciplinary teams should find mechanisms for keeping current on information which

may assist in team coherency. An efficient team must work to foster an atmosphere which promotes cooperation, which may include educational experiences and opportunities for practicing communication skills. If team members work to foster cooperation and understanding, then patients will benefit as the recipients of an efficient team which will promote healing.

Interdisciplinary teams should also recognize that many more patients are becoming interested in their health and are taking an active role to promote it. Thus, whenever possible, the team should consider the patient to be an active member of the team, and encourage his or her participation as well as respect their views.

During some treatment programs patients may request that the team include an individual whose healing arts have traditionally been condemned by professional medical organizations. When this occurs, the team and patient should carefully consider reasons for allowing or not allowing this individual to participate in the treatment process. Whenever possible, such persons should be included; but if the team deems them detrimental, then the patient should be notified of this decision. If the patient cannot accept the decision, then he or she may seek another team or treatment facility to accommodate such wishes.

The _____ (Association, College, Professional Organization) recognizes the importance of interdisciplinary health care teams and will seek to encourage educational institutions to promote them. Furthermore, continued research in such institutions

is requisite in order to assure high quality patient care which meets the changing needs of society.

In order to appreciate the problems of defining a treatment team, it is necessary to understand how teams are structured. This is the subject considered in Chapter IV.

CHAPTER IV

VARIETIES OF HEALTH CARE TEAMS IN MEDICAL SYSTEMS

Medical institutions are thriving centers of collective and individual activities designed to give patients optimum care and treatment. One of the principal treatment modes is the health care team. Anyone who has been in medical institutions such as hospitals recognizes that teams vary in size, tasks, leadership, organization, goals, and types of personnel. These differences are significant, because each team has been designed to function at an optimum level for differing tasks. This requires that each be specifically designed for a purpose, which makes teams different according to institutional and patient needs. Some may think that all health care teams are basically the same, but this is not true. There may be basic defining characteristics which all share, but this analysis of them is too superficial, for it fails to consider their many structural and functional differences. It is these differences which control their operations and which must be studied if theoretical issues such as collective responsibility are to be adequately addressed.

Just as it is important to remember that there are different types of health care teams it is important to recognize that health teams are not isolated parts of a medical institution. Teams, like medical institutions, are organized and dynamic, and influence, and

are continuously influenced by, the institution. Also medical institutions are embedded in society. Thus, the health care team is constantly being influenced by social factors and reacting to them. It is important, therefore, not to forget the organic nature of teams, society, and medical institutions when considering types of health teams and issues of collective responsibility.

In this chapter, I will explore how health teams fit into the larger organic whole of social institutions and society, consider different ways medical institutions function according to their organizational structures, and explore strengths and weaknesses of previous depictions of treatment teams. Also I will show the importance for keeping discussions about collective responsibility and health teams in perspective. Proper perspective requires that the differences of individual teams first warrant not putting each into a stereotyped mold for all health teams, and second, that considerations of individual teams be seen as influencing, and influenced by, medical institutions and society. Finally, I propose to present a symbology for understanding how treatment teams differ, and how such differences are important for understanding that all teams do not deal with issues of individual and collective responsibility the same way.

Narrow Perspectives and Synoptic Visions

Because health teams and medical institutions are only parts of other, larger systems, it is vital to keep them in proper perspective. It is easy for any analyst to make an unintentional error of perspective by being closed-minded in his or her analytical

research methodology. This typically occurs when knowledge about a single idea predominates research. But this has a price. Perspective may be lost concerning the organic nature of reality which created the object of scrutiny in the first place. Alfred North Whitehead addressed these problems.

As a synoptic philosopher he stressed the importance of recognizing the continual flux of the world even when research required an artificial understanding of it as unchangeable. Such a situation might be a laboratory experiment where the scientist necessarily blocks off particular aspects of reality for careful study. If, however, the scientist fails to also keep the flux in perspective, the "Fallacy of Misplaced Concreteness" occurs. Whitehead defines it as ". . . the accidental mistaking of the abstract for the concrete."[1] Whitehead constantly criticized Newton's narrow visions about matter, space, and time. Concerning matter, Newton is accused of studying only one mode of the occupancy of space; a fixed, "durationless moment."[2] Whitehead states that Newton's moments were "nothing," and that "there are aspects of actualities which are simply ignored so long as we restrict our thoughts . . ."[3]

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[1]Alfred North Whitehead, Science and the Modern World (New York: The Free Press, 1967), p. 52.

[2]Alfred North Whitehead, Modes of Thought (New York: The Free Press, 1966), p. 145.

[3]Alfred North Whitehead, Process and Reality: Corrected Edition, ed. by David Griffin and Donald W. Sherburne (New York: The Free Press, 1978), p. 18.

Similarly, medical institutions can be studied from too narrow a perspective. But how does a researcher keep an intense focus on some particular research aspect of the institution and yet retain a broader vision of the whole? This is an unsolved problem. Some scholars try to resolve it by accumulating vast amounts of data and attempt to mesh it into a synoptic whole. This is often a frustrating task, for diverse methods of study plus conflicting data causes problems. Yet medical institutions are interlocking dynamic wholes, and it seems important to understand the whole picture as well as its particulars. The best we can do at present is study its many subsystems and seek general laws and dynamics which govern their interrelations. In this research health care treatment teams are of primary concern, but they too are subsystems in a larger institution, and any study on them is apt to fall into the trap of narrowness of perspective. In this study I try to keep proper perspective on parts of institutions (teams) as well as the wholes which they compose, for both are continually influencing one another. To separate them creates an artificiality which can lead to faulty research data.

Open and Closed Systems

Although the fact was mentioned that medical institutions (such as hospitals) are in continual process, are its subsystems open or closed? A closed system is often characterized as one which has clearly defined parts, is self-contained, and operates without reference to other systems. If treatment teams are understood as systems then it appears wrong to call them "closed," for they are in

continual flux. Considering Whitehead's insights about the interrelatedness of all organic and inorganic matter, it seems that there are no true closed systems. A more common way to understand closed systems is to consider them as receiving limited input from external forces.[4]

Robert Wilson described the surgical treatment team as a closed system in this latter sense.[5] Surgical teams, he believes, are closest to being closed during operating procedures, for there is little interaction between the team and the rest of the institution for the operation period. One only need reflect for a moment, however, to see that such teams are never completely isolated, for communication channels are always open for emergency blood supplies, drugs, and equipment.

An open system is one that takes into account relations between a system and its environment, which is a concept borrowed from the biological sciences.[6] Hospitals are institutions which embody sets of rules that form a basic operational framework for operation of its subsystems. These rules may be viewed by medical personnel as rigid and inflexible, but usually are combinations of

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[4]Edgar F. Huse, Organizational Development and Change, 2nd ed. (New York: West Publishing Company, 1980), p. 49.

[5]Robert Wilson, "Teamwork in the Operating Room," in Medical Care: Readings in the Sociology of Medicine, ed. W. R. Richard Scott and Edmund H. Volkert (New York: A Wiley Medical Publication, 1966), p. 362.

[6]Huse, Organizational Development, p. 508.

both. At the same time hospitals must be fluid and subject to alteration by internal or external forces if they are to change to meet social needs. Thus, medical institutions are constantly seeking to hold the dynamic tension between social change and fixed operational rules.

Medical Institutions: A Broad Perspective

As stated earlier, the importance of keeping the whole and parts of any system in perspective are important. In Living Systems, James Miller presents such visions.[7] Figure 1 is what he calls a "shred-out" of a living system. The detail of the figure also suggests the complexity of analytic tasks for understanding any system, including medical institutions and treatment teams.

By applying Miller's shred-out concept to health care teams we can begin to see their basic relationships not only to medical institutions but also to society and the world. Figure 2 applies Miller's shred-out perspective to health care teams, and shows how teams are embedded in the multiple systems which influence them. It is also theoretically possible to apply the shred-out process to medical institutions for the study of treatment teams as well as relationships of patients and society. The forms of health care teams are strictly determined by the perspectives of the researcher.

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[7]James Grier Miller, Living Systems (New York: McGraw-Hill Book Company, 1978).

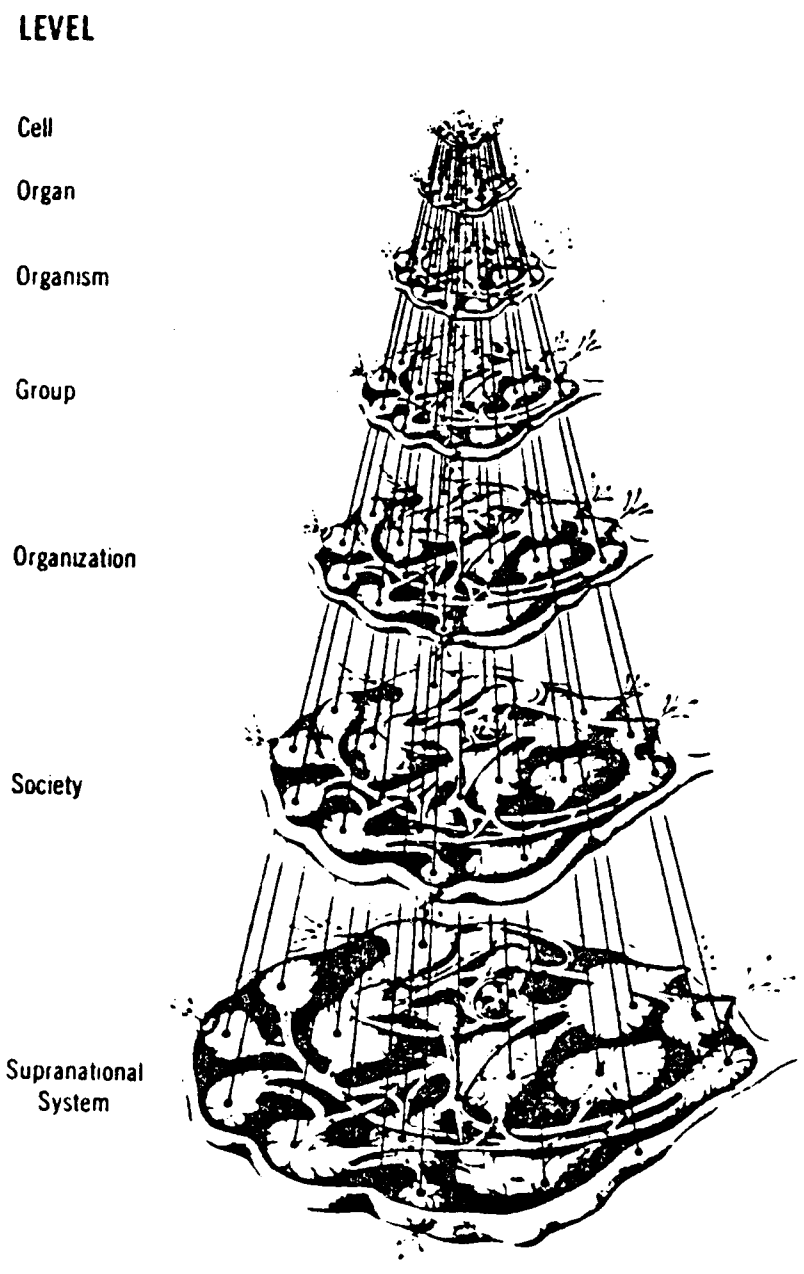


Figure 1. Shred-out of a living system. (Permission to use this figure granted by McGraw-Hill Book Company. From Living System by James Grier Miller, New York, 1978.)

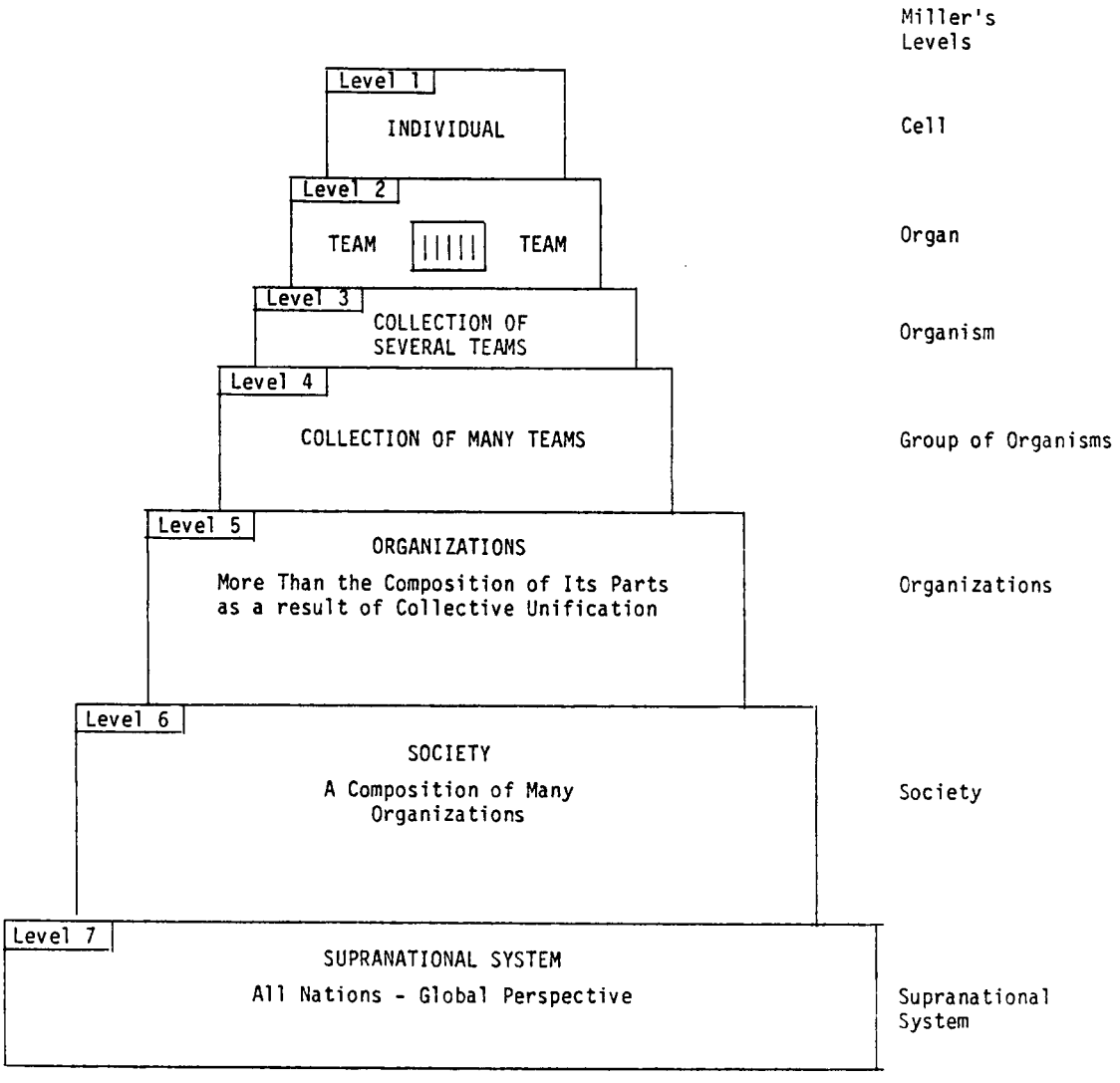


Figure 2. Shred-out of a treatment team.

The Hospital: Characterological and Structural Features

As complex medical systems hospitals operate through diverse health care teams. Because hospitals differ considerably in type and complexity one will be described to give the reader a general sense of the institutional atmosphere, personnel structure, and size.

The hospital to be described is both typical and atypical of others in the United States. It is typical because it fits the model of a large multi-story, multi-wing city hospital. Each floor is divided into many treatment rooms and offices specificially designed to serve patients. There are surgical, neonatal, maternity, and cardiac care units. Also a large emergency room is evident. Auxiliary personnel, such as social workers, chaplains, psychiatrists, and security services are also represented. On one or more floors there is a laboratory complex for testing and diagnostic procedures such as CAT scans, EEG's, X-ray, etc. This hospital has many medical students working with supervisory personnel. Specialists abound, and many of these practice in a physicians office building. Individuals working in a large hospital operate under varying time orientations, and some work eight-hour shifts on wards which have continuous patient care. Information flow is rapid, and diagnosis, treatment, patient care, money collection, and discharge are prime objectives.

A casual observer of this institution would see a busy, hectic place composed of many personnel. Yet visible coordination of their tasks is not evident. These same people seem to do much writing, talking in the halls with one another and with patients, and making

phone calls. The number of intercom pages never seem to cease, and the listener may wonder where all these people go or what they do.

The description above is unlike the atmosphere of a small community hospital which employs few full-time personnel, has little modern equipment, and few beds. Often patients must be referred to larger hospitals a considerable distance away for specialized tests and treatment. In the small hospital most personnel know others by name, but in a large one this is impossible. Thus, the general atmosphere created by the size and type of medical institutions determines to a great extent how it will function.

The Organizational Structures of Hospitals

The way hospitals function is greatly determined by their personnel structures. Every hospital exemplifies one or more methods for assuring high quality patient treatment as a result of organization. Treatment teams are part of such structures, and it is important to consider how these structures influence the function of teams. For instance, whether teams have one leader, or several leaders, is determined by institutional organization, which in turn affects the way decisions are made within teams. Such decisions regularly involve team issues of individual and collective responsibility associated with decision-making processes.

Teams, as well as medical institutions, may be organized in several ways. The model most commonly used contains a hierarchical ordering of personnel and is called the "functional model." This model has a pyramid form with top managers, directors, and department

heads. Other subordinate personnel are assigned to supervisors. This mode, Huse explains, "was based on early management theories regarding specialization, line and staff relations, span of control, authority, and responsibility."[8] Several examples of functional models are presented in Figures 3, 4, and 5. Figure 3 is a simplified version of a functional model which is subdivided into units under the direction of one leader. Figure 4 is an industrial functional model showing only the relationships of managers, supervisors, and foremen, which could be further subdivided to portray individual personnel and their titles. Figure 5 shows a typical functional model for a hospital clinical laboratory and relationships of its personnel. Clearly such models do not express the many inter- and intradepartmental relations which occur on an informal basis, but do present models for understanding the nature of institutional authority structures.

The strength of the functional model is its usefulness for coordinating specialists under the same leader. A few tasks can be centralized with only one or a limited number of coordinators controlling all activities. The fault of this model is evident when a large number of projects are occurring simultaneously, and resource competition occurs. Thus, each department tends to emphasize its own specialized needs during such conflicts, and often ignores the goals of the larger organization.

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[8]Huse, Organizational Development, p. 170.

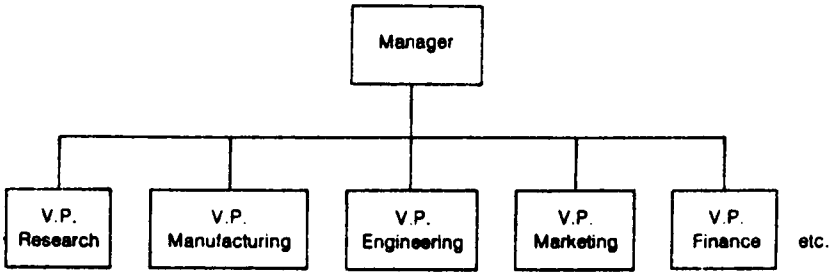


Figure 3. Functional organization A. (Reprinted by permission from Organizational Development and Change, Second Edition by Edgar F. Huse, Copyright 1975, 1980 by West Publishing Company. All rights reserved.)

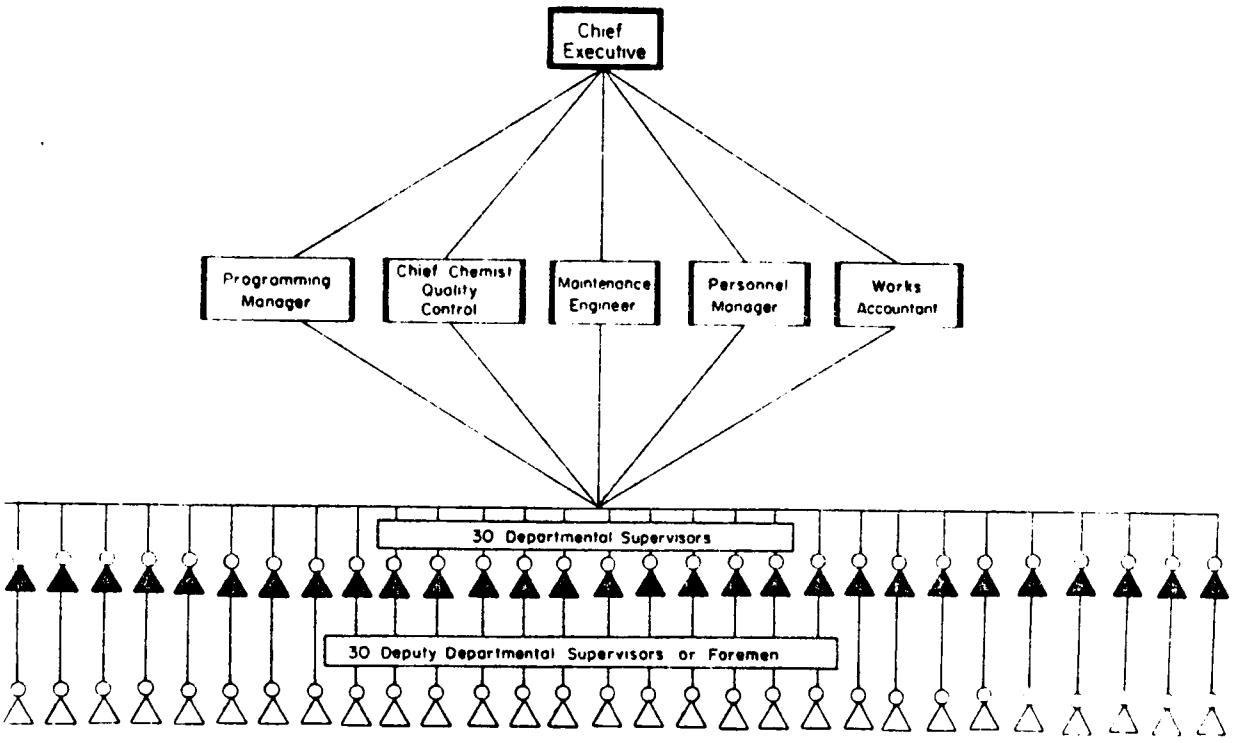


Figure 4. Functional organization B.

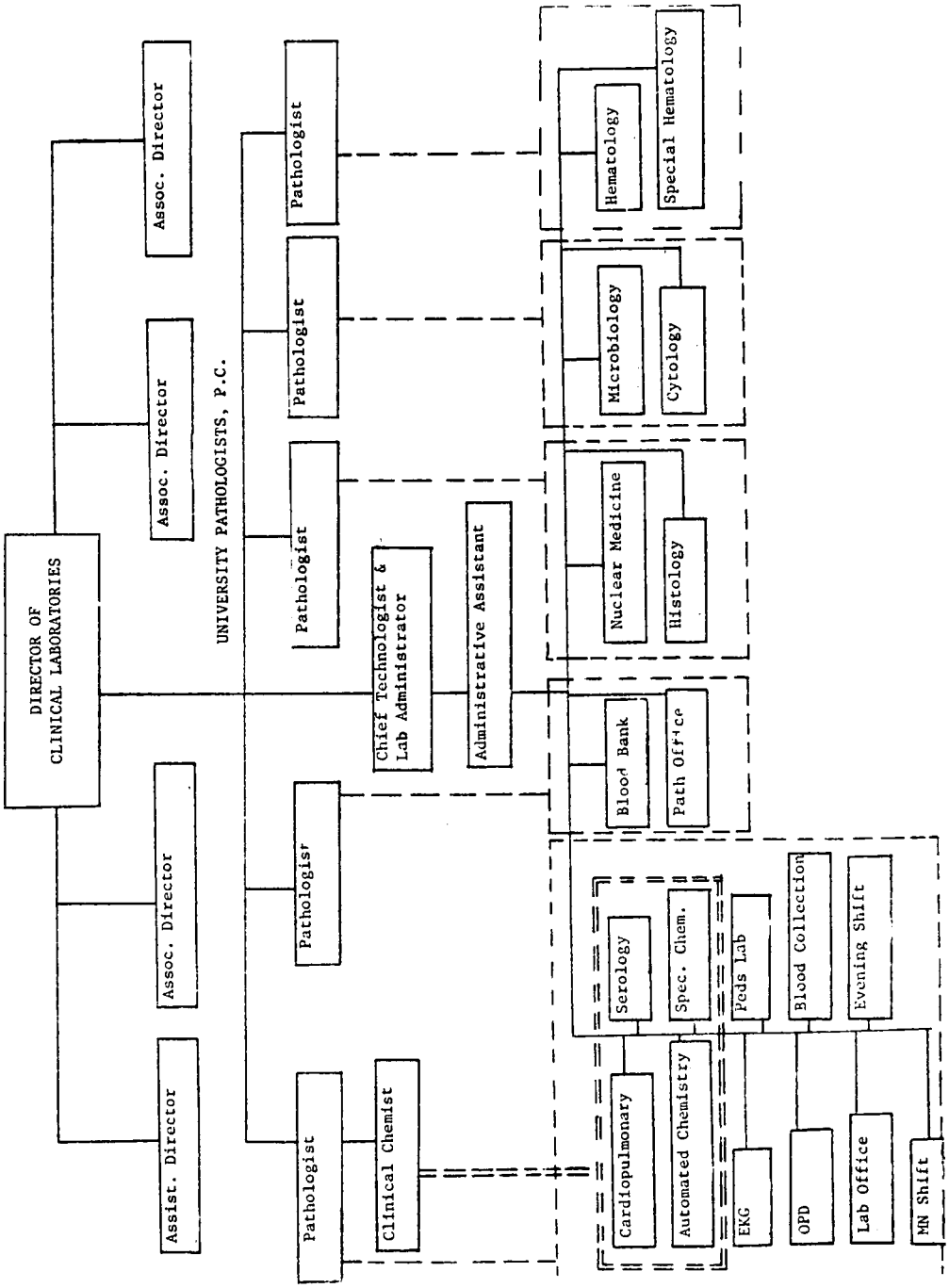


Figure 5. Functional organization C.

The latter statement also rings true for hospitals where competition regularly occurs for grants, private gifts, and local and federal funding. Such situations become more exacerbated if research occurs simultaneously with daily hospital treatment.

A second model is called the product organization, where groups are organized according to goods produced. Units in this model tend to be self-controlled with a department or product manager. For example, Westinghouse specializes in satellite parts, sets up self-contained departments controlled by few external forces, and is specifically designed to create them. The manager is given considerable latitude for obtaining resources in order to complete a smaller task in the larger organization. In short, the total organization creates smaller specialized units (sometimes temporary) for specific accomplishment of some end. Such projects require an internal division of departments into functional subdivisions. One might say that specialized treatment departments in hospitals meet the qualifications to be termed product oriented, such as intensive care units or specialized surgery. Figure 6 shows a typical product model. Note that it is possible to call most hospital departments "product oriented" in light of the way personnel pool specialized knowledge for patient treatment. To consider health care to produce a product like satellite parts may be an unpopular thesis. Some administrations understand health care to be strictly a commodity, while health workers understand it as a right regardless of cost. Thus, medical institutions often reflect these inherent tensions.

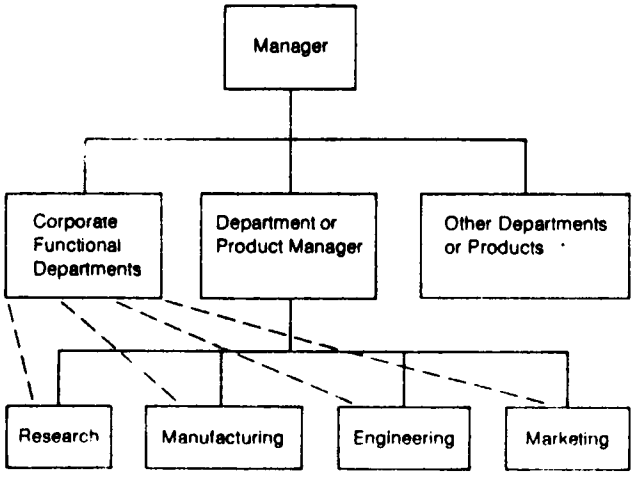


Figure 6. Product organization model. (Reprinted by permission from Organizational Development and Change, Second Edition by Edgar F. Huse, Copyright 1975, 1980 by West Publishing Co. All rights reserved.)

Advantages of the product model are that it brings greater unity or purpose to a department if the goals are clear. Because the manager is in control the department functions smoothly since he or she directs all resources. Product structures have the capacity for quick information flow and coordination, but are reduced in ability to develop specialization—especially for long-term projects.

The third model is the matrix, which comes closer to the ways most large hospitals operate. Figure 7 shows one schematic of a matrix design in an Aerospace Division. This is a structure which is more like a web of relationships aimed at initiation and completion of specific projects.[9] Unfortunately, there is little consensus about

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[9]Ibid., p. 180.

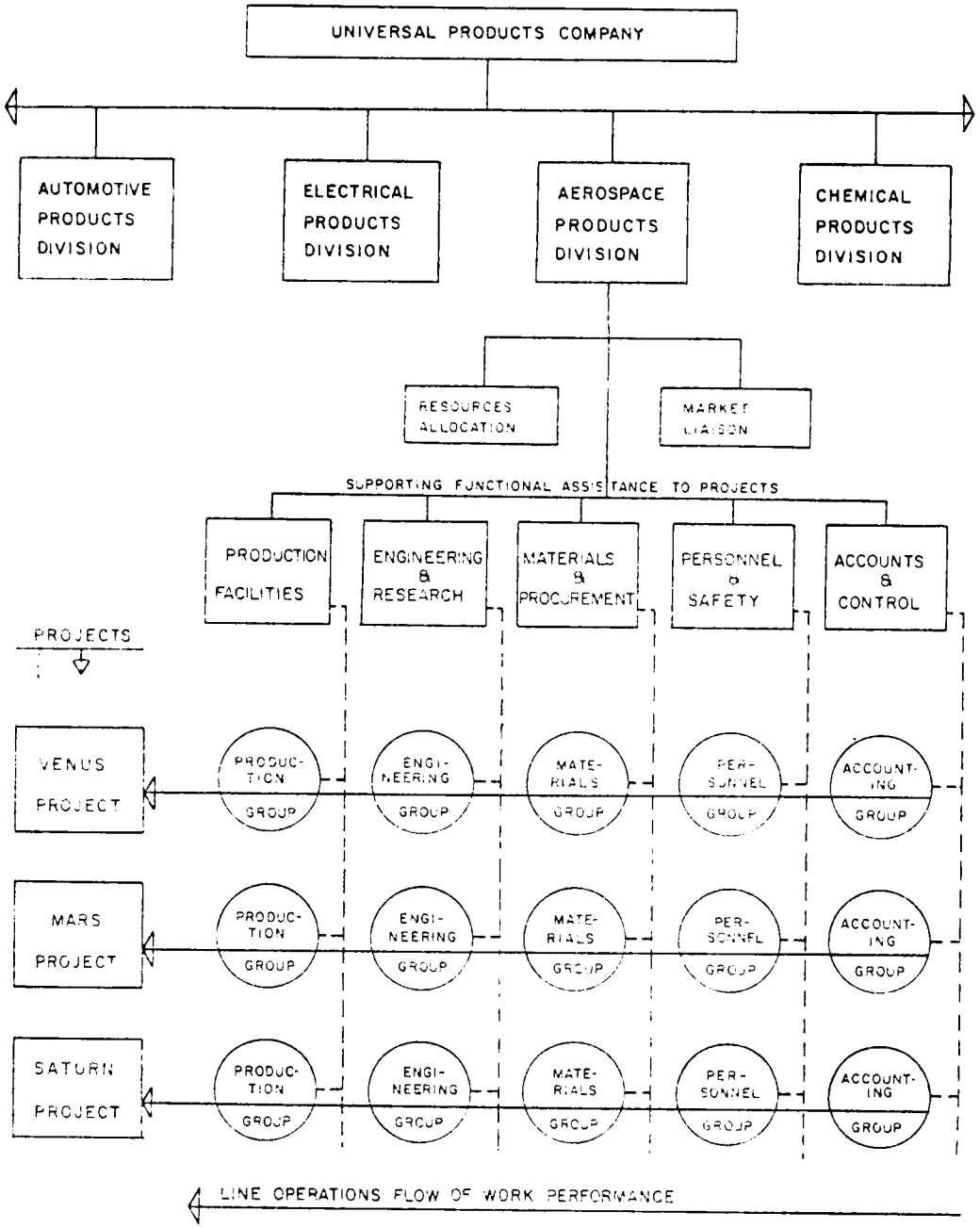


Figure 7. Matrix organization (Aerospace Division). (Reprinted by permission of the publisher from "Matrix Organization," by John F. Mee, Business Horizons, Summer 1964.)

what a matrix model is, and other labels have been used to suggest its function, such as grid structure, multidimensional structure, or global matrix. A matrix organization is, by definition, one that implies continuous organizational possibilities, and is best suited for process analysis.

A recent study suggests that matrix organizations develop under environmental conditions which must adapt to three circumstances: external pressures for a dual focus, pressures for processing capacity and high information processing abilities, and shared resource pressures.[10]

Outside pressure for a dual focus is requisite when one individual is incapable of dealing with a task, a shift toward specialization begins, and multiple persons with diverse professional backgrounds are necessitated for project completion. A high degree of coordination and differentiation is necessary for directing specialists to meet customer needs.

Matrix organizations are commonly formed due to the tremendous amount of information that must be processed. The complexity of treating a patient, for example, requires that many forms be filled out, calls made within and outside of a hospital, personnel be coordinated for efficiency, financial arrangements made, etc. It is mathematically assured that when the number of personnel increase the paperwork multiplies, which requires even more workers to handle

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[10]Ibid., p. 185.

it. If a matrix organization is properly functioning it will have personnel who act in general management capacities for coordination of increased information flows.

Shared information is a third condition for a matrix organization. This is especially critical in hospitals where a few highly trained specialists are available who offer expensive treatments. Strong internal pressures usually exist to share resources in an environment that quickly changes.

Advantages of the matrix organization are the coordination among department lines and a clear visibility of project objectives. But matrix organizations are difficult to manage and are fraught with the two major problems: they encourage power struggles and cause confusion concerning the matrix organization and group decision-making.[11] Power struggles often occur when personnel get caught between two or more bosses, and this sets up conflict. Such conflicts are regular occurrences in medical centers. Recall that on the matrix line chart managers usually report to functional department heads. This is a vertical relationship, but horizontally "the manager reports to the project coordinator or project manager."[12]

The second problem of confusion between matrix and group decision-making is often the result of pilot projects which develop

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[11]S. David and P. Lawrence, "Problems of Matrix Organizations," Harvard Business Review 56(3) (May/June 1980):131-142.

[12]Huse, Organizational Development, p. 192.

into matrix organizations. It occasionally happens that once a matrix organization is in operation, many personnel still want to control decision-making processes as they did in the earlier pilot program. Matrix structures are designed for individuals to make many decisions by relying less on groups. Certainly the roles of members must be clarified so that all workers need not be present for various types of decisions few can responsibly carry out.

Patterns of Dependence in Matrix Organizations

Research has shown that as the number of organizational units increase, collaboration and coordination become more difficult.[13] In matrix organizations there are always many types of interdependent activities of members and teams which complicates coordination and responsibility attribution. Three types of interdependent patterns will be discussed because they are all crucial for understanding how teams relate to one another as well as how team members interact.

Collective, or pooled dependence designates two or more units bound only by the fact that they are owned by the same company, manager, or supervisor. As shown in Figure 8 they rarely interact, and if so, only indirectly. For example, Kentucky Fried Chicken has many restaurants which are franchised and separately operated, but all are required to meet performance expectations of the main headquarters.

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[13] J. Thompson, Organizations in Action (New York: McGraw-Hill Book Company, 1967).

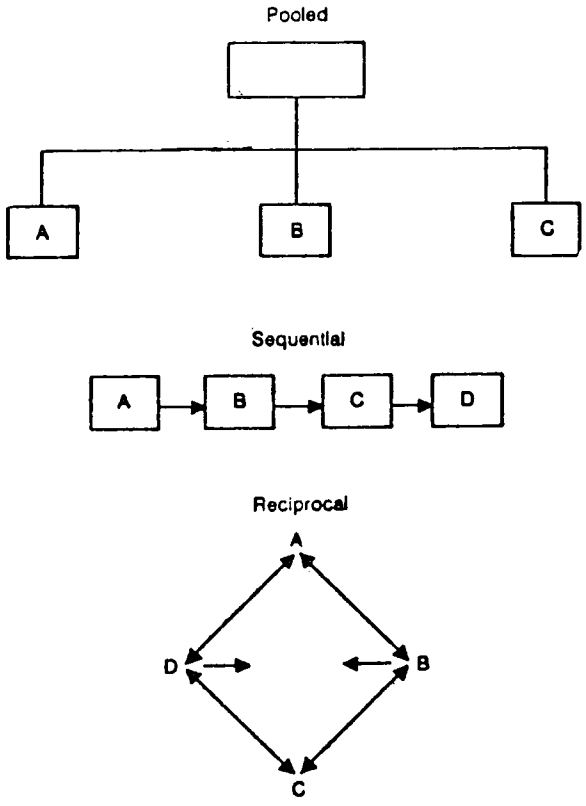


Figure 8. Patterns of interdependence. (Reprinted by permission from Organizational Development and Change, Second Edition by Edgar F. Huse, Copyright 1975, 1980 by West Publishing Co. All rights reserved.)

In hospitals the medical research department may be disassociated from many other services and departments such as social work, chaplain's office, or nutritionist. It is not unusual, however, for persons treating patients to be involved in joint adventures involving many departments. Some departments, though, rarely interact, such as the research and food services departments, or X-ray and accounting departments. Many departments are only related by the fact that they are in the same institution.

A second type of dependence is labeled "sequential," which requires that one unit perform an activity before another can properly do its task. For example, a hospital pharmacy must prepare medications before they can be dispensed on the maternity ward. Sequential activities require more coordination and planning than pooled interactions.

The sequential model is equally applicable to individual relations, for the diagnosis made by a physician is often dependent on a sequence of relationships with other individuals and teams. A distinction should be made between all testing and observations of a patient prior to diagnosis which occurs in a nonspecified order, and the sequential work that is necessitated by previous work of others. One example of necessary sequential work by another is the prepping of a patient for surgery, where the nurse puts an NPO sign on the patient's door and an anesthesiologist administers a shot to make the patient drowsy prior to surgery. These activities must necessarily occur within a particular order. However, the fact that a maid cleaned the bathroom at 10 a.m. has no direct bearing on the patient's preparations for surgery, even though the clearning occurred prior to it. Thus, the concept of sequence is one of causal necessity, not of random occurrence. The sequence of events in treatment teams is also important because relationships of members to one another and patients determines how responsibility attribution occurs.

The third type of dependence is called "reciprocal," for such relationships stress the fact that inputs and outputs penetrate other units, and that those sending out information are also penetrated by other units. Hospitals are reciprocal by necessity and must include both pooled and sequential relationships. Several examples of reciprocal relationships are the interactions between nurses and physicians, conferences of medical specialists, and the interrelations of a rounding health care team. Sequential relations are the best vehicle for rapid information exchange among several medical personnel, but this also sets up greater potential for conflict.

These three patterns of dependence are useful tools for analysis of the interactions of teams and individuals in medical institutions, but again suffer from a lack of process perspective. It would probably be helpful if analysts utilizing them consider multiple dependence patterns in order to obtain a clearer picture of the true complexity of hospital personnel and its structure. This is again reiterated in regard to the often short-sightedness of some analytical discussions about medical institutions and teams, and reemphasizes the importance of enlarging the analytic focus while keeping an eye on particulars.

Previous Depictions of Treatment Teams in Medical Literature

The interrelations of treatment teams and medical personnel have been portrayed by researchers in diverse ways. A useful tool for understanding the structure of teams is to consider how other

scholars have portrayed them through diagrams in contemporary publications.

Parker has presented one of the most interesting depictions of the primary health care team.[14] Figure 9 attempts to show that treatment teams have an expanding and contracting nucleus which involves other personnel and treatment forms necessary for patient care. Around the nucleus are two concentric circles; the outermost representing occasional services by specialists, and the middle circle depicting treatment specialties, paramedical and adjunctive services, support to team services, and team consultants. Parker's examples of resource specialists who have little contact with nuclear members are "the speech therapist in the case of a child with a cleft palate, the psychologist in the case of the neurologically handicapped, and the plastic surgeon in the case of the severely burned patient."[15]

One shortcoming of this model is that it is too simplistic, for it makes no distinctions among possible varieties and types of teams that can be formed, except in the most remote fashion by using a variable nucleus. Second, the division of the middle circle into three sections fails to capture the interrelations of these service

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[14]Alberta W. Parker, The Team Approach to Primary Health Care (California: The University of California Extension Service, 1972), p. 15.

[15]Ibid., p. 16.

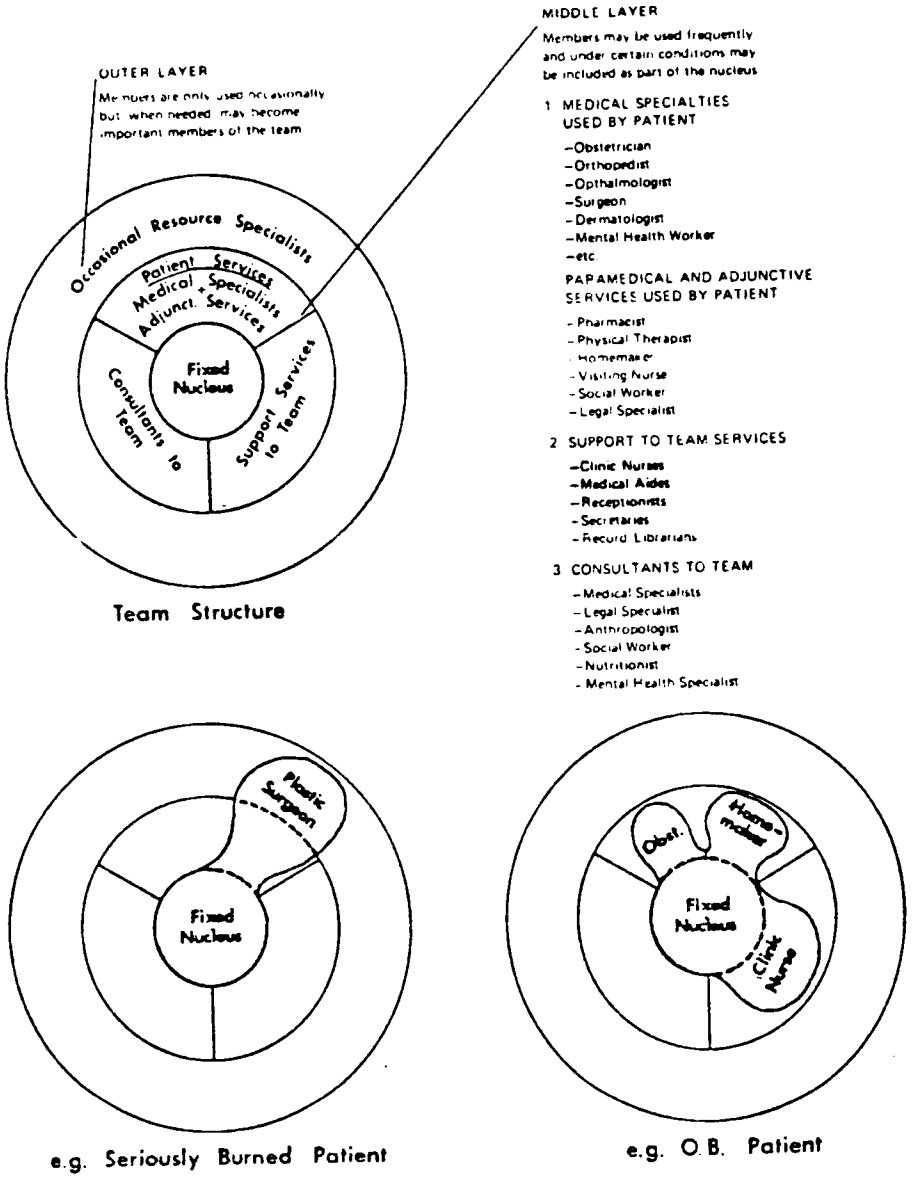


Figure 9. The primary health care team. (Reprinted by permission of Albert W. Parker from The Team Approach to Primary Health Care (California: The University of California Extension Service, 1972.)

departments and their personnel. Also the vague notion of an expanding nucleus does not help resolve this problem. Furthermore, it is not clear what the exact relationship is among the specialists in the outer circle to the middle circle and nucleus. As a general organic representation for the plasticity of the treatment team it services a purpose, but beyond this provides little useful information about treatment team functions or compositions.

Figure 10 is another portrayal of treatment teams by Hurka and is a hierarchical functional model.[16] He attempts to present the composition of three teams by considering their horizontal and vertical coordination patterns in relationship to several medical departments. His depiction is superior to Parker's because it shows relationships among particular team members as well as their departments.

Once more this model suffers from lack of detail because it has a pyramid structure. It presents no clarity about the relationships of personnel on the teams nor gives any suggestion about the diversity of team types. Also, treatment teams occasionally interact and share members, but this factor is not expressed in Hurka's figure. His model does serve a useful purpose by expressing the complexity of team personnel and their departments, but beyond this it is of little value.

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[16]Slavek J. Hurka, "A Mix of Organizational Models," Dimensions in Health Care 56(4) (April 1978):55.

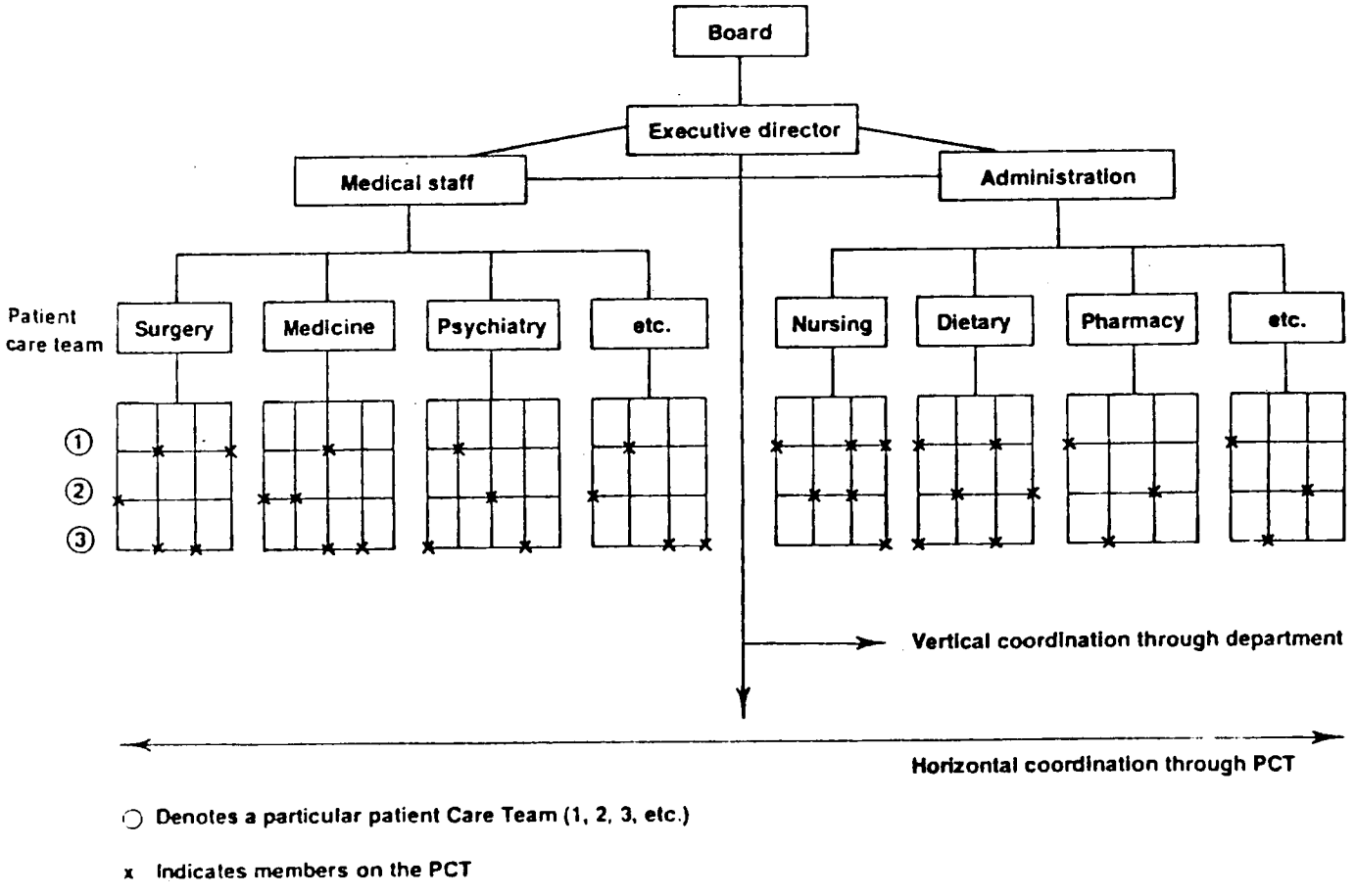


Figure 10. Hurka's team model. (Reprinted with permission from Dimensions in Health Care April 1978, Vol. 58, No. 4, p. 17.)

Figure 11 represents a patient-centered treatment team. This model was designed to depict the interrelationships of medical students with mentors working together in long-term treatment settings. This program was designed to study the "theory and practice of team building, including weekly sessions on leadership styles, communication, group decision-making, and team effectiveness assessment."[17] As a general sketch it serves a purpose by showing limited

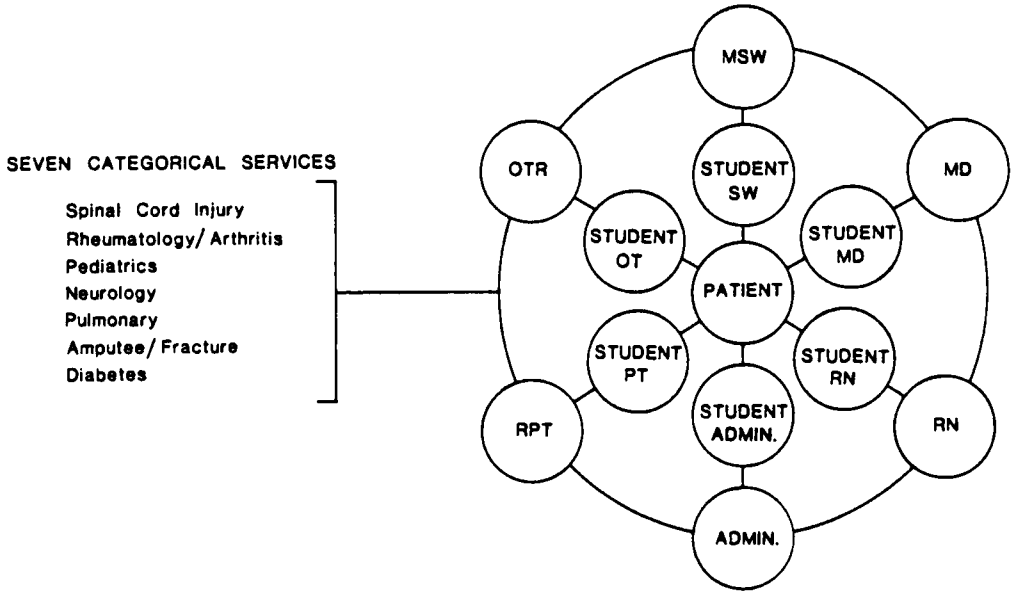


Figure 11. A patient-centered team model. (Reprinted by permission of the Association of American Medical Colleges, as appearing in The Journal of Medical Education, Sept. 1979, "Clinical Interdisciplinary Health Team Care," by Harold Mazur, John Beeston, and Elizabeth Yerxa.)

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[17] Harold Mazur, John J. Beeskin, Elizabeth J. Yerxa, "Clinical Interdisciplinary Health Treatment Care: An Educational Experiment," Journal of Medical Education 54 (September 1979):703.

relationships of medical personnel, students, and patients. Unfortunately, no hint is given in the article it appeared in about the interrelationships of these personnel with one another or patients. Seven teams were formed for the seven categorical services mentioned to the left of the diagram, but no help is given to show the similarities or differences of these team structures. One is led to believe they are merely called teams because a collectivity of persons work together to treat a common patient. It is also unclear if the team members rounded together or worked with patients in some loose collective fashion. The figure used to depict the teams is a poor representation of the reality of the everyday life of medical personnel as well as the functions of their teams.

Figure 12 was created by Wise and Beckhard. It expressed an

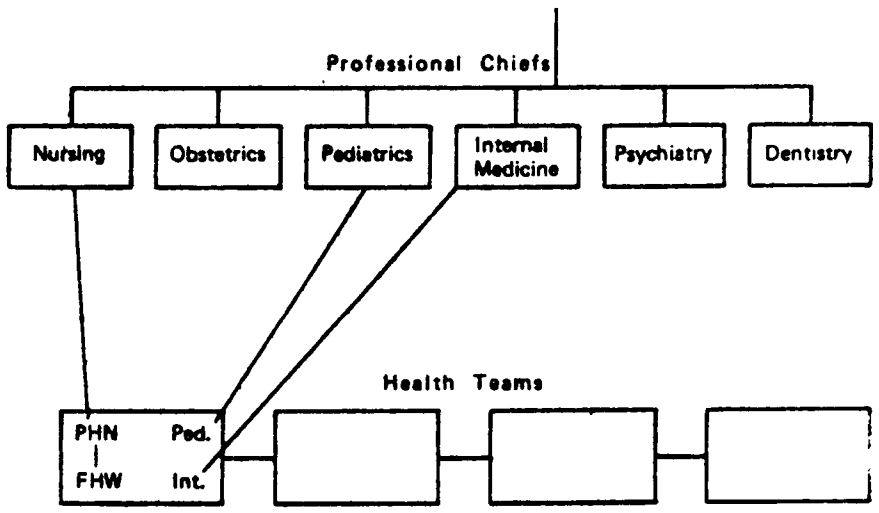


Figure 12. Simplified team model. (Reprinted by permission of Harold Wise from Making Health Care Teams Work (Massachusetts: Ballinger Publishing Company, 1974.))

extremely simplistic form for the formation of teams from various departments of medicine and auxiliary services.[18] This figure is similar to the others in its intent to show how teams are formed from various hospital personnel. Again it lacks recognition of team type differences, does not show interactions of teams, and fails to the diverse work time-frames of teams and their personnel.

It may appear that I have been too critical about these figures because they were designed for some limited purpose. The point in showing their inadequacies is to express concern about the deception of over-simplicity. Such figures tend to depict treatment teams as equivalent in nature and structure, and few consider the importance of including the patient as part of treatment teams. All of the shortcomings of these diagrams must not be overlooked, for the aspects omitted from all of them are important factors for studying health teams and individual or collective responsibility. How the teams' members relate to one another, their patients, and the medical institutions are significant, and determine to a great extent the ways they cooperate, or fail to cooperate, concerning moral issues involving responsibility.

A Symbolic Description of Health Care Teams

After reviewing a considerable body of literature on treatment teams it became clear that language used for describing them is

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[18]Harold Wise, Richard Beckhard, Irwin Rubin, and Aileen L. Kyte, Making Health Care Teams Work (Massachusetts: Ballinger Publishing Company, 1974), p. 76.

inadequate. For instance, nondiscriminative uses of the term "health care team" leads to the conclusions that all health teams are basically alike. In order to avoid this idea it is helpful to have descriptive and symbolic methods for distinguishing the many types. Such clarifications can be based on the team's function, number of members, type of leadership, specializations of personnel, work setting, and relationship to patients. All of these factors, and others, are important considerations when analyzing health care teams and responsibility. These team variables are important for determining how each functions according to some unique manner of collective or individual decision-making designed to suit its structure. In this section I present a rudimentary symbology to explore some of the many differences of health care teams, and propose that such differences do influence problems of personal and collective responsibility of teams.

General team categories. In most medical institutions there are at least three basic types of treatment teams: the open formation team, the representative team, and the leadership-centered team.

The open formation team gains its characterization because it refers to those which never have closure but are constantly expanding and contracting. Such a team might include all nurses who treat a common patient populace. Although each nurse may have particular duties and patient assignments, situations arise where subteams must be formed to meet unexpected needs. Two or more personnel may join

for temporary task accomplishment and then disband upon its completion. All team members in the open formation team are potential subteam workers.

Open teams typically operate around a central office with patient beds or treatment rooms surrounding it. These teams operate 24-hours a day and have three 8-hour work shifts. Thus, continuity of work can occur when assignments are shared between shifts. Such teams may be considered "organic" in nature because of their abilities to be flexible and change to adapt to the environment of day-to-day medical life.

A second general type of team has a more stable structure than the open team. The representative team regularly sends one of its workers to the patient's room for treatment, diagnosis, or samples. There are three basic types of representative teams. Category A teams exercise the option of either sending workers to a patient's room or of bringing the patient to a treatment area. Such teams might be respiratory therapy, physical therapy, or psychiatry. Category B teams must bring a patient to the work area, for the size and type of their equipment prohibits taking it to the patient's room. Such services might be CAT scan, X-ray, and even various types of surgical teams that transport patients to surgery. Type C teams do not transport patients but obtain samples (tissue, blood, urine) and information in the patient's room. Samples are then taken to another area in the institution for analysis in a stable team structure.

Some characteristics of representative teams are that they have a rigid structure, maintain a stable collective identity because of the specializations of the personnel, and usually function during the day. Representative teams differ, however, in the ways they work and meet. Such teams usually work in one room, are surrounded by laboratory equipment, and rarely meet patients. Information sharing is often confined within these settings, and teams' leaders do not need to be present for workers to perform their tasks.

The third type of team category is the leadership-centered team. These teams send a representative to patient rooms for the accomplishment of some task. One example is the surgical team which sends an anesthesiologist to prepare a patient for surgery. Leadership teams are distinguished because of their leadership organization. In such teams leaders must be present during the team's operation, while representative teams do not necessitate this. Another characteristic of leadership teams is that they tend to meet for short periods of time for a task accomplishment, disband, and reassemble again for further work. Surgical teams often fit this description.

The health care monitor. There is a common misconception that physicians who coordinate patients' care in medical institutions are necessarily part of one or more health care teams. If a physician is a full-time staff member and works regularly with health teams, then he or she is considered a team member. A more common scenario, especially in hospitals, is for a physician to set up time for a patient

to be admitted to a hospital, and then monitor test results and care. In this capacity the physician is a coordinator of tests and treatment carried out by hospital personnel, and in this sense does not become a member in a regular team network. For the health care monitor it often makes little difference which hospital workers administer lab tests, but only that the work gets accomplished. The health care monitor also has many impersonal relationships with hospital staff during most of the patient's care and treatment.

Treatment team classifications. Although I have presented several general categories for describing treatment teams, teams can be further subdivided to reflect their differences in greater detail. Such differences do influence decision-making processes and are important for the study of collective responsibility.

Abbreviations

CSTT The continuous substitution treatment team has an open formation. The team operates 24 hours a day, has three 8-hour shifts and maintains a stable identity due to its purpose. The CSTT has a centralized meeting place and can quickly rearrange its members into temporary smaller teams for task accomplishment. Such a team might be found on any patient ward or in any hospital emergency room.

TFTT A temporary fixed treatment team is composed of medical professionals who assemble for a limited time for task accomplishment and who work together on a regular basis. These

teams are "closed systems" using the more liberal meaning of the term described earlier in this chapter.

TSTT Temporary substitution treatment teams are similar to TFTT teams, except that they are constantly changing personnel. Such teams have one or two core workers, while other participants are present on availability and convenience. Once the TSTT team accomplishes its task it disbands, and another team with several different personnel is formed. Many surgical teams could fit this description.

TVRT The temporary variable rounding team is typically interdisciplinary. Co-workers temporarily work together to diagnose and treat patients. These workers can be representatives from other teams or only one specialist may be available. The TVRT usually assembles on a ward, visits a specific number of patients, and discusses cases. After this members go about their assigned tasks as directed by team needs. Such teams are variable because they are composed of one or two core members while others join the team when available. Such a team might be designed for instructing medical students or non-medical staff.

ERC The emergency random collectivity is a formation of medical workers drawn together during emergency circumstances. For example, if a patient needs emergency treatment it is often the case that the nearest medical personnel join together to help even if they are from different wards or various health

specialties. Such persons work together only for the duration of the emergency and then disband. The ERC is not a team even though all workers have a temporary goal: alleviation of patient distress. This factor alone, however, does not qualify these workers as a team, but only as a collectivity.

MTTW This abbreviation represents a multiple treatment team membership. It signifies a health professional who serves on several teams.

DTT The dysfunctional treatment team is one that fails to accomplish some goal or goals.

FTT The functional treatment team is one that is successful in accomplishing its goal or goals.

Classifications of individual health care workers. As mentioned earlier, many teams are represented by one or more of their members. Therefore, it is necessary to have some way to classify the different relationships they have to teams and patients as well as other important individual health workers.

HCM The health care monitor was described as a coordinator of patient care and is usually a physician. The monitor is not part of an ongoing team but visits patients to check on progress of hospital testing and treatment. The HCM are said to be "reduced to a kind of ceremonious middle man whose chief work is to mediate between the patient and an array of technical and specialized resources for both diagnosis and

treatment."[19] Some call this monitoring role one of gatekeeper or communications switchboard.

IA — The independent agent is any health care worker who is not part of a treatment team. This individual might be a priest or patient representative. This does not mean that he or she does not have connections with organizations outside the medical institutions, but usually that this person acts on his or her own cognizance.

P — This letter designates the patient.

IR(TFTT)
IR(TSTT)
IR(CSTT)
IR(TVRT) — Each of these abbreviations signifies that an individual representative (IR) is serving in some capacity away from the team's primary centralized location. For instance, in the case of a rounding team the individual representative is acting on behalf of the team according to an assignment.

OIT — OIT means on-ward intermediary transport. It may be the case that a treatment team does not choose to send one of its members to take the patient from a room to their service area. Thus, they might send an orderly or another worker to transport the patient. This does not change the nature of the team's function, but only its temporary relationship to the patient.

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[19]Wilson, "The Physician's Changing Hospital Role," Medical Care: Readings in the Sociology of Medicine, p. 419.

OWTR The on-ward team representative is a person assigned to represent a team by entering hospital wards for treating patients. The person always treats patients on wards.

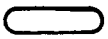
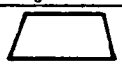
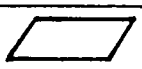
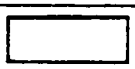
OWTRT The on-ward representative transport designates any individual who comes to a ward as a team representative to obtain specimens, samples, or information which will be taken to a team analysis area.

Table I contains all the above abbreviations plus symbols used to designate each one. These symbols will be used in the rest of this chapter.

Symbolic interrelationships of treatment teams. The previous section presented symbols and abbreviations for the various teams and their individual representatives, but this explains nothing about their interrelationships. In this section a rudimentary symbology will be presented which can be a useful tool for the analysis of the differing health care teams. The differences expressed through the symbology should make it evident that these factors direct creative discussions concerning the topics of health care teams and collective responsibility.

The symbols and abbreviations already presented for teams were general, and each one could represent varieties of teams. For instance, CSTT could refer to an intensive care cardiac unit, a neonatal ICU, or a nursing staff in a hospital. Although the general symbols do not express much about team differences, it is possible to study teams according to these classifications. Such study helps

Table I. Reference Table for Abbreviations, Symbols, and Titles of Treatment Teams and Individual Health Care Workers

Abbreviation	Symbol	Title
HCMS		Health Care Monitor System
CSTT		Continuous Substitution Treatment Team
TFTT		Temporary Fixed Treatment Team
TSTT		Temporary Substitution Treatment Team
TVRT		Temporary Variable Rounding Team
ERC		Emergency Random Collectivity
DTT		Dysfunctional
IRTFTT		Individual Representative from Temporary Fixed Treatment Team
IRCSTT		Individual Representative from Continuous Substitution Treatment Team
IRTSTT		Individual Representative from Temporary Substitution Treatment Team
IRTFRT		Individual Representative from Temporary Fixed Rounding Team
IRTVRT		Individual Representative from Temporary Variable Rounding Team
OIT		On-Ward Intermediary Transport
OWTR		On-Ward Team Representative
OWTRT	TR in Team Symbol	On-Ward Team Representative Transport
MTTM		Multiple Treatment Team Membership
IA		Independent Agent
FTT		Functional Treatment Team

us understand how interactions of personnel, numbers of workers, leadership structures, decision-making processes, etc., are similar or differ concerning the way these factors influence responsibility attributions in such teams.

One problem in using the general symbology is that it explains little about a particular type of team. We may know that a team is a TSTT, but many teams fit this description. By expanding the symbology it is possible to specify both the general and specific type of team. If "NE" means "neurological treatment team," these symbols can easily be placed within the general TSTT symbol, and we obtain the following composite: 

. This can easily be done for any specific letter designation in conjunction with any of the general symbols. Furthermore, if we designate capital letters to represent teams and the same lower case letters to represent individuals, we can distinguish between a team and its representatives. The symbols "ne" indicate that a neurologist is acting as an individual representative for team, but this does not tell us what type of team is being represented. Hence, a more complex symbol, 

, indicates that we are dealing with a TFTT, that the social worker is acting as its representative, and that it is a general practice team. This symbol, 

, indicates that a neurologist from a TFTT is acting as a representative of a neurological team.

In some cases further distinctions are necessary. Some analysts may desire to symbolize the idea that a particular individual

is representing a "specific type" of surgical team. This symbol, 

, represents a TFTT surgical team (indicated by the "S") and that an anesthesiologist is acting as its representative (indicated by the "an"). The "OP" indicates that the team is an opthalmological surgery team. By using the symbols in Table II the possibilities for team representations seem unlimited.[20]

In medical institutions such as hospitals there are many different types of teams embedded in larger ones. For example, on a surgical patient ward there will always be a nursing staff which could properly be considered a team. Within this team there are many subteams and patient representatives coming and going. Hospitals are organic in nature because teams, patients, and their representatives are continually interacting. Thus, it seems important to be able to symbolize many of these interactions. Figure 13 depicts many imbedded teams within a larger one. The larger team is a pediatrics intensive care nursing staff which is symbolized as a continuous substitution treatment team (CSTT). During a particular time of the day several teams interact with the CSTT team: a General Practice TFRT, an Internal Medicine TVRT, and a Nephrology TFTT. Different parts of treatment wards will have several types of fixed teams which rarely interact with others, while some teams are

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[20] Standard Occupational & Classification Manual, 1980, U.S. Department of Commerce: Office of Federal Statistics Policy and Standards, pp. 78-95; 95-96.

Table II. Letter Designations for Medical Personnel and Departments

Letters		Title
GNS	gns	General Nursing, Surgical Ward
GNP	gnp	General Nursing, Pediatrics Ward
GNO	gno	General Nursing, Oncology Ward
GNM	gnm	General Nursing, Maternity Ward
GNM	gnt	General Nursing, Mixed Patients
GNI	gni	General Nursing, Isolation Ward
GNP	gnp	General Nursing, Psychiatric Ward
NGB	ngb	General Nursing, OB/GYN Ward
NIC	nic	General Nursing, ICU Cardiac Care Unit
NIB	nib	General Nursing, Burn Unit
NER	ner	General Nursing, Emergency Room
NIP	nip	General Nursing, ICU Pediatrics
NLD	nld	General Nursing, Labor and Delivery
NNN	nnn	General Nursing, Newborn Nursery
E	e	Electroencephalography
RI	ri	Radioactive Isotopes
BB	bb	Blood Bank
PT	pt	Physical Therapy
GP	gp	General Practice
PA	pa	Pathology
IM	im	Internal Medicine
AN	an	Anaesthesiologist
BA	ba	Blood Analysis
RA	ra	Radiology
XR	xr	X-ray
DI	di	Dietary
FS	fs	Food Services
NE	ne	Neurology
DE	de	Dentistry
OP	op	Ophthamology
UR	ur	Urology
CY	cy	Cytology
GR	gr	Geriatrics
RT	rt	Respiratory Therapy
PR	pr	Physical Therapy
HS	hs	Histology
NM	nm	Nuclear Medicine
MB	mb	Microbiology
CP	cp	Cardiopulmonary

Letters		Title
SW	sw	Social Work
CH	ch	Chaplain
PS	ps	Psychiatry
PY	py	Psychology
SC	sc	Security
CP	cp	Cardiopulmonary
CV	cv	Cardiovascular
O	o	Orthopedics
PH	ph	Pharmacy
AD	ad	Admissions
CT	ct	Colon and Rectal
EN	en	Endocrinology
GE	ge	Gastroenterrorhaphy
GN	gn	Gynecology
N	n	Neurology
NE	ne	Nephrology
IM	im	Internal Medicine
OL	ol	Otorhinolaryngology
RS	rs	Reconstructive Surgery
H	h	Heart Specialist
PH	ph	Physiatrics
SR	sr	Serology
AC	ac	Automated Chemistry
LD	ld	Labor and Delivery
ON	on	Oncology
B	b	Burn
NB	nb	Newborn
P	p	Pediatric
MS	ms	Medical Student
S	s	Surgery
GP	gp	General Practice
NU	nu	Nutritionist
RD	rd	Renal Dialysis
HE	he	Head Specialist
NR	nr	Night Representative
ER	er	Emergency Room
OW	ow	Oncology
G	g	Gerontologist
SN	sn	Surgical Nurse

Capital letters—teams; small letters—team representatives.

are always interactional. Using such symbology has its limitations, because it is impossible to adequately represent the fluidity of hospital life and the many interactions of medical personnel. However, it allows us to capture part of the picture for analyzing types of teams.

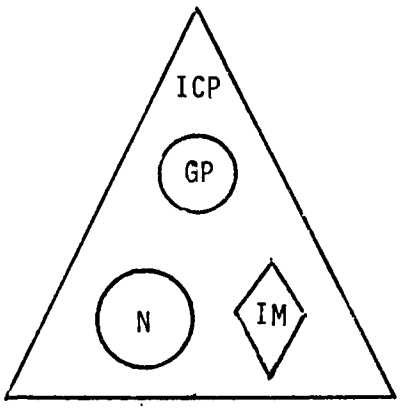


Figure 13. Complex system of teams.

Symbolizing patient and team interactions. Because the patient is often the center of treatment team activities, it is important to symbolize these relationships. By placing the general treatment team symbol in a subscript position to the letter "P," and by using a numeral to designate the number of members on a particular team, many patient-team relationships can be represented. This symbol, P_3 indicates that a TFTT has three medical workers and is interacting with a patient.

Again, it is possible to expand the symbolic explanatory power in the following manner. By using a symbol such as this $P_{\frac{S \cdot O}{a\,n}5}$ it is possible to show that a patient is interacting

with a TFTT opthalmological surgical team (indicated by S-O), and that an anesthesiologist is acting as a representative for a team with five workers. If the above symbol had been left in this form P (S-O) it would have indicated that the patient is interacting with the "team itself" and not a representative.

If an analyst would like to understand the titles of medical personnel who compose a team, then the numeral subscript could be dropped and branches added to the general symbol. These branches would each have a symbol representing a specific worker on the team. The following atomic structures are examples of this possibility (Figure 14). Such detailed analyses may be desirable because they

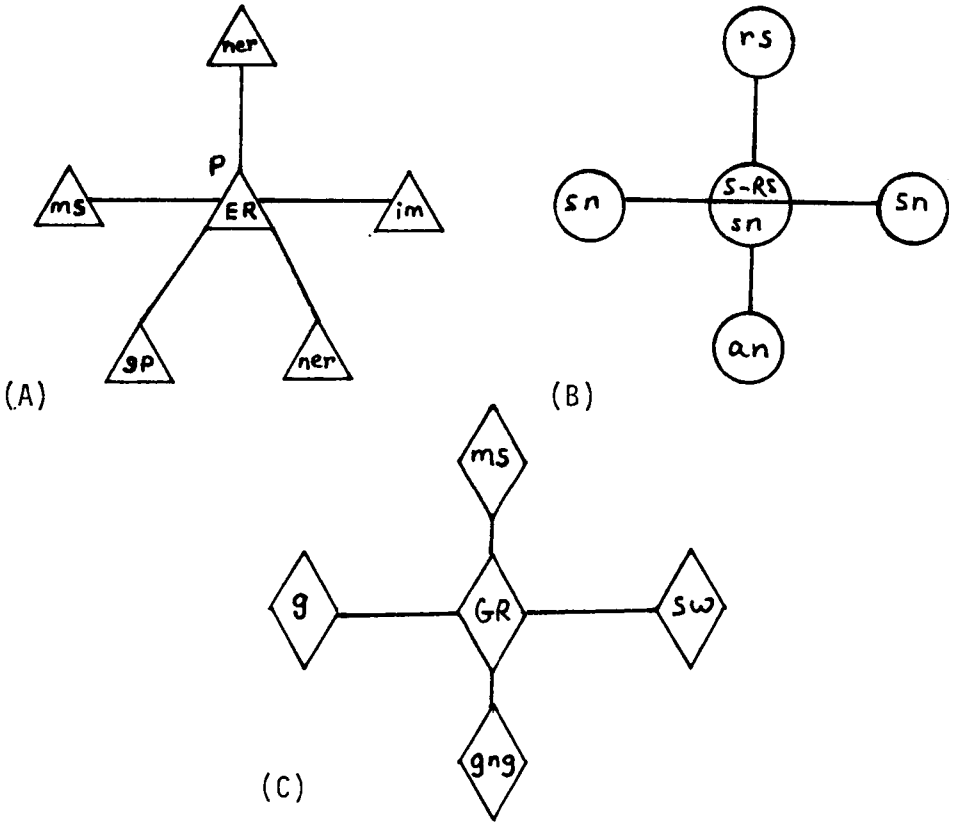


Figure 14. Three atomic team structures.

have the potential for showing great detail about the team structure. Who the leader is, the team type, and how the members interact are important factors to consider when studying health teams and issues which confront them concerning collective responsibility. Some health care teams allow the workers all actively to participate in decision-making when pressing moral issues arise, while others leave the burden of responsibility for team decisions with one person. Other teams deal with decision-making in different ways. Thus, how team decisions are made is dependent on the leadership of the team, its personnel, the power of team members concerning decision-making input, and many other factors. It was the purpose of the symbology to indicate these factors and not explore them in great detail. However, by using such symbols and abbreviations it becomes clearer that theoretical issues such as collective responsibily must include the many particulars about team function and personnel. Such symbology could also be used in sequential patterns for understanding different relationships of teams to one another, of teams to the medical institution, or of teams and society.

In this chapter the idea was presented that it is best to avoid simplistic answers to issues concerning health care teams and collective responsibility, for each team needs to be analyzed separately to understand the characteristics and operational dynamics which make it unique. The team analyst whose vision is too broad or narrow, however, does a disservice to any theory or idea being advanced if caution is not taken. In the following chapters I will

explore how modern theories of collective responsibility and health teams have taken the focus off the individual health care worker. It is a common problem that such theories about treatment teams have fallen into the trap cautioned against in this chapter; of failing to keep theoretical perspective on the members of treatment teams and how they interact, as well as how these teams function in relation to other systems.

CHAPTER V

PHILOSOPHICAL CONTROVERSIES: ISSUES FOR HEALTH TEAMS

In the last chapter it was suggested that there are many different types of treatment teams and that each has a unique way of dealing with collective responsibility. This is in part determined by team structures. In this chapter I will examine how scholars have dealt with historical philosophical issues concerning the relationships of empirical and metaphysical realities. I propose that their theoretical presuppositions about teams are based on answers to these issues. Typically teams are understood as either empirical or metaphysical entities. Such entities may be understood as unchangeable, morphological, or as exhibiting both qualities. It is my position that treatment teams exhibit both metaphysical and empirical qualities, and that these are inseparable. There continues today, however, to be schools of thought promoting the fallacious belief that both empirical and metaphysical aspects of treatment teams exist separately. As we shall see in this chapter, Greek philosophers, as well as modern thinkers, have wrestled with these same issues; problems such as the whole-part and universal-particular controversies. It is important to discuss them prior to considering collective responsibility and health care teams, for they are often unspoken and unrecognized issues blocking creative discussions. These same problems will again be addressed in Chapter VI, but there the focus will be on collective responsibility and health care teams.

The Part-Whole Controversy

An important theoretical issue which underlies the illicit separation of empirical and metaphysical realities in discussions about treatment teams has been called the whole-part controversy. The basic problem of this debate is suggested by the question What is the relationship of any whole to its parts, and vice-versa? This problem is important for understanding health care teams because they are compositions of medical workers.

At first glance the relationships of any whole (whether organic or inorganic) to its parts seems obvious until we begin to ask probing questions such as: Is the whole greater or less than the sum of the parts? If the whole is greater than the parts, what is the empirical and/or metaphysical status of this relationship? Can a whole and its parts be described strictly in either empirical or metaphysical language with the result being an adequate description of the whole and parts? These are significant questions which were studied by the Greek philosopher Plato and he wrote in the "Parmenides":

> Well then, said Parmenides, if there is a one, of course the one will not be many. Consequently it cannot have any parts or be a whole. For a part is part of a whole, and a whole means that from which no part is missing; so, whether you speak of it as a "whole" or as "having parts," in either case the one would consist of parts and in that way be many and not one. But it is to be one and not many. Therefore, if the one is to be one, it will not be a whole nor have parts.[1]

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[1]Plato, "Parmenides," The Collected Dialogues of Plato, Including the Letters, ed. Edith Hamilton and Huntington Cairns (New Jersey: Princeton University Press, 1963), p. 932.

As is evident to the reader, the above passage renders little assistance for the resolution of part-whole dilemmas which is where Plato left the issues. Perhaps one reason for this failure was his inability to show in detail that relationships of parts and wholes can be studied in a variety of ways. The first is the empirical analysis. By "empirical analysis" I mean to suggest that any competent rational person can observe the physical interactions and relationships of both organic and inorganic entities. For example, it is possible to observe the relationships of 1,000 pieces in a puzzle which when properly completed, depict a beautiful country scene. Similarly, I can observe chemicals combine in a beaker to form a substance unlike the original materials by observing changes in color and viscosity.

When discussing human relationships, similar observations are possible. If one were to choose to observe the interactions of any group of people, perhaps a student assembly, he could understand the entire group to be a whole and the students as component parts. Thus, observations of the assembly could be empirical, or in the case of human beings we might say behavioral. As an empirical reality the activities of the students in the assembled whole could be recorded without reference to any psychological characteristics or presuppositions on the part of the observer. Another way to understand the relationships of wholes to parts would be to use psychological analysis to interpret these relationships. Certainly such an analysis would be inappropriate in the case of puzzles or chemicals, but not

so when discussing human beings. It is a common occurrence to discuss the fears, jealousies, inhibitions, joys, and other characteristics of interacting persons.

Although both psychological and empirical factors are important, consider what happens when any group is discussed from only a psychological or behavioral viewpoint. To advocate a behaviorist theory without reference to the thoughts and psychological relationships of persons engaged in mental acts seems lopsided, and for most people this is antithetical to common sense. On the other hand, to present a picture of a group as a psychological entity of interacting persons without consideration of body language and observable characteristics also seems inadequate. These inadequacies of group descriptions in part stem from the fact that many theoreticians advocate some type of body-mind dualism for individuals as well as for groups. Advocates of dualisms commonly assert the existence of both bodies and minds, but generally are pressed to find some way to reunite these in some logical fashion.[2] Such inadequacies present a common problem for any theorist of groups, and often show up in the presuppositions of textbooks as unsolved problems.

But what does the whole-part dilemma have to do with minds and bodies? Everything. The way any group is considered for study influences the theories evolved by scholars. Most part-whole theories,

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[2]For an insightful introduction to mind-body problems, see Gilbert Ryle's The Concept of Mind (New York: Barnes & Noble, Inc., 1949), p. 16ff.

especially those in application to groups, advocate build-up or dissection analyses stressing either empirical, metaphysical, or psychological realities as a separate way to understand groups.

By "build-up" theory I mean that the researcher starts with one or more basic assumptions about groups. One assumption might be the belief that a thorough study of the parts of anything will explain what would be seen when the whole was observed. By observing a group, for example, a researcher may believe he can explain it after a thorough study of the individual members and their relationships. This presents some interesting problems, for it is a commonly advocated belief that wholes of individuals are more than their parts, for a whole behaves differently than the individual member.[3]

The belief that any whole is "more than" the sum of its parts raises questions for logic and metaphysics. Can a logical analysis of a group occur without committing fallacies if theorists argue from its parts to some idea of their equality with the whole? Traditional logic provides a warning about a possible fallacy of reason if this is attempted. For example, the fallacy of composition occurs when one attempts to argue from the properties of a whole to the whole itself.[4] One possible example would be to argue that because particular

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[3]This is a common theme throughout Michael Smith's work Groups as Moral Agents (Ph.D. dissertation, University of Chicago, 1979).

[4]For a more thorough discussion of this fallacy, see Irving M. Copi's An Introduction to Logic, 5th ed. (New York: Macmillan Publishing Co., Inc., 1978), p. 144ff.

individuals of a group exhibit the characteristic of being responsible, that the entire group must therefore be responsible. Little reflection is needed to see that this is fallacious. Some researchers are constantly attempting to build such cases, especially for psychological theories about groups based on one or more characteristics of the members. Thus, they often jump to hasty and often unwarranted conclusions.

As mentioned earlier, some researchers attempt to study groups through what might easily be described as a dissection process of analyzation. Such a process initially considers the whole group as primary, and its component parts as secondary concerns. The group is understood as a whole phenomenon and dissected for understanding, as one might dissect an animal for laboratory study to understand its composition and how the parts function.

By using this approach we are again faced with possible fallacy of reasoning. Traditional logic challenges the researcher doing dissection activities on groups to consider the fallacy of division.[5] The fallacy of division posits that to argue that what is true for any whole is so for the individual parts is fallacious. Such a belief presupposes that wholes have such properties. The treatment team, for example, has been described as behaving like a responsible agent or whole: a questionable presupposition. If we accept this we would argue that since a team is responsible, it

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[5]Ibid.

follows that each individual in it is responsible. In fact, it may be the case that several of the team members are responsible persons and others are not, which shows that this argument involving division is fallacious.

It is important for any group analyst to keep in mind that the way a group is presented in a textbook is the advocation of a particular metaphysical or empirical understanding of it and shapes the way persons come to perceive groups. Too often theories commit the logical fallacies mentioned through psychological, empirical, or metaphysical biases. It is possible that a reader may begin to get the impression that each of the three aforementioned approaches for studying groups (psychological, empirical, metaphysical) has independent and separate existences from the other methods, which I contend is wrong. It is true that such separate analyses do occur, but it should be the task of the researcher to present an accurate picture of the relations of his or her area of specialization to other fields. If this is not done, readers may begin to believe that metaphysical or psychological ideas have a separate and real existence apart from the concrete, everyday world.

Part of such confusions are the results of misunderstandings and misconceptions about the language used to describe groups like treatment teams. In order to understand why groups are described as having separate metaphysical or empirical realities, it is important to consider the role language plays in such dilemmas. The debate to be discussed in this study is called the particular-general controversy.

Groups and the Particular-General Language Controversy

There are many modern theories about the relationships of language to various concrete and abstract ideas. All studies of groups are influenced by such theories, for language is a plethora of concrete and abstract terms intermingled by authors in their theoretical views. What is not always clear, however, is what kind of understanding is evoked in a reader's mind when considering such words. It has always been a primary tenet of philosophy that language is notoriously vague due to different connotative and denotative "understandings" readers may have about particular words and sentences. Such problems have caused misunderstandings and disagreements about what particular words mean, and hence have led to confusions in theoretical discussions about groups and teams.

One debate about language and meaning pertinent to this study is called the particular-general language controversy. This debate focuses on the relationships between general or universal terms and the particular objects or ideas these terms represent. Such debates, I contend, are in part responsible for the misplaced idea that groups can be adequately described in purely metaphysical or abstract terms without reference to the concrete world.

It may be helpful when considering this controversy to first make a distinction between generally held notions and universal terms. By generally held notions I mean beliefs to which a majority of people assent. In the United States, for instance, a majority of people believe that persons should be free to behave as they choose

as long as their activities do not infringe on the same freedoms of others. We may say that this is a generally held notion.

"Universal," on the other hand, is used in a technical philosophical sense. By a "universal" philosophers mean a common and repeatable property capable of being shared by more than one particular object. Their properties, Hospers believed, are those things which all similar things share, which may be either psychological or empirical.[6] A group, for example, may exhibit the property of shared information, which we might call a psychological property exhibited in a concrete way. As a common property of groups it is clearly visible to any astute observer. But for the same observer to seek instances of shared information apart from particular groups in action would be futile; no such entity or metaphysical reality exists. Unfortunately, the idea that separately existing metaphysical realities do exist apart from the concrete world is a commonly advocated position.

There is an important place for discussions about abstract ideas or metaphysical realities when considering topics such as groups and their behavior. It is common to talk about qualities and ideas in abstraction from particular concrete objects when discussing subjects such as groups. But, as Hospers reminds us, we must continually be aware that there are "two kinds of entities in the world: the

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[6]John Hospers, An Introduction to Philosophical Analysis, 2nd ed. (New Jersey: Prentice-Hall, Inc., 1967), p. 356.

particulars that have properties and the properties that the things have,"[7]—both of which must be seen in perspective as important aspects of the subject under consideration.

No discussion about abstract or metaphysical entities should end without recognition of the value of such discussions for understanding their application to the concrete world. Conversely, no discussion about concrete realities should end without acknowledgment of abstract and metaphysical issues which challenge empirical understandings of the world. By doing this we are at least creating an openness of thought which acknowledges not only the limitations of human understanding but also allows for the recognition of the vagueness of our language. Such discussions do not necessarily solve disagreements about the relationships of metaphysical, abstract, or empirical realities associated with language; but they do acknowledge the dependency of the empirical world and metaphysics.

In summary, to assert that universal terms have meaning is correct, but to believe that such terms refer to independent metaphysical realities having no references to the concrete world is wrong and may lead to dualism. Groups, therefore, can be meaningfully discussed without talking about particular groups if abstract language is used to discuss them. Also, particular groups can be discussed as empirical realities which exhibit universal characteristics of other groups. But to talk about groups without giving proper

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[7]Ibid., p. 354.

recognition of the dependent relationships of both concrete and metaphysical realities, as captured in language, is wrong.

Aristotle on the Whole-Part and Universal-Particular Dilemmas

Aristotle, like Plato, wrestled with the same dilemmas previously mentioned in this chapter: the relationships of whole to parts, of universal and particulars, and fallacies of composition and division. In book "Zeta" of his Metaphysics he attempted to address these questions, which he believed are related to Primary Being; the ultimate material out of which the universe is made. Early in this writing he asserted that all empirical entities including human relationships have a form which accompanies matter, but is unlike it.

It is impossible, Aristotle believed, to know anything in its entirety, but he set out to consider what it was possible for the human mind to discover about objects of consideration. We may choose to understand an object or event by listing observed characteristics, he believed; but this is not wholly satisfactory. Such listings do not tell us about the basic "form" of anything.[8] For example, to list the characteristics of a group does not tell us about the whole of the being or existence of the group, but only about characteristics we consider essential for a group to exist. By considering the observed characteristics of objects as well as their form, we begin to see an historical precedent for the advocation of both empirical

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[8]Aristotle, "Zeta," Metaphysics, trans. by Richard Hope (Michigan: The University of Michigan Press, 1966), p. 136.

and nonempirical realities. For groups this means that they may be understood as having observable characteristics as well as unobservable forms (or essences).

To understand the form or essence of anything (such as a group) can best be accomplished, he asserted, by the creation of a definition.[9] Through carefully created definitions we capture something's essence. Definitions tell us what is knowable about something, but such definitions must attempt to capture the essential qualities of the object under consideration, and not nonessential qualities. For example, a definition of "team" would probably include qualities such as "meets regularly, works toward some common goal, and requires interpersonal communications." These might be considered essential characteristics. Such characteristics as the height of the members, the color of their skin, or their shoe size would be inessential to the formation of a proper definition of "team."

In Chapter II I advocated a particular definition of "treatment team" and listed its essential characteristics, as well as others some people may regard as unessential. But at no time did I advocate the separation of such characteristics from the activities of the members. Aristotle suggested that it is wrong to separate the universal qualities exhibited through any definition from the concrete activities of the subject under consideration. The word "team"

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[9]Ibid., p. 136.

represents a universal concept, but it has no independent reality apart from the individuals who compose teams. Thus, we see an unwillingness on the part of Aristotle to separate the essential qualities encompassed in a universal definition from the many particular instances of the things being defined.

But what are the implications of this belief for the relationships of the parts and wholes if we desire to do scientific analysis on them? Aristotle believed that "Each individual thing is one and the same with its intelligible structure and not merely accidentally so, because to have knowledge of the individual is to have knowledge of its essence."[10] This suggests that any attempt at reduction of empirical realities through scientific analysis, no matter how thorough, will not be able to capture its essence or form. The best we can do is list the essential characteristics of that object with a definition. This could have serious implications for theorists who advocate definite knowledge about the form, essence, or metaphysical status of anything apart from observable characteristics of the concrete object under consideration.

Aristotle considered individual things (living and nonliving) as the basic or primary realities of the world. To begin discussing universals, he asserted, we must first start with individual things; "this man, this dog, this plant."[11]

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[10] Ibid., p. 152.

[11] Ibid., p. 139.

By distinguishing between primary individuals and the universal forms they exemplify, Aristotle attempted to solve the dilemma of the relationships of things which have the same form but are numerically different. For example, two individual tigers have the same basic form of tiger, but each animal is numerically separate. Both animals are universal instances of tiger, but each considered separately relates to the universal definition of tiger. But the form captured in the definition of tiger has no reality apart from the observations of particular tigers. His emphasis on the importance of focusing on individual things to discover their essence is seen in the following passage:

> Now, as to things that are organized so that the whole is one, not like a heap but like a syllable: the syllable is not its elements, but "ba" is not the same as "b" and "a"; nor is the flesh fire and earth. For when these are separated, the wholes (flesh or syllable) no longer are; but the letters are, and so are the fire and earth. Accordingly the syllable as a whole is something distinct, and not only the letter, vowel, or consonant, but also something else.[12]

In this passage the letters and elements are numerically unique, and when combined form a new whole that in some sense surpasses the uniqueness of individual things considered separately. However, each particular letter or element still maintains a universal relationship to other letters or elements even when in combinations that make new forms. If we apply some of Aristotle's insights about universals, particulars, and form to considerations of groups such as health care teams, we get a picture of individuals uniting to

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[12]Ibid., p. 141.

create a unique form as a result of their associations. Also, we might believe that the individual workers are in some sense the primary objects of study in order to understand this form.

If new forms arise as persons associate or disassociate themselves in varying configurations, we seem to have a unique "tertium quid" (third thing) beyond the individual numbers. It seems that new forms involving new relations are constantly arising as a result of the association of individual persons. New relations between individuals can generate new forms.

Concerning groups, this means that when a new group is created a new form simultaneously exists that did not previously exist. I suggest, however, that admitting this does not require us to look beyond the concrete activities and relationships of the group members.

By taking such a position I am not advocating the abolishment of metaphysics as an important discipline to assist in understanding groups. I am, however, opposed to any metaphysics which attempts to understand the relationships of wholes and parts, or universals and particulars as a function of groups separate from the concrete activities of group members.

The Enigmas of Methodological Individualism and Methodological Holism

The part-whole and particular-general controversies have not only greatly influenced philosophical theories, but have had great impact on disciplines such as sociology, history, psychology. It is not uncommon for theorists in these disciplines to defend either a

position called methodological individualism or methodological holism. Methodological individualism is a theory which stresses the importance of individuals when studying groups, while the methodological holist advocates the importance for keeping the focus on the whole.

Methodological individualism, according to Watkins, is the theory that "social processes and events should be explained by being deduced from (a) principles governing the behavior of participating individuals, and (b) descriptions of their situations."[13] In a more detailed description, Danto proposes a list of beliefs which methodological individualists advocate: (a) that sentences about social individuals are logically independent of individual human beings, (b) that social individuals are ontologically distinct from individual human beings, (c) that social individuals are causally dependent upon the behavior of individual human beings and not the other way about, (d) that explanations of the behavior of social individuals are always to be rejected as ultimate unless these explanations are framed exclusively in terms of the behavior of individual human beings, and (e) explanations of the behavior of individual human beings must never be in terms of the behaviors of social individuals.[14]

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[13]J. W. N. Watkins, "Ideal Types and Historical Explanation" in Modes of Collectivism and Individualism, ed. John O'Neill (London: Heinemann Educational Books, 1973), p. 149.

[14]A. C. Danto, "The Historical Individual" in Philosophical Analysis and History, ed. William H. Dray (New York: Harper and Row Publishers, 1966), pp. 276-277.

The methodological individualist is clearly attempting to explain social behavior as primarily a phenomenon of individuals, and not of groups of individuals. On the other hand, the methodological holist advocates a contrary position, believing that the behavior of individuals be deduced from "macroscopic laws which as 'sui generis' and which apply to the social system as a whole, and [from] (b) descriptions of the positions (or functions) of the individuals within the whole."[15]

Both theories may seem opposed in their emphases. The methodological individualist believes that a researcher "should never be satisfied with an explanation (of persons) in terms of so-called 'collectivities' (states, nations, races, etc.)."[16] Collectivities are therefore best understood as compositions of individuals who each have attitudes and dispositions and who each act in a distinctively separate manner. The individualist posits no metaphysical realities such as form when studying individuals. Although willing to recognize social group phenomena, he still contends that such must have individuals as their prime focus, even when research about them is couched in general terms or laws. Hayek expresses this sentiment when he says that "social sciences do not deal with 'given' wholes but their task is to constitute these wholes

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[15]Watkins, "Ideal Types and Historical Explanation," p. 150.

[16]Karl R. Popper, The Open Society and Its Enemies (London: Routledge & Kegan Paul, 1945), p. 98.

by constructing models from the familiar events . . ."[17] What is considered familiar to the individualist is the empirical reality of individuals as primary for research, which was also one of Aristotle's prime tenets.

But does it necessarily follow from the individualist's beliefs that this theory should be exclusively used as a basis for group research? Not necessarily so. The fact that a group is a composition of individuals does not necessitate that no metaphysical laws (or universal principles) are in operation and serve some cohesive function. Methodological holism in fact advocates that groups of people have a type of mind of their own in distinction from the individuals which compose them. In other words, the holist believes that a unique phenomenon occurs when persons associate in groups which is not explainable simply by studying the individuals who compose it. This thesis has had strong support from persons who advocate the existence of subconscious or extra-mental phenomenon. Many of these theories have led to beliefs in the existence of metaphysical entities which are real and have separate existences apart from the sensory world. Such beliefs leave the impression that abstract words represent independent realities; words such as consciousness, spirit, soul, entity, mind, and many others. As stated

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[17] George Hayek, The Counter-Revolution of Science: Studies on the Abuse of Reason (Illinois: The Free Press, 1952), p. 56.

earlier, such considerations do have meaning, but not apart from some final grounding with the concrete world.

Although methodological individualism and holism may appear incompatible, some scholars have attempted to unite tenets from both. Agassi sees no difficulty with asserting that "if 'wholes' exist, then they have distinct aims of their own."[18] He sees no problem with the individualist's claim that persons who have goals can also have goals as group participants. Furthermore, Agassi thinks we can simultaneously accept the holist's ideas that groups have goals or aims while acknowledging goals of individuals.

Maurice Mandelbaum also attempts to unite individualist's and holist's beliefs. A primary tenet of his system is that individualists cannot do reductions on statements about groups "without remainder."[19] To understand what he means I will apply his theory to one type of group: the treatment team. The treatment team, he might suggest, is composed of individuals. To study teams as a methodological individualist means one may attempt to describe the team through the generation of a list of statements which would be verifiable. The individualist is often faced with a theoretical language problem when

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[18]Joseph Agassi, "Methodological Individualism," in Modes of Collectivism and Individualism, ed. John O'Neill (London: Heinemann Educational Books, 1973), p. 186.

[19]Maurice Mandelbaum, "Societal Facts," in Modes of Collectivism and Individualism, ed. John O'Neill (London: Heinemann Educational Books, 1973), p. 227.

describing teams. In these descriptions words such as "health, profession, medical institution, treatment, and value, etc." must also be used to make sense of team activities. Mandelbaum states in passing that it may be possible to omit abstract words from team descriptions by creating long strings of descriptive sentences which describe the relationships of team members, but he seems unconvinced of this theory throughout his writings. Even if it were possible to eliminate abstract terms from descriptions of groups, Mandelbaum suggests that we could never capture the "why" of the team's orientation. By this "why" Mandelbaum meant that all teams have concepts which must necessarily be included in any adequate description of what a team is and does. Some of these questions might be: Why have these professionals chosen to practice on a team? Why does the physician refuse to disperse power to other team members? Why would anyone want to become a medical worker? These questions are often answered with abstract or universal terms. These questions cannot be answered and have the same meaning as those referring strictly to concrete observations of the members. Thus, Mandelbaum advocates that attempts by methodological individualists to describe health teams without the use of irreducible concepts is an error. But does this mean that Mandelbaum is repudiating further attempts to reduce abstract ideas to observational statements? No. This becomes clear in the following passage:

> Yet it is important to insist that even though societal concepts cannot be translated into psychological concepts without leaving this societal remainder, it is not only possible but is indeed necessary to make the partial

> translation. It is always necessary for us to translate terms such as "ideologies" or "banks" or "a monogamus marriage system" into the language of individual thought and action, for unless we do so we have no means of verifying any statement which we make concerning these societal facts. Ideologies and banks and marriage systems do not exist unless there are aggregates or individuals who think and act in specific ways, and it is by means of establishing the forms of their thoughts and actions that we can apprehend the nature of the societal organization in which they live, or that we can corroborate or disallow statements concerning their organization.[20]

This paragraph has a two-fold emphasis. First, researchers must inevitably make reference to societal facts for understanding human interactions; and second, reductions (as far as possible) are requisite for attributing thoughts and actions to persons rather than undefined, vague concepts.

Mandelbaum's ideas are insightful, for even if it were possible to make a complete reduction of group actions through statements coupled with the criterion of verifiability, it would still be meaningful to use words such as "team, group, organization, and corporation." Complete reduction seems a fruitless adventure as well as an undesirable one given the richness of the meanings we associate with many abstract words and ideas. In fact, attempts by the methodological individualist to eliminate abstract terms from team descriptions may have little useful basis. Would such elimination of terms, if accomplished, serve a societal need? What questions would be answered if we could eliminate them? Goldstein in fact believes

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[20]Ibid., p. 229.

that the individualist has not made a convincing case for the evils of believing that abstract terms are dangerous to society and have little value.[21] Goldstein's point is not very convincing. The fact that a strong case has not been made for the disvalue of using abstract terms does not mean that they may not be abused if improperly used and understood. For example, it is possible for considerable harm to result when persons do not make proper distinctions between concrete realities and ideas which represent them. Such harms can lead to unbridgeable dualisms.

Both Mandelbaum and Agassi suggested that the best approach to the analysis of groups is through a combination of methodological individualist and holist tenets. This conclusion is one which I support, for observations and studies of health care teams indicate the concurrent operations of both unseen occurrences (ideas, universals) as well as easily observed activities (empirical realities). Treatment teams are compositions of observable individuals. This is a major principle of the methodological individualist. Teams do exhibit principles which stress the importance of persons and not the group. For example, an unspoken operating principle of treatment teams is that each member is individually responsible for his or her behavior. Also, many medical

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[21] L. J. Goldstein, "Two Theses of Methodological Individualism," in Modes of Collectivism and Individualism, ed. John O'Neill (London: Heinemann Educational Books, 1973), p. 279.

institutions respect the moral beliefs of workers by not requiring them to participate in medical procedures which violate these principles.

Health teams also exhibit holist theses, for they act as wholes composed of persons cooperating for some particular task. All workers in the group are important for the attainment of some goal which could not be reached without cooperation between individuals. Thus, the significance of the whole for task accomplishment suggests the recognition a holist tenet. This tenet stresses the importance of cooperation. Groups also behave as wholes which can only be described in psychological language. For instance, the survival of a team as a working force is often dependent on the abilities of members to make decisions by which all will abide. These decisions must be followed by everyone even if some dissent to the majority opinion. Team decision-making proceeds with the presupposition that coherency of the whole team necessitates continued unification even in the midst of value disagreements. Thus, the holist could say that such instances of teams in action support the idea that wholes, such as teams, are more than descriptions of the members' activities, for they make decisions, have goals, and set priorities.

Throughout this chapter I have advocated the necessity of using both abstract ideas and concrete realities together for describing collectivities such as treatment teams. Separation of these easily leads to mistaken theories and beliefs that metaphysical realities have separate existences apart from the empirical world,

or that only empirical descriptions adequately explain the function of teams. In the next chapter I will examine how some theorists attempt to create such separations concerning the subject of collective responsibility and health teams.

CHAPTER VI

COLLECTIVE RESPONSIBILITY AND HEALTH CARE TEAMS

In this chapter the belief will be defended that individual health care team members must ultimately be responsible for their own actions both in moral and professional senses. There is a recurring tendency in current professional writings to assert the belief that health care teams as such are proper objects of responsibility. Such claims often attempt to show that because treatment teams do activities commonly attributable to individuals, they can be designated as moral agents. Such team agency is considered to be somehow real apart from individual team members; hence, teams have a special moral status. This I consider to be wrong. Any meaningful discussion about treatment teams must address the individuals who compose them. As I attempted to show in the last chapter, this does not mean that abstract words or universal terms do not have meaning when discussing teams. It does suggest that the positing of meta-physical entity or entities apart from the individual members is erroneous. To talk about group agency and omit considerations of the individuals composing the group—as if they are insignificant—is in error.

This chapter will first address several types of individual and collective responsibilities in order to delineate distinctions of type. Such considerations will assist in avoiding confusions when discussing team responsibility. These distinctions will also be

addressed with historical applications of collective responsibility and their significance for modern health care teams.

Second, further distinctions will be considered concerning legal definitions of collective responsibility, which help to explore similarities and differences with the ways responsibility is dealt with in health care teams.

Third, a brief discussion about moral obligation will address reasons why persons choose to carry out perceived duties, and how society and institutions enforce rules designed to guide employees. This section suggests that social beings are daily involved in multiple situations that require both written and unwritten rules for behavior structuring, and that each day people are involved playing different types of "social games." Such game playing also occurs in medical institutions, which has a profound effect on the interrelations of health team members.

Fourth, a theory will be presented which will consider two general categories of responsibility: weak and strong.

Fifth, a commonly advocated theory, collective monadism, will be examined. This will provide some interesting contrasts and similarities to the ways treatment teams make decisions.

Sixth, Whitehead's notion of the fallacy of misplaced concreteness will be examined in conjunction with Michael Smith's belief that groups can be moral agents.

Seventh, I consider how medical institutions often place health care personnel in moral dilemmas when conflicting values arise.

Finally, I consider collective responsibility for three different types of teams presented in Chapter V. This is important to show how the structure of each team determines how responsibility attribution occurs for both individual members and the entire team.

Responsibility: Some Classifications and Delineations

The term "responsibility," as John Ladd calls it, is a "weasel word,"[1] meaning that it is ambiguous. This word is regularly conjoined with adjectives and adverbs to describe various types of responsibility. A common problem is that the same term is used indiscriminately and type distinctions of responsibility are lost. "Responsibility" can have many emotional, moral, and causal overtones which must be separated for conceptual clarity. In order to avoid some of its ambiguous uses several distinctions will be made using a hypothetical medical case.

> Jane Alport was the head nurse in a cardiac intensive care unit which had a capacity of 12 beds and a nursing staff of five workers per shift. At 2 p.m. on the night shift one of the patients suffered a severe heart attack, but the monitoring equipment failed to register the trauma. The patient died as a result. Upon examination of the monitor it was discovered that a loose wire in the machine had caused the problem—which had occurred precisely at the time Mrs. Alport was on her break. The next day she was called in to see the department supervisor. It was clear from the general atmosphere that this was not going to be another "these things do happen" conference. In a polite tone the nurse was blamed for not keeping a closer eye on the equipment and staff. She had been warned about

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[1] John Ladd, "Philosophical Remarks on Professional Responsibility in Organizations," Applied Philosophy 1 (February 1982):5.

problems with the monitor wiring and was told to check it regularly. Mrs. Alport was also told that the family was considering suing her and the hospital, which could put her career in jeopardy.

It is possible in this case to distinguish several types of responsibility which can be understood by the way and context in which the term is being used. In ordinary language the term has at least two general uses; first as a synonym for duty or obligation, next as suggesting causal relatedness which may or may not imply blame and possible sanctions.[2]

When responsibility is used as a synonym for duty we can say that Mrs. Alport had duties to supervise her workers, check the monitoring equipment, and to protect and assist her patients in a professional manner. These uses of duty lead to little or no clarification of duty types. Such uses do, however, point out which activities are morally or professionally obligatory for Mrs. Alport.

It is common to hear discussions about a nurse's role and responsibilities which accompany it. Unfortunately, role responsibility is regularly confused with the nurse's tasks. To talk about role responsibility is to discuss the nurse's mission in and for society which might include qualities and characteristics traditionally understood as part of the image of nursing. We could say that role responsibility focuses on the welfare of others.

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[2]George Agich, "The Concept of Responsibility in Medicine," in Responsibility in Health Care, ed. by George J. Agich, Vol. 12, in Philosophy and Medicine, ed. by H. Tristram Engelhardt, Jr. and Stuart F. Spicker (London: D. Reiderl Publishing Co., 1982), p. 60.

It is possible to consider all of the activities of a nurse as being part of his or her parameters for participating in a traditional nurse's role. But the idea of role responsibility as implying social duties can be so inclusive as to contain task descriptions, idealistic thoughts about the nurse's social role, and moral considerations. Such a complex notion might not lead to accuracy. Thus, for clarity it seems professional to restrict discussions of role responsibility to the nurse's social role, but this is not often done.

The second general type of responsibility is causal. One thing might be said to be responsible for another when it has a direct or indirect causal relatedness to another. To seek causal responsibility between persons is to seek events and activities which show that one person's actions caused effects on another. Such relatedness may be strong or weak, depending on the association of causes between two people. Causal responsibility can be just as confusing as responsibility in the obligatory sense unless one carefully delineates what one means.

In this study causation will be considered in two senses: evaluative or descriptive. To say that Mrs. Alport was responsible in the descriptive sense means merely that one thing is the cause of another. This relationship is meant to be exclusively descriptive and avoids blaming or praising. To say that I think Mrs. Alport is responsible for some result in this sense means that I have adequate information and evidence that she is the cause of some effect.

On the other hand, if I say that she is responsible in the evaluative sense, I am suggesting that a judgement of blame or praise is requisite and that possible sanctions be considered. A descriptive sense of responsibility is presupposed by an evaluative sense, for if Mrs. Alport is not causally responsible for an event, moral condemnation will be inappropriate. This type of responsibility as blameworthiness also seems to involve violations of behavioral rules, i.e., duties.

As a theoretical consideration it is helpful to distinguish between descriptive and evaluative causal responsibility. In reality the two are often confused and not distinguished. Often a person being evaluated is condemned or evaluated before all facts are known about descriptive relatedness to an event. At other times it is clear that an agent is simultaneously responsible in both an evaluative and descriptive sense. If, for example, another nurse had observed Mrs. Alport intentionally ignore the pleas of a patient for help, and the patient died, then there seems to be incontrovertible evidence that she is guilty both in an evaluative and descriptive sense. In the case presented earlier, however, it is not completely clear whether she was directly responsible, indirectly responsible, or not responsible at all for the patient's death.

Another type of responsibility, task responsibility, is associated with nonmoral notions of responsibility as duty. Task responsibility is, as Agich believes, is that associated

with offices, jobs, and functions. A characteristic feature of such responsibility is that it can be divided up and limited like the jobs it is associated with: "'This is my responsibility, not yours,' 'That is your responsibility, not mine,' 'That is their responsibility, not ours,' and so on."[3] Also task responsibility does not require reference to social roles, but is commonly distinguished by time constraints for task accomplishment. In short, the work expectations which do not suggest moral evaluation are classified as task responsibilities. Certainly job descriptions commonly suggest sanctions for particular types of aberrant behavior, which are meant to be evaluative; but these step outside my meaning of task responsibility—which is strictly descriptive.

To say that Mrs. Alport was responsible in the task sense means that she has a continuing obligation to fulfill her requirements as stated in the hospital job description. The activities considered essential for her task fulfillment are usually technical skills, but there is a gray area related to emotional and moral sensitivity to patient and staff needs that may also be important, even if it does not appear on any job description list. It becomes clear to most nurses that many of their expected activities are not written into a task manual and that expectations of patients, staff, and institutions may dictate what these will be. A nurse may be

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[3]Ibid., p. 66.

expected to regularly lend emotional support to the ill, be courteous, or to assist families of patients, but such tasks are not usually included in detail as part of a standard nursing job description. When considering task responsibility, therefore, it is best to understand that it usually includes descriptions of a nurse's tasks as described by the institution, as well as consideration of other on-the-job activities not written down which are deemed essential. Certainly all of these activities can be described without moral evaluation, which is important if we are to distinguish the descriptive from evaluative-causal explanations.

The above sense of descriptive responsibility was one that included Mrs. Alport's task-oriented activities, which also addresses the type of equipment she is expected to work with. A general task description usually is one of human-machine symbiosis. It is possible, however, to consider descriptive responsibility as solely addressing considerations of the quality and functioning of machines. In the earlier case the monitor failed, and it is important to consider the machine alone. Such considerations might address the issues of whether the equipment might have failed even if Mrs. Alport had checked it thoroughly. If it is determined that a failure would have occurred no matter what activities preceded it, and that it was beyond her ability to prevent a malfunction, then Mrs. Alport can be excused from responsibility in relation to the machine. At the same time this would remove her from considerations of responsibility in an evaluative sense.

But if her relationship to the machine suggests that she could have prevented a malfunction by reporting a fault or by replacing a part, then she may be found wanting in both descriptive and evaluative senses.

A final type of responsibility related to the medical case is institutional responsibility. Institutional responsibility could logically be included as part of Mrs. Alport's task responsibility. When assuming a task within an institution (such as a hospital) a worker accepts the assigned tasks dictated by a job description. There is a symbiotic relationship, then, between Mrs. Alport's activities within the institution and the institution itself. Such a relationship in this sense can be considered causal in a descriptive sense.

Generally moral issues are not brought to the attention of an institution's board of directors unless they have important implications for its image, functioning, or survival. Usually moral issues are dealt with by personnel other than directors such as department heads, supervisors, or physicians. If a problem is important enough to catch the attention of a board of directors, it becomes significant because Mrs. Alport's activities caused attention to be focused on her, the deceased patient, and the institution. This is a possible threat to the institution's public image as well as creating financial threats. Hence, she will now be scrutinized by the institutional board in order to understand her relationship

to the intensive care unit accident. This evaluation includes her responsibility in the causal sense as well as an evaluation for blameworthiness.

Typically institutions are sued along with individual workers considered causally responsible for an incident, and little or no distinction is made between the two. The institution must, therefore, decide whether it will support Mrs. Alport in a legal battle because she acted as a responsible institutional representative, or whether it will suggest that she under- or overstepped the limits of her assigned tasks. Such support or lack of support for Mrs. Alport typically enters two phases, an internal investigation with or without sanctions, and an external presentation to external inquirers such as injured parties or courts of law. Both phases involve investigations intended to understand how she was responsible in the normative and descriptive or causal ways, with each phase inundated with reference to her social role, obligations, duties, and tasks and the consequences of her behaviors. Thus, we might say that institutional considerations of responsibility become very complicated and usually involve all the senses of responsibility discussed in the chapter, as well as a few not discussed.

The Law and Collective Responsibility

Not only is it important to make distinctions among types of individual responsibility, it is also important to recognize the way the law categorizes collective responsibility in the sense of blameworthiness. Although considerations of the types of legal

collective responsibility may not directly address treatment team concerns, such distinctions are useful, and in fact medical personnel typically think of legal responsibility when considering medical group activities.

One type of collective responsibility is labeled liability with noncontributory fault. This means that persons of a group may all share the same fault where no evidence shows that harms were intended by the members. A team member, for example, may turn off a patient's respirator as agreed by the team, and the patient ceases breathing and dies. As a result, the hospital and team representative are sued, but the team itself is blamed for the patient's death by institutional authorities. No harm was intended by the members, and not all actively participated in removing the respirator, but they are still blamed. Such blame makes them subject to punishment by the medical institution, law, and even perhaps their own professional organizations such as the American Medical Association.

A second type of responsibility is called group-fault, which is both collective and distributive. Sometimes each member of a group is considered at fault for an event, as is the totality of persons in relation to it. There are many types of group-fault. Consider the case where a man is murdered on a New York City street during a parade, and at least fifty people witness the event but never help the victim. To blame all fifty would be impossible except through general statements of censorship, and to incarcerate them would be impractical given the state of our jails, prisons, and legal system. Also, if all

fifty had attempted to help at once they might have caused more harm than good, and it is better if a few at a time feel convicted to help. Hence, the possibilities of spotting all individuals in large groups, blaming, prosecuting, and punishing them is impractical, even though they might be verbally blamed without being physically punished.

A third type of collective responsibility is observed when situations arise where it is distributed to all members who act as joint operators within a situation, but where degrees of responsibility are unequal. A series of persons who aid a criminal escape from prison, hide him, give him traveling money, and fail to produce evidence that would indicate his location are all guilty by complicity. Feinberg points out that "the common law, therefore, divides guilty felons into four categories: 'perpetrators,' 'abettors,' 'inciters' (all three of these are accomplices), and 'criminal protection.'"[4]

The final type of responsibility attribution concerns the contributions of all members of a group, where responsibility is collective but not distributive. There are cases where one might be tempted to say that the collective was responsible and had acting capacity within its power, yet did nothing. Consider the case where a terrorist on an airplane threatens to shoot anyone if his demands to go to Cuba are not met. The individual members do nothing, allow him to have his way, and the plane goes to Cuba. No one attempts to

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[4]Joel Feinberg, "Collective Responsibility," Journal of Philosophy 65 (1968):674.

stop the hijacker, and thus we might call the group cowardly. Others might call it prudent. The group, however, is blamed for inaction.

These types of collective responsibility in the sense of blameworthiness, as well as earlier discussion about individual responsibility, are important in order to make correct distinctions of types for theoretical discussions and practical applications. One aspect of collective and individual responsibility which needs to be discussed in more detail concerns types of moral obligations and duties. This is the subject to be considered next.

Moral Obligation

Our society is a complex fabric of institutions, mores, folklores, laws, and spoken and written rules. Each person in this fabric is expected to follow a certain set, depending on the contexts he or she lives in. Many rules of society can often be broken with little or no threat of sanctions, such as putting out one's cigarette on a floor by stepping on it even though a sign in the bus station forbids this activity. Other rules cannot be broken, for the probability is high that severe punishment will occur. For a policeman to drink while on duty is sure to bring severe punishment if he is caught. Thus, each type of particular group or organization in society has its own set of rules and sanctions which vary in degrees of punishment from verbal rebuke to death.

Medical institutions are also complexes which have built-in operational rules with moral and nonmoral implications for sanctions. All obligations have, however, varying degrees of what Kurt Baier

refers to as "binding force." He believes that a directive has binding force when "it is not solely the addressee's business to decide whether or not to follow the directive."[5] In other words, other persons, groups, or institutions are making some type of claim on an agent that cannot be ignored due to their relationships. Hans Jonas calls this same type of relationship "substantive responsibility," which provides a "forward determination of what to do; by whose command, therefore, I feel responsible, not in the first place for my conduct and its consequences, but for the matter that has a claim on my acting."[6] In these cases there is a liability to incur sanction if the claim is not taken seriously. To be a professional health care worker requires that one act out a particular professional role by described tasks and duties of one's organization and working place. Failure to do so may mean verbal reprimand, loss of pay, or may cause one to lose a job. The individual worker, by entering into a system, agrees to abide by its rules, either verbally or through contracts, and is bound to do so.

Every group or system has noncodified rules, which John Locke called "the Law of Opinion of Reputation."[7] For instance, there is

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[5]Kurt Baier, "Moral Obligations," American Philosophical Quarterly 3 (July 1966):223.

[6]Hans Jonas, "The Concept of Responsibility: An Inquiry Into the Foundations of an Ethics for Our Age," in Knowledge, Value, and Belief, Vol. II, ed. by H. Tristram Engelhard, Jr. and Daniel Callahan (New York: The Hastings Center Institute of Society, Ethics, and the Life Sciences, 1976), p. 176.

[7]John Locke, An Essay Concerning Human Understanding, ed. Peter H. Nidditch (Great Britain: Oxford University Press, 1979), p. 353.

no formalized rule that says "Don't vent personal feelings in front of patients," but most health care workers abide by it. Some workers feel that they have an obligation to co-workers as well as patients not to let emotion blur their objectivity. If a worker were to scream at a patient in a fit of anger, he might receive many types of punishment from verbal rebuffs to suspension. More likely this person would receive social reinforcements with nonmoral techniques of persuasion. Mill points out that such reinforcements are intended to encourage citizens to pursue happiness by acting in ways which go beyond the minimal requirements of moral rules which aim primarily at harm avoidance. Such reinforcements are persuasion, exhortation, remonstration, reasoning, entreating, education, and encouragement—but they are not enforceable through legal sanctions.[8] On the other hand, those sanctions with moral claims are all socially enforceable, and provide a motive for observance. These might include legal, moral, and religious sanctions.

In reality, both moral and nonmoral reinforcements get integrated, for persons in medical settings constantly persuade and exhort each other daily while at the same time suggesting possible sanctions for many actions.

Concerning obligations, medical workers certainly are obligated to perform their assigned tasks as well as possible and abide by the

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[8]John Stuart Mill, "Utilitarianism," in Ethical Theories: A Book of Readings, ed. A. I. Melden (New Jersey: Prentice-Hall, Inc., 1967), p. 409.

general operational rules of health institutions. It becomes less clear what obligations are imposed by nonwritten rules. Is the nurse obligated not to argue in front of a patient? Is the lab technician obligated to knock before he or she enters a patient's room? Is a physician in a rounding treatment team obligated to allow others an equal voice in decision-making processes? Infractions of all the above can cause social sanctions with possible severe consequences. It appears, then, that the noncodified rules are just as important as codified, and that their continual observation is requisite for a properly functioning institution.

There appears to be a direct relationship between the medical institution's rules—both spoken and unspoken—and the avoidance of harm and the maximization of good for others and oneself. Both written and unwritten rules function for guiding action, compelling one to act in a particular fashion to avoid sanctions, to promote security, and to avoid unhappiness.

Rules function in peculiar ways, for they are often known only to insiders of institutions or groups. In a sense it appears applicable to say that one must be on the inside of an operation to learn and understand them. The interiority of rule acceptance appears to imply obligations and duties to persons regularly associated in the setting, but it must not be assumed that others entering such settings are automatically obligated to follow the same rules or even be aware of them.

Wittgenstein had much to say about rules following in his lifetime which is equally applicable to moral obligation. He stated that

> all testing, all confirmation and disconfirmation of a hypothesis takes place already within a system. And this system is not a more or less arbitrary and doubtful part of departure for all our arguments: no, it belongs to the essence of what we call an argument. The system is not so much the point of departure; as the element in which arguments have their life.[9]

Again he states that

> if language is to be a means of communication, there must be agreement not only in definition but also (queer as it may sound) in judgments. This seems to abolish logic, but does not do so.—It is one thing to describe methods of measurement, and another to obtain and state results of measurement. But what we call "measuring" is partly determined by a certain constancy in results of measurement.[10]

Wittgenstein spent most of his life trying to show that each context involving humans changes the nature of the rules, the number of players, the way the game is to be played, and the language utilized. For instance, within a medical institution there are multiple games. By "game" I do not mean to imply play but goal-oriented activities of human beings with rules. For example, it is a type of game when a nurse interacts with a physician in the nurses' station, for she uses a specific set of mannerisms, words, and body

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[9]Ludwig Wittgenstein, On Certainty, ed. G. E. M. Ansconbe and G. H. Von Wright (New York: Harper and Row Publishers, 1969), p. 16.

[10]Ludwig Wittgenstein, Philosophical Investigations, trans. G. E. M. Anscombe (New York: Macmillan Publishing Co., Inc., 1958), p. 886.

language during this encounter not used at other times. If the same nurse is working with a patient the rules change as well as the language and mannerisms. Again when this same person is enjoying a light chat on her break with other nurses she is once more playing another game.

What are the possible implications of this for varieties of moral and nonmoral obligation? This means that the medical actor must recognize and be aware of the type of games being played in order to properly participate as rules and games change. Many such persons are actually painfully aware of these and move in and out of the games so quickly that it is hard to discern when one stops and another begins. As the games change, obligations and responsibilities change, for the nurse may feel particular types of role and task obligations toward her patient, but different types of obligations toward her friends in the break room. A physician may have a moral obligation to inform patients about possible side-effects of drugs but have no moral obligation to make sure that the patient takes them once he or she leaves the office. However, the physician may have nonmoral obligations to exhort and educate the patient about using medication.

In this section we have considered moral obligations concerning sanctions and rules for individuals, with the idea brought forth that obligations vary from individual to individual concerning his or her relationship to institutions, groups and other persons are are therefore situation relative. In the next few sections we begin

considering the moral obligations and responsibilities of larger collectivities such as groups, teams, and corporations, in order to understand if the same types of responsibilities and obligations apply to them as for individuals.

Weak and Strong Moral Responsibility

One possible way to understand responsibility attribution for collectivities is to consider the minimum and maximum number of individuals necessary and sufficient for an event to occur. While discussing the stoning of a martyr, Schedler distinguishes between weak and strong collective responsibility. He states that "we shall call those of 'strong' collective responsibility where the contribution of each agent is necessary to cause death, while in the other subclass (weak collective responsibility) each participant's contribution is not even necessary."[11] The fact that members of a treatment team act together is sufficient in some cases for team blame, which is directed at the specific number of individuals involved in causing some objectionable consequences of rule violation as well as a vague notion of group disposition. For example, suppose that a patient's mother recently died of natural causes, and he experienced severe mental trauma and was hospitalized for depression. His treatment team is warned by the psychiatrist that mention of the mother at this time might cause him to attempt suicide, which he has been threatening.

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[11] George Schedler, "A Theory of Collective Responsibility and Some Applications," Heythrop Journal: A Quarterly Review 23 (October 1982):395-412.

Accidentally each team member at various times mentions his mother. When the last member makes this error the patient commits suicide soon afterwards. During a conference between the team and psychiatrist these facts are revealed, and the entire team is blamed in the strong sense. It is discovered that a weakly linked causal connection is seen among all four mentions of the mother's name and the suicide. and that any one mention alone was not necessary for the patient's death. Here we have a strong case of moral responsibility in which the exact number of individuals can be found leading to an event.

Weak collective responsibility might occur if, for instance, the patient had decided after the third mention of the name to commit suicide, and mentions this fact in a note. Although the fourth member mentioned the mother's name, the patient had already made his decision. The fourth member's contribution mattered little in terms of the patient's conclusion, although it was an error subject to blame. Weak responsibility is thus an excess of rule violation beyond that necessary to bring about a particular result or response.

In theory, cases can easily be mustered for discovering responsibility in the weak and strong senses. One only has to consider such events as the Beirut bombing on the United States Embassy, or the discovery of a person kept in a mental institution for ten years with a treatable disease, in order to understand the difficulties of knowing where strong responsibility ends and the weak begins. Such clear-cut cases of strong and weak responsibility might occur in confined units of time and location, but life rarely can be divided so easily.

Collective Monadism and Responsibility

In the last section, responsibility was attributed to individuals in a group. Not all societies distribute it this way but blame entire groups without blaming individuals. I will call this Collective Monadism. Recall that Leibniz named a monad "a simple substance, which enters into composites; simple, that is to say, without parts."[12] Such is the way some groups and persons have been viewed as subjects of responsibility; as wholes, and not as wholes composed of individuals. Recall that Feinberg used the legal terms "collective liability" to describe this same idea.[13]

Many instances of collective monadisms have occurred throughout history and in modern times. For example, Iran as a whole is blamed for the hostage situation at the United States Embassy, the United States is blamed for assisting Israel bomb Syria, and Russia is blamed for shooting down a Korean airliner. Such accusations tend to diffuse responsibility to the point where no one who uses it is quite sure exactly who is responsible, and use such words for quick convenience rather than an accurate description for blaming individuals.

Anthropologists occasionally find an isolated tribe in Africa with a patrilineal structure, whose members make no attitudinal or dispositional distinction between the members and the tribe. A system

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[12]Leibniz, "Monadology," in Leibniz, Selections, ed. Philip P. Wiener (New York: Charles Schribner's Sons, 1951), p. 533.

[13]Joel Feinberg, "Collective Responsibility," Journal of Philosophy 65 (1968):675.

of compulsory universal suretyship had been developed where the members of the tribe and community are guaranters of the conduct of all other members. Such activities are still common in countries where close family ties keep a group of individuals together in a centralized area of a town, country, or nation. In such groups, the errors and rejoicing are equally shared by all.

The basic philosophy of collective monadism is still evident in modern society in places such as public schools. Occasionally a teacher is unable to determine the individual offenders and punishes an entire class, hoping that the guilty individual will come forward as a result of peer pressure. Or consider a basketball team which violates recruitment practices and is suspended from playing in title games for a year. In each of these cases all members are punished equally, even if one individual originated the problem. Teams, tribes, classrooms, etc. are blamed, but such blame is often considered as a convenient label blaming individuals in them in order to distribute responsibility.

Both the Old and New Testaments contain multiple reference to notions of collective responsibility such as "the children of Israel,"[14] "the people of Jerusalem,"[15] "the house of Israel and Judah,"[16] "Jerusalem greviously sinned,"[17] "and therefore did the Jews persecute Jesus,"[18] "and the Pharisees said unto him."[19] These

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[14]Exodus 14:22. [15]Jeremiah 8:5. [16]Ezekial 9:9.

[17]Lamentations 1:8. [18]John 5:15. [19]Mark 2:24.

collective labels and addresses were often used to suggest blame throughout generations. In many instances when a leader's behavior offended God an entire nation or tribe was punished. In the New Testament we read that "by one man's disobedience many were made sinners, so that the obedience of one shall be made righteous."[20] In this case reference is being made to Christ who will provide the propitiation for every sinner in all generations.

Similarly, in World War II, the Jewish people were called a despised and inferior race by many in Germany, and all were attributed with blame for the human race's problems despite differences in personalities, ages, or beliefs. When such prejudices are held and sufficient sanction is used to reinforce them, then the entire race, people, or tribe suffer. Clearly, however, all people of any race are not responsible on an equal plane for the acts of a few, and to blame all in such cases is an absurd doctrine, unless one wants to uphold some metaphysical or causal linkage uniting all who are in a particular race, nation, tribe, and so on.

When considering the application of collective monadic responsibility to the treatment team, we must wonder about its value, for it seems to diffuse responsibility. Lewis posits that

> if we believe that responsibility is literally shared, it becomes very hard to maintain that there are properly any moral distinctions to be drawn between one cause of action and another. All will be equally good, or equally evil,

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[20]Romans 5:19.

> as the case may be. For we shall be directly implicated in one another's actions, and the praise or blame for them must fall upon us all without distinction.[21]

The concept of collective monadisms as discussed in this section is important because it is evident in modern ethical theories where it is claimed that groups, corporations, and nations are proper objects of blame.

Whitehead's Fallacy of Misplaced Concreteness

Before considering treatment teams and collective responsibility it is important to recognize the significance of Whitehead's belief that everything we understand as reality is in a process of continued evolution. Not to understand this is to commit the Fallacy of Misplaced Concreteness, which is "the accidental error of mistaking the abstract for the concrete."[22] This error occasionally occurs when, through narrowness of perspective, an individual recognizes the significance of an isolated, concrete event but fails to understand the dynamic relatedness of it to other events. This relatedness is an understanding of the world as a unified continuous process, where any attempt to isolate an event for study is necessarily a static understanding of a continuously changing world.

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[21] H. D. Lewis, "Collective Responsibility," Philosophy 23(84) (January 1943):3.

[22] Alfred North Whitehead, Science and the Modern World (New York: The Free Press, 1953), p. 51.

In application to collectives of people, Whitehead's fallacy assists in exposing problems with theories which attempt to describe collectivities as if they were frozen objects in time and space without continual, dynamic processes of change.

If we consider the converse of the above understanding of the fallacy, some interesting facts emerge. It seems equally possible to mistake what are considered to be abstract ideas and realities as having a separate existence apart from the concrete world. Because Whitehead applied his concept of misplaced concreteness to "all" things in existence, it seems fair to interpret him this way. Therefore, it is just as destructive a fallacy if ideas are given static fixity over against a dynamic and changing concrete world. To merely consider the word "responsibility" evokes for most persons both an abstract idea and possibly concrete references of persons being responsible. We might even talk about responsibility apart from concrete references of responsible persons. To some, the ability to think and discuss an idea such as responsibility separate from concrete examples of it may indicate a dual status for each activity; the former being one of fixity about a real existent, and the latter being one of continual variableness of human activities in a changing world. But such dichotomies suggest a fixed, static, and nonrelational belief over against a continually changing world which would again commit the Fallacy of Misplaced Concreteness. These problems also have significance for health care teams.

When we consider health teams and collective responsibility we find similar problems. To begin with the idea that responsibility has a separate existence apart from concrete actors in teams seems fallacious. In order to commit this fallacy a person might believe in a Supreme Reality with some type of ontological fixity to uphold the belief in a fixed notion of responsibility. If such a belief is held, however, it is difficult to understand what the relationship of this fixed responsibility could be to the concrete world. Do health teams reflect this responsibility? Do they tap into it upon communication during team efforts? Does responsibility still exist after the team disbands? These and many other questions must be addressed by advocates of a fixed notion of responsibility, and the burden must lie with them for justifying such ideas.

Such fixity appears in modern discussions about the status of groups such as health teams. Typically it is asserted that a collectivity is more than the sum of the activities of the individual members with the justification that no one member alone could accomplish what a group can. I agree with the latter belief in group accomplishments, but object to the way groups are typically seen in a sense of "beyondness," past the members which is said to justify giving them a special status. This status is understood by some to indicate a unique separateness generated by interactions of members, which in some unknown sense exists parallel to, alongside, or integrated with the activities of the individual members. When a team is viewed as having such a dual status—of concrete individuals

working together, and of a separately generated something resulting from these interactions—then an insurmountable dualism seems to appear when the two are separated in thought. Whitehead would object to this duality and suggest that both the concrete interacting group members are in process as well as any generated concept, event, or idea (such as responsibility) we might use to describe what is observed. If in fact responsibility is a process evolved with the activities of group members, then this helps to undercut a stagnant notion of responsibility as generated alongside or separate from the interactions of persons.

Although Whitehead's beliefs in the total process of existence are exemplified in much of the scientific world, his views are regularly challenged. In the next section I will address several of these challenges in recent philosophical literature which discuss the concept of collective responsibility and moral agency.

The Moral Agency of the Health Care Team

In this section I will present an analysis of the moral agency of health care teams by exploring how some authors create dualisms between the interactions of team members and the concept of collective responsibility. Furthermore, I will purport that the concept of collective responsibility loses meaning in concrete application to health settings unless moral responsibility is ultimately seen as belonging to individual group members.

In Groups As Moral Agents Michael Smith attempts to show that "a group of persons can be a single moral agent, responsible for its

own actions";[23] a task similar to De George's when he attempts to show that hospitals are agents.[24] Smith's analysis includes considerations of several characteristics that are attributed to human individuals which make them moral agents. With these ideas he builds a case for the moral agency of groups. As stated earlier, I expressed some skepticism about attempts to assert that groups are moral entities in the sort of metaphysical sense which tends to take the focus off the individual actors. It is important, therefore, to examine some of the typical characteristics commonly ascribed to persons which are said to make them persons.

Joel Feinberg believes that commonsense persons undoubtedly

> give evidence of being conscious of the world and of themselves; they have individual emotional lives, just like me; they can understand things and reason about them; make plans they can communicate with me, argue, negotiate, express themselves, make agreements, honor commitments, and stand in relationships of mutual trust; they have tastes and values of their own; they can be frustrated or fulfilled, pleased or hurt.[25]

In Smith's work he chose to discuss two broad categories of personhood with several characteristics each; having goals and making decisions, which he attempts to ascribe to groups.

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[23]Michael Smith, Groups As Moral Agents (Ph.D. dissertation, University of Chicago, 1979), p. 1.

[24]Richard T. De George, "The Moral Responsibility of the Hospital," The Journal of Medicine and Philosophy 7(7) (February 1982):91.

[25]Joel Feinberg, "Abortion," in Matters of Life and Death, ed. Tom Regan (New York: Random House, 1980), p. 189.

All of Feinberg's characteristics will not be considered here, but it is important to ask whether treatment teams can exhibit some of them. First, can treatment teams give evidence that they are conscious of the world and of themselves? The members certainly can, as well as members in relationship with others, but this does not imply that the team itself is conscious. It is fallacious to assume that because a few of the members are conscious and aware of the world around them that the group itself has its own distinctive consciousness or awareness. Each person in a team expresses varying degrees of consciousness during the day and takes turns being fully or partially aware of the group's activities, or members are preoccupied with other events even when present in the group. But none of these things can be said about groups as such in abstraction from the individuals that compose them.

It is often said that treatment teams can exhibit interiority, which is close to Feinberg's idea of emotional lives of individuals. If by interiority we mean emotional or subjective states or attitudes shared by team members, then the team can be said to have an emotional life which is an accumulation of the emotional interactions of its members. If we mean, however, that the team as a whole has an interiority like an individual human being, then this is false. In a team one must consider only the multiple emotional states of all participants. This does not mean the persons do not influence each other's emotional states. Individuals have emotions which influence other individuals, but there is no metaphysical sense of team emotionality apart from the participants.

Can treatment teams understand things and negotiate? Again, the members can in relation to one another and may even come up with a group decision. This itself does not qualify the team as an agent, but as a collective of individuals that pool thoughts and ideas and perhaps even appoint a representative. When anyone interacts with the team in order to negotiate, he or she does not deal with a team but with persons.

It is curious that Smith warns the reader to

> avoid unwarranted anthropomorphism of groups. We must avoid assuming that the agential characteristics of groups are similar in all respects to that of persons, the agents with whom we are familiar. Instead we must describe what we see.[26]

What one sees when observing a group, as already mentioned, are individuals working with one another. The notion of "group agency" is nowhere to be found except as an abstract orienting concept used to describe the activities of the individual members and their interactions. I suggest that Smith's entire thesis of attempting to prove groups analogous in agency to individuals is itself unwarranted anthropomorphism in association with abstract concepts. This error is a good example of Whitehead's fallacy of misplaced concreteness applied to individuals.

Smith posits that groups can have agential characteristics resultant from following its rules but also that groups have no consciousness of their own. He furthermore maintains that

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[26]Smith, Groups As Moral Agents, p. 46.

characteristics of groups are always evident "in virtue of some characteristic of acts by persons in the group."[27] This latter statement would not be so puzzling if it did not involve a leap from individuals as agents to the group as agent. The term "agency" is commonly used to discuss individuals, and rarely does one hear the terms "corporate agency," or "group agency" used except as convenient labels for asserting the responsibility of each individual within these collectives. It is true that corporations are held legally responsible for activities, but rarely do we call a treatment team an agent in the sense of suggesting that it be considered so for responsibility attribution, or praise and blame. When teams are blamed, individuals are, and the notion of group agency only tends to disperse the idea that anyone is culpable. As with corporations, teams and groups may have within them one or more individuals who are blameworthy, and the entire collectivity may suffer as a result of their punishment. This in no way entails that the entire collectivity is responsible or that because all members suffer the whole must be a moral agent.

For the moment, consider Smith's claim that groups can be moral agents. There are several difficulties with this thesis which he fails to address. The individual health worker, as a moral agent, enters into contracts or agreements of varying types with patients or with health care institutions. Such contracts may specify the nature

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[27] Ibid., p. 47.

of the agreement with statements about professional goods to be provided, tests done, and claims about impropriety by either party. Rarely are written contracts made with patients. Oral agreements, backed by ideals embedded in particular medical institutions, express the nature of such relationships. In institutions it is often the case that a patient contracts with one physician to oversee his or her care.

Consider a team-patient relationship. The patient contracts orally with a group of persons such as a family practice team. One member is generally recognized as the leader or coordinator, but the networking makes the relationship of the patient to the team different than that of one patient to an individual practitioner. Team members may question a patient and work with him, but inevitably they report to the other members through the leader, who is deemed ultimately responsible for team function. If this is usually the way a team functions in terms of leadership, then this defines how teams are usually held both morally and legally responsible: through the agency of a team leader. The possibility is that health teams are not treated as moral agents by most medical personnel, legal institutions, or patients. This may not mean that whole teams should never be punished, but only that the wisdom of our present legal system seeks ultimately to blame individuals.

Smith takes the relationship of teams and members farther than some theoreticians. For example, he claims that since individual

agents have goals, groups do also.[28] This is problematic. Most individuals set goals of varying types for structuring their lives and attempt to act in rational fashions to achieve them. There are multiple types of long and short-term goals, and biologists suggest that these are part of our physiological heritage as organic beings beyond conscious control. But the goals Smith considers are those which individual persons in groups choose to create, and he makes a distinction between goals for oneself and goals set for oneself: "goals of an agent and goals for an agent."[29] In his analysis he attempts to make a distinction between goals of groups and goals had for them by persons or corporations. His claims that individual agents can have goals or that goals can be set for them is non-problematic. For example, I can work toward a Ph.D. in biology—a long-term goal—or, I can enter a corporation structure where goals are set for me.

A problem arises when he attempts to claim that groups have goals. This in itself is understandable in the sense that each member agrees to abide by some orienting ideas. But to ignore the individuals and assert that the group itself makes goals, and thus acquires a new status apart from individual decision-makers is erroneous. Certainly each member of a group may share goals with others, but this sharing is not analogous to a jig-saw puzzle, where each member holds a piece that, when properly placed with the others,

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[28]Ibid., p. 50.

[29]Ibid., p. 51.

makes a whole. Again we are dealing with a fallacy of composition, for the fact that the individual members have goals does not imply that the group does. The starker realities of medical practice verify this. Although each member of a group may verbally attest to idealistic goals, secretly each may harbor a set of personal ones which may be unknown and may even conflict with group goals. The goals of each member may be attained through treatment teams, but cooperative efforts are no guarantee that these are its primary goal. Physician A may want to help the ill, nurse B may desire to improve her status in physician A's eyes, and medical student Q may seek an improved salary and a degree. Where do these goals fit into the concept of group's having goals? Is it logical to consider that both group goals and individual goals exist together for the benefit of its members and the patient? Is it also logical to thus argue that the group has a goal or goals beyond the individual agents who accept tehm? Smith seems to think so: "To agree that there can be goals of a group is already to argue that this important agential characteristic is attributable to the group itself rather than to any particular person in the group."[30] This is false, for Smith uses the concept of group goal as a metaphysical glue to bind the assenting individual goal-makers who agree to accept the same goals. He draws upon a false conclusion of group agency by confusing goals that individuals

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[30]Ibid., p. 60.

set for themselves when functioning as members of a group with goals belonging to the group itself as a separate metaphysical entity.

Another characteristic of groups which Smith discusses is voluntariness.[31] Groups can act voluntarily if by this we mean that the members have the capacity for making decisions. For Smith to assert that groups act voluntarily throws no light on his beliefs. For him this seems to be either an existential proposition, a metaphysical reference, or a shortened reference to individual members; but the former meaning seems more likely. Voluntariness seems to imply that an individual agent makes decisions, considers alternatives, and acts on them. Can groups do so? Agents in groups can, but groups are composed of many individuals with varying degrees of autonomy. Physician A might have threatened nurse B with repercussions if she did not keep silent on an issue during morning rounds. At the same time medical student Q is keeping quiet to protect his self-image around the physician, while social worker M speaks her mind at all times. This is a treatment team or group, but can we say that they can collectively act voluntarily as an agent given the above circumstances? I think not. To call a group an agent based on the quality of voluntariness is to ignore the varying degrees of freedom and coercion within the group structure. It also asserts a truism for the members which does not hold for the whole.

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[31] Ibid., p. 70.

According to Smith groups are also able to have moral obligations and rights just like individuals in similar contexts. He claims that groups can enter into contracts like individual agents, for "they can agree to buy and sell; they hire and fire; they guarantee their products; they agree to limit their political activities in order to gain not-for-profit status, etc."[32] Furthermore, he suggests that groups incur obligations when they do so. Again Smith's language causes difficulty. Does a group actually "enter into a contract?" The way this is stated makes one think that the group is something besides the members who compose it. Actually, individuals work together and enter into a contract through agreements and decisions. The obligations of the group may require that its members make and sign contracts, but a group does not affix a signature on it. The individual members do.

Smith also claims that groups can be accorded virtue and praised for their actions in relation to obligations, duties, and responsibilities.[33] For a patient to say to a surgical team, "I thank you for the fine work you did" means that each individual is the recipient of praise, not the team as an abstract entity. Smith's notion that groups can be proper objects of praise has merit if the uses of praise-oriented words are recognized merely to be markers or abbreviations for praising each participant, not for asserting the

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[32]Ibid., p. 96.

[33]Ibid., p. 98.

existence of a new metaphysical entity. One might wonder why the virtue or praiseworthiness of groups should even come into question as something beyond the individual members except perhaps to support another equally abstract idea such as group agency.

Another important question arising out of the group agency controversy concerns the relationship of group obligations and the identity of its members. It is claimed by Smith that group moral agency is not superfluous because if one or more members dies, "there would be no reason for maintaining that the group still has this obligation should Jones or Brown die, take a leave of absence, or simply resign."[34] Smith fails to recognize that the individuals of the group agree to accept the rules or obligations of it which the members decide upon. Also he does not recognize that the loss of one or more members does not destroy the group because there is no group to destroy. What might be destroyed is the existence of a collective body of ideals held by existing persons. The fact that a group may still be held responsible, even if it disbands, is a function of the activities of its members during their association as well as the rules and views they held while together. In a group where one member dies, the group continues because its ideals are extended by being accepted by the other existing members. If all the members die, someone might claim that the deceased persons were

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[34]Ibid., p. 116.

responsible for particular acts, but in this case there is no object of praise or blame except abstract traces of the group recorded on paper or in film. Individuals must exist for a group to exist, and obligations for them cease when no group member or relative can be verbally or legally blamed.

In another passage Smith claims a super-obligatory role for the group. He suggests that the obligations of a group are not identical with those of the persons who have roles in it.[35] Consider the following case. If a sales representative from IBM sells an XZ100 Computer to TAMEX Corporation, and the representative dies, IBM is still obligated to fulfill the contract. Does this provide a case for saying that corporation is in some sense more than the association of its members? It is a common myth that corporations have a type of supernatural character because of their abilities to survive and grow over hundreds of years, but this is due to careful planning of personnel structures, financing, and marketing. The individual company representative is obligated to his customer in the same way that the company is as long as he is associated with it. The fact that he dies or leaves means that he no longer agrees to or can abide by its rules and beliefs. Thus, any transactions previously made with customers will be fulfilled by the company. This is not a reason for saying that corporate obligations differ in metaphysical sense from

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[35]Ibid., p. 117.

individual obligations because a company continues after individuals die. It is, however, a reason for asserting that the breaking of contracts or dealth alters the relationship so that it no longer is maintained. Who maintains the obligations, then? Those who remain true to the company's ideals do, but if these persons likewise die, then so does the company. Smith might claim a super-obligatory power for the corporation, but as with groups, survival is dependent upon at least a few faithful avowers holding to their ideals even when flux of personnel occurs. The identity of the group or corporation is maintained even through generations at times. There is no super-obligatory status of groups or corporations, but only obligated faithful individuals who together are called the group or corporation.

Like Smith, Cooper attempts to use an example of a tennis club to show that the "identity of a collective does not consist in the identity of its membership,"[36] and that "no determinate set of individuals is necessary for the existence of a collective."[37] Cooper assumes that an imaginary tennis club fails, and he attempts to show that any set of statements about individuals and their actions could not adequately describe who or what was responsible for the club closing.

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[36]David E. Cooper, "Collective Responsibility," Philosophy 42 (165) (July 1968):260.

[37]Ibid., p. 263.

To talk about the club failing is to talk about members who did or did not contribute to its failure in a descriptive causal sense, and not about an abstract entity called a club. We may not be able to trace all the activities of members and external forces which led to the closure because we may lack data about the situation with all its members. It does not theoretically seem to be an impossible task to trace all causal elements. The fact that we do not eliminate the terms "tennis club" is irrelevant to the fact that individuals are the composition of a club, and their activities over a period of time in some way lead to its closure.

Cooper claims that the club's identity is not equivalent to its membership, but if this is true, what is it equivalent to? It may be that Cooper is uncomfortable with identifying an abstract form such as "club"—a term which gives us no hint of its size, possible period of existence, etc.—with a variable collectivity of individuals which, not by coincidence, comprised its membership even when all members were not present at one time and while some were lost and others gained over a longer period. The club, like the corporation in the previous example, is only a constitution of persons who faithfully ascribe to its rules and tenets during any one time period. If Cooper means that the club's identity is not equivalent to its membership during the entire time of its existence, then I disagree; for all persons, present or absent as members were part of the club and fed into the process directly or indirectly which led to its demise.

If Cooper means that the club's identity is not identical to the membership of a particular time in its history, then this is acceptable. During any time unit the membership fluctuates as the club continues as an extension of a past history.

His claim that no determinate set of individuals is necessary for the existence of a collective is correct, for a collective's existence strictly depends on the fact that enough persons exist who continue to uphold its tenets to preserve its identity. These persons can be said to be equivalent at any one time to its membership, even if that membership changes every day. Cooper makes the mistake of equating the concept "club" with that of its membership, which is a category mistake. The club is its members, but not something alongside them. "Club" is simply a shorthand designator for considerations of individual members; members who choose to adhere to a common set of rules and beliefs regarding their activities together for varying durations of time. These facts form the identity which the members call a "club."

Another of Smith's main reasons for calling the group as agent is that it can make decisions. He considers three types of decision-making: behavorial, systematic, and volitional.

Behavioral accounts "analyze decisions as either observable physical behavior or as some verifiable quality of the behavior decided upon."[38] In a rather unexamined fashion Smith suggests that

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[38]Smith, Groups As Moral Agents, p. 62.

if the behaviorist can accept rule constituted group performances and not merely focus on the individuals, then groups can be said to be voluntary and act as decision-makers.

Traditionally behaviorists have been individualists who deny or are skeptical about metaphysical realities which fall out of the category of observables. For a behaviorist to import unqualified labels such as "group performances" would be a considerable compromise. By "unqualified labels" I mean that he would fail to admit that such terms as "team, group, committee, and corporation" are convenient labels for discussing collectivities composed of individuals.

Smith's second type of decision-making is called "the systematic account." He cites several characteristics that an agent might incorporate into his performances of an act. He presents them in an analytic manner. They are:

1. It is analytically true that, if A decides to do Y but does not do Y, then A either was prevented from doing Y, or changed his mind.
2. It is analytically true that, if A assents to the proposition "I ought to do Y," then A has decided to do Y.
3. It is analytically true that, if A decides to do Y, A intends to do Y.
4. It is necessarily true that, if A decides to do Y, then A has certain knowledge that he will do Y, unless prevented.[39]

His point in citing these is to suggest that these agential characteristics of asserting a capacity to change one's mind, to act with intentionality, assent to "ought-propositions" can be equally

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[39]Ibid., p. 65.

attributed to groups. Smith is thus seeking what Risser calls "an identifiable disposition of groups or collectivities."[40] Groups, he claims, like individual agents, know what it means to assent to propositions, change one's mind, decide to act, or be voluntary agents who take responsibility for them. From what has previously been said I disagree with such ideas which involved fallacies of composition. For example, what it means to say that a group makes a decision is decidedly different than what it means to say that the individuals in it make one. The final product of a decision-making process may be conveniently labeled "the group decision," but rarely do groups immediately come to complete consensus without members raising doubts and conflicts occurring. Often the group overrides individual's independent ideas. But to label this the "group decision" fails to take into account these details of the decision process. It seems that we can probably agree that the terms "group decision" are a convenient label implying that the group arrived at a decision after discussion and controversy. "Group decision" would thus imply that total agreement is not required for decision-making. This use of the term is more acceptable. But Smith wants to give this final product of decision-making, as well as the group, an existential status that goes beyond the individuals in some sense.

I agree with Peter French's criticisms, which are applicable to Smith's beliefs about metaphysical group agency:

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[40]David Risser, "Power and Collective Responsibility," Kinesis 9(1) (Fall 1978):68.

> Responsibility in the moral sense does not seem to be ascribable to aggregate collectivities primarily because of the sense of saying that such a collectivity can intentionally act, let alone could have intentionally acted differently, is hopelessly unclear. What, after all, is a collective intentional action? There is, by definition, no standard way within an aggregate collectivity for collective decisions to be reached or to determine that the collectivity per se has certain intentions.[41]

As with groups, treatment teams are subject to the same considerations. To say that a team acts with intentionality, has goals, makes decisions, and is virtuous are hopelessly vague concepts that serve little purpose for understanding teams and the concept of moral agency.

Lest I am accused of being too harsh on Smith, he does admit that when groups perform, persons in them act. He says that "a group performs in fact only through or by the force (or power) of the acting or persons, so that a group without persons acting is an inactive group."[42] Furthermore, he claims that

> there is a sort of identity of a group's performance with acts of persons in them in virtue of which it performs. But this identity is not absolute, so that the performance by the group is not reducible to the acts by the persons in virtue of which it performs.[43]

These claims draw closer to some of mine, but what I find objectionable is his metaphysics. He moves from concrete to abstract entities with ease, as if it were understood that each has an independent metaphysical status.

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[41] Peter French, "Collective Responsibility and the Practice of Medicine," Journal of Philosophy and Medicine 7(1) (February 1982):77.

[42] Smith, Groups As Moral Agents, p. 25. [43] Ibid., p. 25.

In this section I have presented what I believe to be compelling reasons for rejecting any claim that a team, group, or corporation can be a moral agent. I think this is more in line with common sense views about blaming individuals even when collective labels are used as orienting guides, markers, and abbreviations for focuses on individual actors.

Divided Loyalties in Collectivities

Professional literature abounds with expressions of one-sided theories about collective actions. Some fail to consider the uniqueness of the group or individuals in it. Others attempt to discover an integrative method for expressing both, which for many reasons may be impossible given our present exclusionary concepts associated with wholes and parts. Such problems clearly spill over into discussion of group and individual responsibilities. The following passage is representative of many which express the aforementioned problems and tensions in current literature.

> A structural rather than purely individualistic analysis of a group or organization (e.g. problem or difficulty such as low morale, poor team effectiveness, etc.) shows another important practice function as well. When individual analyses are predominant, we not only blame individuals for their problems, but also hold them responsible for doing something to change it. It is then easy for such people to feel guilty, as if they failed; they blame themselves; self-esteem is lowered, and they may express frustration and despair as they continue to duplicate failure. A structural analysis suggests that the individual's woes may not be entirely of his or her own making; that is, a person may be caught in a situation that would make anyone feel troubled and disturbed.[44]

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[44]Edward E. Sampson, Group Process For the Health Professions (New York: John Wiley & Sons, 1981), p. 67.

This passage, quoted from a current book on group processes for health professionals, expresses the need for a type of sensitivity to individuals in collectivities such as treatment teams. It also suggests a shift to other factors away from the individual as completely responsible for his or her difficulties. Hence, it contains the essence of the dual bind individuals in collectivities find themselves in: to blame themselves, be blamed as an individual, or to blame external factors, such as institutions, other people, accidents, or bad luck.

What is disturbing is that the passage above leaves the concept of responsibility as an "other centered" idea and fails to emphasize the importance of the individual's own responsibility. This may have merely been an oversight by the author, but this is typical of books which consider group responsibility. By placing blame in external factors the individual worker may begin to get the idea that he or she is a victim of circumstances and is powerless to alter them. Furthermore, by encouraging off-centered responsibility emphases in medical structures where it is easy to hide within bureaucratic processes, persons may begin to consider accepting this as a type of norm for themselves merely because it is convenient and psychologically comforting to be in a collective. When this occurs it is easier to avoid taking personal responsibility by being entangled in complex interactions where causal chains cannot be traced directly back to one agent.

I am not advocating insensitivity to the fact that it is true that people become victims of external circumstances. All co-workers need encouragement, but I am advocating that medical personnel are constantly given mixed signals in their work settings about being personally responsible and about the benefits of taking the responsibility focus off themselves. There is security in not having to worry about blame being traced back to oneself and considerable insecurity when it can.

The desire to lose oneself in the bureaucratic shuffle is due to individual fear about taking total responsibility for anything. Horosz claims that

> This is the fear of taking on the responsibility for systems of responsibility. One would rather follow the leads of a totality, by being responsible to its directives, and avoid the burdensome task of being responsible for informing it, either by reflection of participation—or by both.[45]

A strong psychological need exists in persons to avoid blame, which regularly is reflected in both life and literature. I believe there has been too much emphasis on placing responsibility on things other than the individual. Persons in collectivities—especially treatment teams—need to be encouraged to find a sense of courage, if not of comfort, in taking personal responsibility as opposed to the hiding process. But as long as social systems encourage what I call "off-centered" responsibility, this task will be more difficult.

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[45]William Horosz, The Crisis of Responsibility: Man As the Source of Accountability (Oklahoma: University of Oklahoma Press, 1967), p. 67.

After encouraging individual responsibility, several reasons will be presented why this may be extremely difficult given the structure of existing medical institutions.

The Moral Schizophrenia of Medical Institutions

The health care team, it has been asserted, is imbedded within a broader corporate structure. To consider the health team as the subject of responsibility in reference to formal hospital structures is important, for it is not necessarily the case that both interact to encourage moral decision-making in health teams. The administrators, boards of directors, and stockholders, do not necessarily consider or are even concerned with the goals of its particular subunits or teams, except to assure their proper function for the institution's survival.

Consider the typical portrait of a hospital. A hospital functions by a set of institutional rules made for its protection and survival. Kenneth Galbraith aptly points out that although hospitals may say that their goals are to maximize profits and promote health, they actually attempt to secure their own survival, autonomy, and economic growth.[46]

Hospitals are so structured that they employ subordinates within a hierarchical structure who are expected to surrender or abdicate choices to the institution. They are often required to give

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[46]John K. Galbraith, The New Industrial State (Boston: Hough ton Mifflin, 1967), pp. 171-178.

up personal considerations which may conflict with institutional rules and goals. As Flores and Johnson believe, "The individual as a private person seems to disappear in the organization as he takes on a public role,"[47] and one may question whether the individual "is him or herself" when they act on it. Hospitals do maintain a strong identity in spite of the flux of personnel by being able to retain those willing to abide by its rules by culling out the rebels.

Furthermore, hospitals are places for empirical considerations, and matters of morality are not officially written into the charter structure. Hospitals must regularly do the "rational thing" and not the "moral thing" which may not necessarily coincide. It is in the best interests of hospitals to attempt to present a public image of morality and certainly to pay attention to community matters of religious and moral interest which can affect institutional survival. Otherwise, morality is not of prime importance for them. What would often be morally abhorent to the individual may be acceptable to the institution; becoming rational if it serves the institution's objectives. Such actions are viewed as "no less wrong than, say, bluffing is in poker."[48]

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[47]Albert Flores and Deborah G. Johnson, "Collective Responsibility and Professional Roles," Ethics 93(3) (April 1983):541.

[48]John Ladd, "The Idea of Rationality in Formal Organizations," Monist 54 (1970):550.

A dilemma arises, however, when an attempt is made to reconcile the goals of individuals who daily enter their organizations and to integrate themselves with its rules. The health care worker in an organization is "envisioned as more or less ethically neutral . . . (and) the values to be taken as data are not those which would guide the individual if he were a private citizen."[49] Workers are asked to be neutral institutional representatives, work toward its goals, and yet to be sensitive, kind, moral individuals who express the highest standards of care and compassion. They are sometimes told to do acts which conflict with personal beliefs, to maintain a double standard.

To be an institutional representative in one sense makes one not responsible for personal acts, for he or she is an agent in submission to an institution which provides orders. To act as an institutional representative may mean one is not culpable because of acts done for its administrators. However, these workers are asked to accept full responsibility for their behavior. When the acts of its workers are in accord with the institution's best interests, workers usually get institutional support. When they conflict, the acts may be disavowed as nonrepresentative of institutional policies.

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[49]Quoted from A. Bergson by Kenneth Arrow in "Public and Private Values," in Human Values and Economic Policy, ed. S. Hook (New York: New York University Press, 1967), p. 14.

Ladd calls these conflicting polarities the "moral schizophrenia" of medical institutions.[50]

If hospitals are described as nonmoral or neutral in intent and structure, even if immoral in activities by some person's standards (functioning more like a corporation with replaceable parts), can they be considered moral agents with responsibility? Holmes claims that although some corporations act as if the profit motive were a moral end, this is not true, for the corporate structure is not designed for agential assumptions of responsibility and moral obligations.[51] In corporations, as hospitals, whatever is utilized is the most efficient, or most rational thing; i.e., the thing most likely to result in a profit.

Health Care Teams: Caught In A Dilemma

Where does the individual health care team member fit into the dilemmas in the last section? He or she is caught between two often competing value systems, and may express these ambivalences by acting in inconsistent ways. Health care workers know these dilemmas well in their daily work. For example, they may be asked to "cut costs" by eliminating particular types of diagnostic procedures but feel that

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[50]John Ladd, "The Idea of Rationality in Formal Organizations," Monist 54 (1970):501.

[51]Robert L. Holmes, "The Concept of Moral Responsibility," in Ethical Theories and Business, ed. Tom L. Beauchamp and Norman E. Bowie (New Jersey: Prentice-Hall, Inc., 1979), p. 5.

they are doing a disservice, both morally and professionally, to patients. Or consider the physician who feels he must overdiagnose as a result of possible legal problems and who is encouraged to do so by the hospital. He may feel that this puts a burden on both the patient and insurance companies but may feel helpless to stop it. Or consider medical workers in an emergency room who want to help all patients but must turn some away because the institution can't afford to care for the indigent.

These individual cases of moral schizophrenia are no different in health care teams. If the team is interdisciplinary, each member usually recognizes the rules of the institution associated with his or her activities. Because of differing value systems, conflict between teams and the institution will occur where responsibility loyalties get split; a phenomenon Zerubavel calls "Floating Responsibility."[52] A treatment team may try to maintain the highest professional and moral standards when treating patients, but this regularly is thwarted by "institutional reminders" of the realities of life where funds, shortages of supplies, and institutional survival come into play.

As a rule treatment teams are allowed considerable freedom in their activities as long as these stay within the general range of institutional goals and as long as the personnel reflect allegiance

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[52]Eviater Zerubavel, "The Bureaucratization of Responsibility: The Case of Informed Consent," Bulletin of American Academy of Psychiatry and Law 8(2) (1980):182.

through conformity and professional standards. As mentioned earlier, I think teams can and should be encouraged to choose their own decision-making structures as long as it is recognized that their rules of operation must interface with those of the institution. It is entirely conceivable that Wittgenstein's insights about games and rules can be played out through multiple team games within a larger game called a medical institution. In such games rules and game types constantly alter which allows new ones to emerge; new ones which can improve patient treatment.

Variations of Responsibility and Health Care Teams

It would be an error to believe that the various types of treatment teams functionally operate the same, or that professional, moral, or task responsibilities are exactly the same for all. Time constraints, team structures, roles, and many other factors determine how responsibility function in teams. In this section three treatment team types discussed in Chapter V will be examined in order to explore their similarities and differences. The teams to be discussed are the temporary fixed treatment team (TFTT), the continual substitution treatment team (CSTT), and the temporary variable rounding team (TVRT).

Recall that the temporary fixed treatment team is composed of the same members who regularly meet for short times in order to perform a task, and then they disband. One example is an orthopedic surgical team. Usually in such teams primary responsibility for the duration of surgery is vested in the surgeon, and he or she must take

final responsibility for the team member's actions. Surgery is not a system of democratic processes but a dictatorship where each member obeys without question the demands of the leader. No time is given for debate or voting, and each member is responsible to the leader for his or her own behavior. All team members are viewed by the leader as of equal importance, for the failure of one can mean the failure of the team's mission. This temporary distribution of equal power for all members but the leader lasts only for the duration of surgery. Then each member disperses into other teams or hospital tasks and new responsibility games are played.

The surgical team is the closest one can come for knowing the exact descriptive causal sequences of events and placing appropriate blame if one member is at fault. There is no place to hide during surgery, and every member of the team observes the actions of all others. If a patient is injured or dies, all members in a team may psychologically suffer for the error of one participant. However, the leader is ultimately blamed, and he or she must in turn mete blame to others.

This type of team has a relatively stable identity. The same persons from diverse professional backgrounds meet regularly. When required, a substitute for another worker may enter the team, but its general identity as an orthopedic team stays the same; for enough members still maintain the skills and the ideologies of its tasks.

The moral responsibility of the surgical team may not be evident from observation, but each member usually takes it upon him

or herself to play a watchguard role on the activities of others. Here the tight interrelatedness of descriptive and evaluative tasks and morality are inseparable, for if one fails to note the slipped tube on the oxygen tank, this may endanger the work of all others. In this sense we might say that each member temporarily takes responsibility for others concerning their tasks. This may or may not be for purely selfish motives, but responsibility distribution is ultimately particularistic.

A second team type, the continuous substitution treatment, is one that operates 24 hours a day in three shifts. During each shift a common meeting place is utilized by the members, and each member has a particular number of patients assigned to him or her. A nursing team on a maternity ward could be one example.

The interesting part of this team type is that the individuals serve in five capacities as a result of being on the team. Each serve (1) as part of a larger floor or ward team on a particular shift, (2) as part of an ongoing 24-hour team, (3) as an individual representative of the floor team, (4) as a subteam volunteer, and (5) as an institutional representative. Thus, several types of possible responsibilities or duties are in play. The nurse is responsible to the rest of the nurses as they act as team representatives on the ward. Also they are responsible for coordination of chart notes and patient observation in order to allow those on the next shift to continue the work, and in a sense they stand in the middle of a past future treatment sequence. Again, a nurse has a

responsibility to be available to assist others in times of emergency for patient needs.

This latter type of responsibility is interesting. When a ward crisis occurs, a new subteam is formed from those available personnel. In such a new team quick decision-making occurs, authority powers may change, and temporarily nurses work quickly to alleviate the situation. For these subteams there is no stable identity except from the fact that those composing it are from the larger ongoing ward team. Their coming together is often one of necessity and availability, and has little or nothing to do with likes and dislikes of personnel or rank. Responsibility attribution is still hierarchical. Members of the subteam are responsible to the head nurse even during such team formations.

As with the surgical team the activities of subgroups are very evident, and responsibility attribution can often be closely linked to a task activity of a nurse. However, when the nurse is on the floor alone it is more difficult to trace a causal chain back to a particular individual.

When subteams are formed, we might say that each member is responsible for the activities of others, for one failure may not remedy an emergency situation. It is more difficult to consider the individual nurse doing floor duties as responsible for the other team members because of the separation of time and proximity of tasks, but this does not mean that the nurse is relieved of the responsibility to report unprofessional conduct.

The temporary variable rounding team is a common one and is often composed of members from various disciplines. Sometimes such teams are formed for short periods of time, and round through treatment wards until a specific task is accomplished. A team leader usually coordinates its activities and must bear final responsibility for any decisions and activities of the members. Each usually carries out a specific task as assigned by the team when it disbands. Usually such teams have one or two core members who always show up for rounds, but the other participants can vary greatly—depending on desire to participate and time schedules of personnel.

In such a team the physician usually assigns tasks to its members and they blame or praise others of the team. Rounding teams are often not considered to be composed of equals, for such factors as training and competence are considered in the physician's evaluation of a member's activities. The failure of any one member to carry out a task can lead to serious consequences for a patient, but usually such faults are not as serious as errors during surgery.

In variable teams it is difficult to maintain a sense of identity due to the changing personnel, and it is equally difficult to have any interdisciplinary monitoring occurring where each member polices the activities of the others.

From the three teams discussed it is clear that any consideration of various kinds of responsibility must take into account the unique nature of each team's structure.

In this chapter I have tried to argue that the concept of group agency serves little practical purpose for understanding responsibility attribution in treatment teams. Responsibility must in the final analysis be attributed to individual team members. This keeps the focus on personal responsibility and away from tendencies to disperse it into abstractions or bureaucratic systems. This does not mean that it is always possible to find one or more definite individuals responsible for some occurrence, but such must be attempted. There is a tendency in modern society to seek ways to disperse or evade responsibility for ourselves when we know we are responsible.

It has also been argued that medical institutions, due to their value systems and hierarchical structures, create value conflicts for employees. Because of this, attribution of responsibility to treatment team members also gets dispersed within the structure. The concept of an isolated team with no references to other parts of the institution or other superiors who govern each team member is shortsighted. Given the varying conceptual bases and abilities of each team member, the divided value loyalties, and the large number of superiors most personnel are responsible to in modern medical institutions, it seems fair to conclude that what are called treatment teams are only so in the loosest sense. This merely means that the team concept needs further development in order to foster stronger bonds among members. This can be accomplished by encouraging educational experiments and studies in order to discover ways that

will allow all team members to gain more respect and appreciation for the educational and ideological backgrounds of other professionals.

CHAPTER VII

INCOMMENSURABILITY AND COLLECTIVE RESPONSIBILITY

Research data are scarce on the conceptual differences of health care workers and how these affect the attribution of individual and collective responsibility. Many times different health care professionals find themselves in conflict over treatment issues with other team members that seem unresolvable by either argument or compromise. By "unresolvable" I mean that reasons behind the incompatibilities of views may remain issues even though they are temporarily settled by power plays, intimidation, or indifference. In this chapter I will argue that medical training, role expectations, and especially the new wave of specialization have created differing conceptual frameworks through which medical personnel work to treat patients. This in itself is not controversial. I suggest, however, that many of the difficulties in understanding personal responsibility in health teams may occur because of differences in each member's treatment paradigms. Such differences have been inadequately researched, but personal assumptions about the knowledge bases of other members from differing treatment perspectives is bound to create unidentifiable conflicts. Such problems make the parameters of reasons for blaming and praising quite vague. For instance, a team worker may be blamed for not knowing about a particular piece of information. The worker, however, believes that this fact falls

outside of his area of competence and that it is the responsibility of other members to have such knowledge. Conflicts of this type, both moral and technical, regularly occur. But many of these could be eliminated if research was able to "map out" the paradigms of each interdisciplinary team member in order to seek clarification of roles and the limits of responsibility for each participant. If a more scientific understanding could occur concerning responsibility in relationship to the training and professional expectations workers receive, then this would be an invaluable step for understanding how responsibility functions in teams.

The Paradigm Model of Thomas Kuhn

Thomas Kuhn's research of paradigms in The Structure of Scientific Revolutions[1] provides some valuable insights into the notion of exclusionary conceptualizations and how these affect the relationships of persons. In his studies he primarily considered scientific communities in conflict, but I will apply his ideas to the health care treatment field and its participants. A brief review of Kuhn's ideas will assist the reader in understanding them.

A paradigm, Kuhn believed, is the basic model of research followed by the scientific community, meaning that there are sets of beliefs and rules which a majority of the scientific members follow

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[1]Otto Neurath, Editor-in-Chief, International Encyclopedia of Unified Science (Chicago: University of Chicago Press, 1970), Vol. 2, No. 2: The Structure of Scientific Revolutions, by Thomas S. Kuhn.

for communication and problem-solving. For example, at one time in history the community followed the Newtonian paradigm of physics which provided a scaffolding of basic accepted thought while further experimentation continued. As time elapsed, this model became inadequate. A majority of scientists became unhappy with it for various reasons and protested against it in professional literature, at meetings, and between themselves. A new scaffolding was eventually required to accommodate new scientific discoveries.

During transition periods between models considerable conflicts occur. There are always scientists who attempt to maintain the old model and are pitted against those who desire change. Splits in the scientific community occur, and professional views become incommensurable. The two paradigms no longer are compatible. As a majority of scientists become convinced that the new paradigm is more adequate it becomes the "official" one. Those who continue to hold on to the old are ridiculed or ostracized. Such events can be seen in the movement from Newtonian to Quantum mechanics. Such shifts are difficult to map out in a clear manner, for these transitions are conceptual ones which are expressed over long periods of time, and no neat starting or ending point can be found for them. Also it is usually the case that the new paradigm adopts parts of the ideas of the old one but refashions them to suit its purposes. Paradigm shifts are building processes as well as ones of discarding and exclusion.

Of special importance is Kuhn's views that as two paradigms conflict, scientists actually have two different ways of viewing the

world. They are seeing or conceptualizing different worlds although they are physically in the same one.[2] The paradigms chosen by each have totally different meanings for the holders and are so divergent that no bargaining or manipulation can bridge or merge them.

Paradigm shifts occur when a traditionally valued system gets challenged by an anomaly that fails to fit current scientific views, and frantic attempts are made to find a way to fit it into the existing paradigm. As such attempts fail, theories are evolved which explain the problem, and the scientific community begins to change in viewpoint if the new information seems logical. Such changes get reflected in textbooks and teaching methodologies.

Thus, paradigm shifts are an attempt to provide new meanings to information that challenges the community and which causes conceptual changes which by necessity exclude older ones. For purposes of clarity it is necessary to consider Kuhn's ideas of incommensurability and paradigms in more detail for discussing their applications to treatment teams.

Further Clarifications of Paradigms and Incommensurability

The concept of paradigm must be understood in order to appreciate the importance for discussing treatment team responsibility. According to Webster's New Twentieth Century Unabridged Dictionary,

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[2] Ibid., p. 193.

a paradigm is "a pattern, example, or model."[3] Kuhn chooses to describe it as "what the members of a scientific community share, and conversely, a scientific community consists of men who share a paradigm."[4] Furthermore, Kuhn says

> I mean to suggest that some accepted example of actual scientific practice—examples which include law, theory, application, and instrumentation together—provide models from which spring particular coherent traditions of scientific research.[5]

In short, Kuhn believes that a paradigm is commonly defined by the current practicing scientific community as codified in texts and literature, consists of those views which are regularly defended, and gives a sense of security to current workers which indirectly relays the message that there is something stable to work from.

In medical practice there is a dominating paradigm about how patients should be treated accompanied by a host of methodologies commensurate with it. Within this paradigm are also other models of treatment and care which are incommensurable in the sense that the focus of care excludes other models or aspects of others. Concern with the patient's emotional welfare as a prime treatment concern may be exclusionary of the focus on curing a diseased body, or a medical

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[3]Noah Webster, Webster's New Twentieth Century Dictionary of the English Language, Unabridged, 2nd ed., ed. supervisor Hean L. McKechnie (United States: William Collins + World Publishing Co., Inc., 1970), p. 1298.

[4]Kuhn, Scientific Revolutions, p. 116.

[5]Ibid., p. 10.

worker's interest strictly in nutrition may exclude other patient focuses. This does not mean that health care workers on a treatment team do not communicate by utilizing a common stock of words and concepts, but it points out the limitations of such communications due to each worker's treatment model and "tunnel vision": the product of specialization.

Cases of incommensurable treatment modes cannot be resolved by empirical observations, for what each worker sees is strictly determined by his or her conceptual treatment base. The notion of "seeing" referred to suggests that each member brings different meanings to treatment teams which are expressed to others. It has traditionally been believed that the diversity of meanings enhance the treatment situation by considering more aspects of the patient's life, but few have considered how the conceptual conflicts might work against this thesis. Hence, there is a great need for research in this area.

Although Kuhn's focus was on scientific communities which change, we might consider the treatment team a composite of "X" number of individuals who each rigidly hold and defend a particular set of differing ideas about patient treatment. Although all members may be somewhat flexible, they are unwilling to give up their paradigms. Not only does holding a strong view about forms of treatment give one a way to treat patients, it also provides a sense of security due to expertise. Both of these factors provide good reasons for team members to feel the need to defend their models when required.

A team is thus a collectivity of possibly incommensurable world views which seeks ways to mesh these for better patient treatment. No one individual is willing to admit that other models are completely right and theirs wrong, for one underlying assumption of the team concept is that no one can possibly be the embodiment of all necessary information for treating patients. Hence, we have the problem of composition, where the task of the team is to find some way to make the treatment process an embodiment of the whole through the individual team member's expressions of care. This can only be accomplished by the creation of new theories and team models which discover ways to bridge these gaps both in theory and practice.

Types of Incommensurability

There are several types of incommensurable relationships that could exist between the health care workers, or between a worker and a medical institution. Figure 15 should be referred to during the

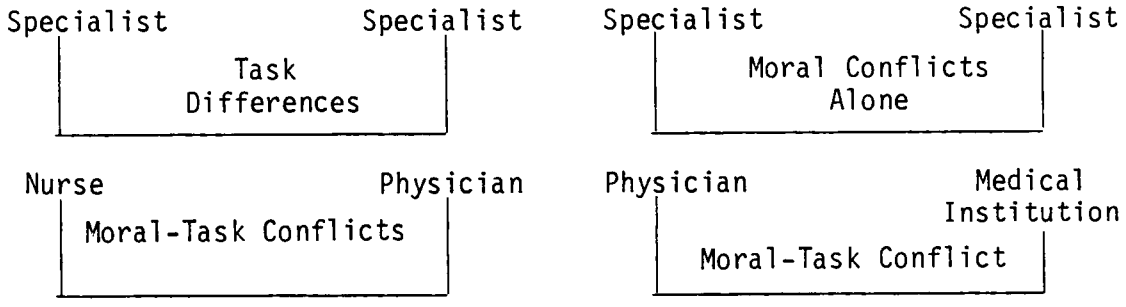


Figure 15. Types of incommensurability.

discussion of these types. To this point I have only considered incommensurability resulting from one's training which excludes

understanding other models. But there are other types of incommensurability, especially when one considers that moral views regularly enter into treatment discussions.

First, there are incommensurabilities between specialists. In one case a radiological specialist may believe that radiotherapy is the best choice of treatment for a patient, while the surgeon thinks that surgery is best for cancer. Each specialist has a strong opinion about the superiority of his technique, and no way can be found to resolve this issue. In this case, we are dealing strictly with two types of task incommensurability.

A second type occurs when two specialists disagree on moral issues concerning patient treatment. Moral views, unlike specialized training, are more particular and may differ from person to person. Usually there are other persons who share a set of technical skills through similar training, but no one else has another's moral ideas although there may be basic agreement about some issues. For example, suppose a Jehovah's Witness has suffered severe abdominal injuries and requests that no blood be administered because this would violate the patient's religious beliefs. Physician A claims that the patient's right to refuse treatment should be respected, but Physician B disagrees, stating that he has a moral obligation to help patients and not let them die. In this case we are not strictly dealing with the technical capabilities of the physicians, but with conflicts concerning moral outlooks.

A third type of incommensurability occurs when there is debate between team members which involves a medical and moral component. For example, suppose a patient is in an automobile accident and has difficulty breathing because several ribs have punctured his lungs. The patient is aware of his dilemma, and can whisper questions to medical personnel. However, he is lucid one moment and delirious the next. It becomes evident to an internist that a respirator will be required if the man is to live, and he prepares it. The nurse, on the other hand, has heard the patient request to let him die, and recognizes possible moral consequences of respirator use. She therefore urges the physician to wait longer to see if the patient will again become lucid enough to express his desires. An argument ensues about the physician's responsibility to treat his patient and the moral responsibility to respect patient wishes. Such arguments vacillate between technical and moral issues.

The final level of incommensurability to be considered is that between a medical institution and an individual. For instance, a physician might desire to treat indigent patients in the emergency room but is told not to do so because of the expense. In this case the practical concerns of financial survival conflict with the moral concerns of the physician, who believes that health care is a right.

All of the above levels of incommensurability could equally be applied to the relationships of teams to each other or of teams to the institutions, but this will not be studied here.

A Model of Incommensurability

Figure 16 is one vision of the similarities and incommensurabilities of four members in a treatment team: a physician, social worker, nutritionist, and nurse. Note that there are four parallel horizontal figures which represent the team members. These are joined by vertical bars which depict the common set of terms and concepts which allows them to communicate. The covering over the bars, which has been cut away from this figure, depicts the general paradigm of health care treatment within which all health care members operate. Specifying this general paradigm would be possible, I believe, through careful observation and consideration of the rules and visions which all health workers share about patient treatment along with their own special models. Such a study could also assist in identifying the limitations of the various health care workers in regard to their treatment models. The examination here is meant to be superficial by discussing paradigms, but it indicates the importance incommensurable visions have concerning patient treatment and collective responsibility. The implications of incommensurability suggest that unless ways are found to both theoretically and practically bind the team members, that team treatment will remain superficial, particularly with interdisciplinary teams. Second, the fact that the limitations of treatment models have not been adequately studied suggests that until this occurs, responsibility attribution for both members and teams will be unclarified, not so much from the standpoint of task responsibility, but more in the areas of role and moral responsibilities.

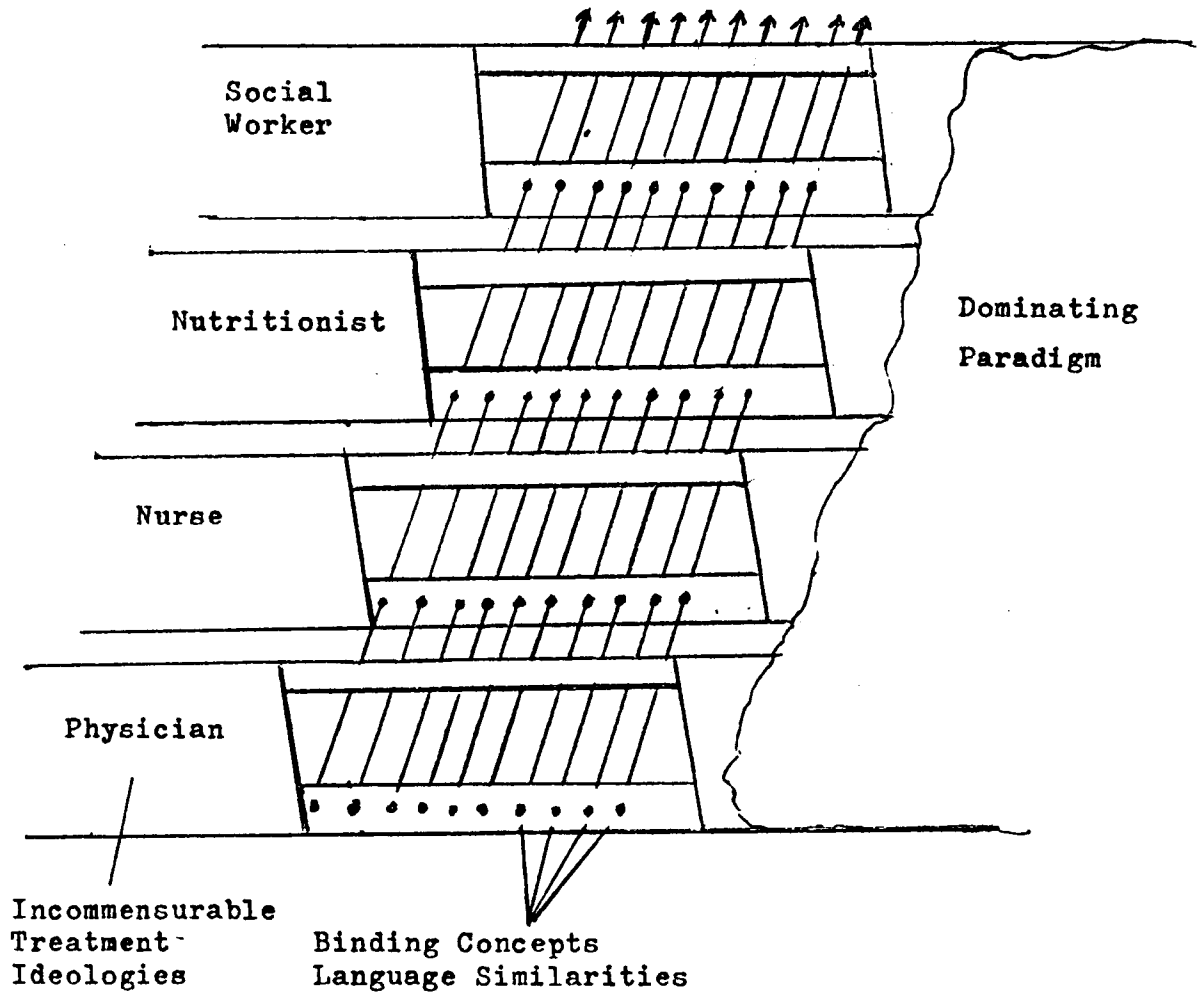


Figure 16. Incommensurability of an interdisciplinary health care team.

Paradigm Conflicts and Team Decisions

In the preceding sections the belief was presented that differences in education and training for medical professionals create problems concerning decision-making in treatment teams. An issue which has not been addressed is one of fairness in group decision-making. The question to be addressed is "Whose view of what ought to be done should prevail when paradigms conflict?"

In an interdisciplinary health team many views and ideas will be presented for solving both technical and moral dilemmas from many perspectives. It is important, however, not to confuse technical and moral expertise. All persons in an interdisciplinary team are expected to have technical expertise; to be knowledgeable about their particular fields in detail, and from such knowledge contribute knowledge to the team which other members cannot. Certainly some knowledge areas overlap, but the purpose of having different types of team workers is to expand and broaden the shared knowledge base in order to treat patients more effectively. Thus, technical knowledge is exclusionary in the sense that each member is expected to know information others do not have.

When matters conflict among members on technical subjects, the person whose background best qualifies him or her to address the issue is usually the best spokesperson. Such views are respected and often accepted as final. Team members, however, can argue that their training qualifies them to speak on particular subjects others are not aware of or do not adequately understand.

Although it may seem clear who is the expert on technical issues, the realm of moral expertise is less precise. It is a regular occurrence in treatment teams for moral issues to arise in conjunction with technical activities. Though team members can claim technical expertise it is questionable whether any are better qualified to make final decisions on moral issues. Justifiably we might ask "Is there such a person as a moral expert?" Medical education certainly trains persons to be technical experts, but are they simultaneously trained to be moral experts? This does not seem to be true. If it were, it would seem to follow that medical workers could appear in a strong sense to their moral superiority as decision-makers in difficult moral dilemmas. This is rarely the case. In many instances the opposite occurs, and a team comes to a point of utter frustration, not knowing what idea or suggestion to follow when no one seems superior in moral viewpoint.

How are such conflicts typically resolved? Sometimes they are not resolved at all. At other times the team asks a patient's family to make a final decision or a physician resolves a dilemma. In such cases no one person feels knowledgeable to make a decision based on educational background alone.

This does not mean that experience is not a valuable guide. A medical worker can, and often does, appeal to exposure to particular situations; and this is often used as the basis for moral authority. Even when this occurs it is fair to ask if exposure to moral dilemmas alone qualifies one to be a better decision-maker than others on a

team. A person with more experience dealing with particular types of cases may be able to present the facts and alternatives in greater detail, but does this qualify them as a superior decision-maker over the other members? This is questionable. There have been many instances where a supposed knowledgeable medical worker made a poor moral decision, while a worker with less exposure to some particular dilemma made decisions with positive results. Usually it is the case, however, that exposure to particular medical-ethical dilemmas is assumed to make a worker more qualified than others in a treatment team.

If we accept the belief that there is no such person as a moral expert, but only persons with more knowledge about particular dilemmas, then what does this imply for team decision-making processes and moral dilemmas? It seems to lead to the idea that all persons on an interdisciplinary team are equal in terms of moral vision concerning dilemma outcome but not equal, as stated earlier, in terms of situation exposure.

The implications of the inability of any team member to be a moral expert suggests that all team members should have equal input and an equal vote during a moral dilemma. Some team members may be able to provide more information about the dilemmas than others, but each member should be allowed to independently consider and vote, or suggest ideas that are understood as equal in value as other ideas. The reality of present-day decision-making on such matters is that professional authority often plays key roles in teams even when such

authority does not qualify a person as an expert in moral matters. Typically, such decisions are left to physicians who often take this role, claiming that they are ultimately responsible for what happens to a patient, especially in legal matters. Such arguments are compelling in terms of authority and final decision-making, but they do not resolve issues of who is or is not best qualified to make moral decisions.

The moral egalitarianism discussed above does not mean that all persons, no matter what their backgrounds or experiences, are qualified to be moral decision-makers in medical settings. An ever-present assumption of decision-making processes for health teams is that each member will act in a generally accepted professional manner as a member of the medical community. The fact that every medical professional has undergone a type of initiation through educational processes carries with it a professional sanctioning power for his or her abilities. This process, unfortunately, provides no guarantees that the products of medical education are excellent decision-makers in moral matters. Such prestige is carried over into medical settings and influences his or her relationship to other team members. Thus, to say that all medical professionals on a health team are in some sense equal is a radical idea (except as an ideal), and is usually resisted in practice as an operating premise for team decision-making concerning moral dilemmas.

It is my belief that teams can function creatively and efficiently using two operating premises: (1) that there are obvious

differences in technical training for all health team members which imply inequalities, and (2) that no member has a monopoly or claim to superiority on decision-making for difficult moral dilemmas. The first premise suggests that it is ridiculous to pretend that health care workers are all equal human beings even in the broadest sense given the tremendous differences in training—training which forms the worker's paradigm world. Some theorists attempt to take the dictum "all people are created equal" as a type of across-the-board equality designator, but common sense suggests otherwise. This is not meant to condone prejudice or unjust laws, but is a recognition of inequalities created for and by medical personnel by differing educational methods. Each worker is trained to represent a set of differing values conjoined with a unique knowledge base to which society attached varying levels of prestige. The second premise, if accepted, could imply a revamping of the way difficult moral decisions are made in health teams. In reference to the original question at the beginning of this chapter, it means that no one worker's paradigm should dominate, but each person should be given an equal vote and expression of his/her treatment ideas. As a theoretical consideration, this has promise, but practical aspects of teams such as role differences may undercut a belief in equality for moral decision-making.

Concerning collective responsibility, the premise about moral decision-making equality has some fascinating implications. If each team member had an equal vote in treatment dilemmas, then it seems wrong to only blame the physician when a team decision has negative

consequences. Society typically places power in physicians as team leaders, but if the operating premise of teams is that each member is morally equal in decision-making abilities, then this seems to suggest that an entire team can be blamed and punished. Society, I suggest, is not ready to consider such possibilities, but finds it more convenient to blame an individual or two given our existing legal and penal system.

To suggest that each member on a health care team has an equal vote in pressing moral matters gives more meaning to the idea of "team decision." A team with voters who have equal power in determining an outcome suggests equal individual representation, which is Democratic. But a problem exists. A "team decision" gives no hint about how the members voted. When a team decision has negative consequences, it seems unjust to punish those members who disagreed with the dominating majority. Guilt by association in team decision-making processes is unjust, and only those voting whose decisions led to a negative consequence should be punished.

In a reciprocal fashion, only those members whose decisions led to a positive outcome should receive praise and be recognized. Those members whose decisions did not accord with the majority's, and which would have probably had negative results, need to reevaluate their decisions.

The fact that each member has a vote implies a risk of praise or blame. Difficult moral dilemmas are usually risky because no person can foresee the future and accurately know all consequences for

alternatives. Each member's power to vote implies that a valuation occurs, and each valuation will bring varying degrees of praise or blame for each person. If a person or persons vote in a minority, and are right, then they should be respected because their vote was accurate—even if the majority chose not to follow it. If a minority vote is wrong, then majority should be respected for their accuracy. Thus, equal voting power should assure protection for both majority and minority team voters.

But the question must be asked: Does each member of a team necessarily have to vote? Earlier it was assumed that all team members must vote in every moral dilemma, as part of their responsibilities as a result of team association. However, it seems reasonable to suggest that another alternative exists: not to vote at all. If a team member or members believe that participation in a voting process places them in a dilemma where any decision is reprehensible, then they should have the option of not voting. In some medical institutions this is already practiced, such as team decision-making concerning abortion.

The very spirit of voting abstension, however, is a potential threat to team decision-making processes. If all members are potential voters, then theoretically all members could choose not to vote when a dilemma arose. This threat is usually checked by the cohesive belief in most teams that all members participate (to varying degrees) in decision-making processes. If members were allowed to abstain from team voting, most would probably choose not to do so. Part of

being a professional health care worker is participating in difficult decision-making. Most workers merely accept this as part of their task, and do not choose to abstain from decisions altogether.

More medical professionals would probably choose to abstain from voting if there were some institutional protections for them. Such protections might be written rules or unspoken ideals which would insure that team members who did not vote would not face censure of any type. Even if this were the case, I suspect that health team members would rarely abstain for reasons stated above.

In light of each member's voting possibilities, it would seem important to have some system for recording votes. This would assure that only those members who vote particular ways would be blamed or praised for their actions, for it seems unfair to blame all members just because each one is associated with others and are called a team. By recording such votes, this places considerable emphasis on individuals as responsible agents. In the past, it has been a matter of comfort for some members in treatment teams to have an appointed leader make all final decisions, and hence take primary blame for a team's activities. But if each team member becomes morally responsible for decisions, then this changes the entire decision-making structure of teams.

By focusing again on the individual moral responsibility of each team member, I am attempting to undercut the ability of medical personnel to hide within the bureaucratic system. Throughout this study I have fostered the idea that individuals in teams, and not

teams, are ultimately responsible for their behavior both in a technical and moral sense. By restructuring the decision-making process of health teams it is possible once again to place full responsibility in each member for their decisions in moral dilemmas.

In this chapter I have advocated that the knowledge bases, or paradigms of medical workers in health teams creates differing types of unavoidable technical and moral conflicts. These conflicts can only be properly understood if they are seen as the results of differing treatment perspectives for team members. Knowledge about the educational assumptions and training methods which form each team member's unique paradigm will assist in smoother team functioning when such information is shared among members. Unfortunately, there is a tremendous body of literature on group processes but only limited information about how educational processes form paradigms. However, as more research occurs this information will be available to treatment teams, which should make them more efficient. But while this research is continuing, teams can begin to moderate their treatment structures by recognizing that no one member has a corner on moral decision making, especially when dilemmas arise. This acknowledgment will help evolve more democratic decision-making processes on moral matters if those in positions of power will allow this to occur.

Whether treatment teams will be progressive in making suggested changes is unknown. Medicine tends to be quite conservative in its viewpoints and slow to change concerning its general operational

structure, especially when conflicts occur between operational efficiency and morality.

CHAPTER VIII

MAJOR FINDINGS, LIMITATIONS, AND PRACTICAL APPLICATIONS

This research addressed a wide range of topics related to health care teams. The primary purpose was to defend the thesis that when issues of moral responsibility arise in treatment teams, the individual workers and not teams must be held responsible for treatment outcomes. The organization of the chapters was designed to address important topics which laid theoretical groundwork for discussions of teams and collective responsibility. Because of the extensiveness of this project it is important to summarize major findings, present limitations, and suggest its practical implications.

Summary and Major Findings

In Chapter I it was stated that health care teams have received renewed attention because of technological and social changes. One reason for this is that persons are becoming more interested in what has been called the holistic health movement. As a result patients are seeking new modes of treatment to satisfy their needs and have placed these requests before the medical system. One response by medicine has been to initiate experimental projects to expand the use of treatment teams. Interdisciplinary health teams are receiving special attention in these experiments. Whether such teams will be more effective for patient care than traditional treatment forms is unknown.

In Chapter I I also presented an exegesis of the words "team," "treatment team," "interdisciplinary team," and their synonyms. No common characteristics of teams were found to form a workable definition. The ambiguities of the usages of "team" by laymen and professionals caused me to create a stipulative definition, one primarily based on functional characteristics of teams. The implication of this problem expressed the need for universal agreement on one definition of "team" to tighten its usage. Because there are multiple ways to understand what a team is (psychological, behavioral, biological, etc.) it seems unlikely that in the near future one definition will be satisfactory.

Chapter II was an evaluation of the health team concept which explored the opinions of medical professionals. I expressed the fact that there is still considerable skepticism in the medical community about the value of expanded uses of health teams. In the midst of criticism, however, experiments are continuing in medical centers and schools despite theoretical and practical difficulties. Such experiments are being used to evaluate whether teams can be cost effective, meet patient needs, and efficiently treat patients. In this chapter I concluded that it is still not a proven fact that team treatment is an improvement over traditional one-to-one patient-physician relationships. Many medical institutions and workers still seem optimistic that interdisciplinary teams will be the primary treatment mode of the future.

One reason why medical personnel have been skeptical about the treatment team concept (especially for interdisciplinary teams) is that personnel often have difficulty agreeing on how to diagnose and treat patients. Persons in teams come from varying educational backgrounds and have diverse understandings about how to treat patients, which often leads to strife.

Chapter III addressed how medical education influences the way personnel conceptualize patient treatment, and how education creates a type of specialized myopic vision for medical specialists. Research shows that some medical schools are beginning to require interdisciplinary field work to attempt to correct this problem. Most medical schools, though, still provide traditional educations in which students who specialize do not regularly interact with personnel from differing treatment backgrounds. Such might be the case of a medical student training to be a physician and a social worker training to be a counselor in a cancer treatment ward. Thus, interdisciplinary training is not a regular part of most medical educations. This suggests that most medical schools do not have adequate programs to promote the skills needed to help prepare students to function well in many types of treatment teams. Most students obtain a few of these skills in clinical training, but these are often indirectly learned. Many medical workers must enter regular practice before they directly face problems of interdisciplinary communication and cooperation.

In this chapter I also addressed whether current codes of medical ethics do or do not include references to the importance of interdisciplinary cooperation and communication with other health-related workers. I concluded that such references are few, which in part reflects ambivalences of the medical community concerning the practicality and value of expanded treatment team practice.

Chapter IV attempted to show that treatment teams are not isolated medical units but are parts of larger systems. Treatment teams are constantly influencing, and being influenced by such systems. Ignoring these influences can cause short-sightedness on the part of researchers and leads to the fallacy of misplaced concreteness. One reason for discussing teams and systems interactions was to show that internal and external factors affect their function and decision-making processes. Thus, to ignore these influences gives only a partial picture of teams which is usually inaccurate. To consider issues of collective responsibility for teams is not only to study particular teams but their systems relatedness as well.

In this chapter I also explored the idea that there are many different types of treatment teams. These differences are not only functional but also structural and behavioral. Through the use of symbols I expressed some of these differences, with the goal of showing that issues of individual and collective responsibility for teams also depends on the uniqueness of each. Health care teams are responsible in different ways, meaning that each team, according to its particular composition, goals, and personnel structure, will deal

with problems of individual and collective responsibility in different ways.

Chapter V addressed some of the theoretical issues which lie at the base of discussions about health teams and collective responsibility: the whole-part dilemma, general-particular dilemma, and logical fallacies. These are often the real, unrecognized issues which lie at the root of discussions about health teams and collective responsibility. They may easily be overlooked. I attempted to show that treatment teams are historically related to these controversies and are thus subject to them. Also I presented several theories which attempted to resolve these issues.

Chapter VI addressed the question about whether medical personnel working in health teams should be held responsible for their actions or whether teams should be held responsible. It attempted to show the fallacious conclusions which follow from the idea that teams can be held responsible without individuals being so. Such a belief grows from the mistaken idea that teams can be moral agents like individuals and that they (teams) have a separate metaphysical status apart from, and different from, the individuals who compose them. If a theorist chooses to follow the implications of such a position, an unbridgeable dualism is created between the team as a metaphysical entity and the individuals who compose it. Such beliefs are still evident in modern treatment teams and affect decision-processes. It is a common occurrence for medical workers not to know who, if anyone, is to be blamed when a treatment crisis

occurs. Sometimes causal chains can be traced directly to particular events or persons and blame easily placed, but other times many persons and activities become entwined to the point where no one individual can seemingly be held responsible for a treatment outcome. This is extremely frustrating when team workers believe that blame should be placed but do not know who or what to blame. It is at this point that a metaphysical explanation may be used by workers to blame a team. Where such explanations are used, no individuals are directly accused of error. Each member may feel disturbed over the incident and yet be secretly satisfied with the knowledge that he or she cannot be held personally responsible for a treatment outcome. In this research I claimed that individuals must ultimately be held responsible for treatment outcomes, even if they participate with others in a team setting; for it is individuals who treat patients. It is common for medical personnel in bureaucratic structures to be able to escape responsibility by becoming lost in its events and groups, but this tendency must be checked. Hiding does occur and is fostered by work settings which make it easy to escape personal responsibility. If medical personnel are allowed to hide their personal actions in medical systems and escape into metaphysical explanations by blaming teams and other events (especially when they know they are to blame and will not admit it), then individuals will continue to find ways to avoid personal responsibility.

Chapter VII attempted to provide one possible explanation for understanding why treatment team members come into conflict over

issues of individual and collective responsibility. By using Thomas Kuhn's theories on paradigms it was suggested that team members may be unable to bridge gaps in understanding created by specialized training. This is especially apt to occur in interdisciplinary teams, where persons have been educated differently and do not treat patients with similar theoretical understandings. Thus, patient diagnoses and treatment suggestions are apt to differ considerably. If, as I have proposed, team members have become specialized to the point where they cannot fully appreciate the treatment modes of others, then it follows that when interdisciplinary members assemble to deal with patients they can never fully understand each other's treatment forms or ideas. It is common for team members not to grasp the knowledge bases, limitations, and assets of the treatment views of others. This is in part due to modern education, where persons training to be medical workers get little practical experience in interdisciplinary communication and understanding to prepare them to become active members of treatment teams. There is, however, optimism among many medical workers that ways can be found to help bridge interdisciplinary understanding for more effective treatment team work. But if ways are not found to promote such understanding, theoretical issues of collective and individual responsibility will also remain unclarified. No member will ever quite know what responsibilities belong to particular workers following from their technical training. Thus, it seems to follow that they should not be held responsible for aspects of treatment for which they are not trained. Yet, it is an open question

about what falls within the parameters of one's training. The concept of team responsibility is often lost in this confusion because members do not recognize or understand the other's skills, limitations, and assets, as well as their own.

Limitations of the Research

Throughout this study the belief was promoted that patients are seeking a more holistic health care mode. A serious question can be asked about whether this is just a passing phase which will revert back to more traditional treatment forms. If in fact health teams do not become more pronounced forms of future patient care, then it may seem that questions about collective and individual responsibilities are red herrings. This skepticism, however, seems unjustified, for the use of teams is increasing as technology advances, and at present I see no trend to indicate regression.

A second limitation was my inability to know if members of interdisciplinary teams understand the treatment methods, limitations, and expertise of other members. At present experiments are occurring in medical schools and institutions to promote efforts of team communication and cooperation, but there is no overwhelming evidence suggesting that paradigm differences can be effectively bridged.

Another problem encountered was the inability to find adequate definitions of "team" and "treatment team" which were neither too broad nor narrow. My reaction was to create a stipulative definition, but this did not solve the problem. Continual abuse of these terms has caused part of the problems I encountered, but I found no reason

why it is not theoretically possible to apply scientific understanding to such definitions. By doing so, limitations could be placed on what kinds of collectivities could properly be called teams and which could not. I see no easy resolution for this problem, for theorists from diverse backgrounds believe their particular definitions are superior. In Chapter III I discussed medical codes of ethics. Although I did obtain a considerable number of current codes, new ones have been published since I began work on this project. Thus, the only way adequately to confirm my skepticism about the lack of references in them to interdisciplinary concerns would be to continue to collect them for a longer period of time. Any researcher who has attempted to acquire these codes will understand the difficulty in keeping current, for they are constantly being revised. Not only is it a problem to collect them, but it is often perplexing to wade through their ambiguous language; especially when there is no interpretation.

Another limitation concerns collective responsibility and causality. Throughout this study I have attempted to point out that individual health workers must ultimately be held responsible for outcomes of team treatment. There may be cases, however, when institutions and/or teams may find it desirable not to blame individuals, especially when some factors of treatment seem beyond the abilities of any individual to control, predict, or prevent. Such an event might be equipment failure or a patient's peculiar and unexpected reaction to treatment. In some cases, therefore, events enter into

treatment programs which cannot be traced back to particular persons as proximate causes. The ability to distinguish these nonagential events from those directly caused by agents is an epistemological problem. Thus it seems impossible, given our limited perspectives, to know or even understand the intricacies of complex causal chains in order always to place blame on individual workers. This does not mean that blame should not be sought when there is suspicion that persons should be blamed, only that we cannot always trace causal chains back to responsible agents. This can and sometimes should result in not placing blame. This limitation is in part imposed by the state of modern knowledge and in part by that fact that some causes do not involve moral agents. Unless these limitations are acknowledged metaphysical explanations and frustrated searching will occur when individual blame is sought in team settings. This is especially problematic when team members feel that someone should be blamed but cannot point to any one individual.

In Chapter VII I advocated that in medical institutions there are no moral experts in the same way there are treatment experts. The implications were that each treatment member should have, and would desire, an equal vote in decision-making processes when moral dilemmas occur. However, it may be an unjustified assumption to presume that team members desire freedom of choice. It may be the case that even if members were given the choice of having equal votes, many would prefer to leave decision-making to an appointed leader.

Customary forms of decision-making in health centers may be so imbedded that new ones might be quickly rejected.

Practical Applications of the Research

As a result of this research I have arrived at several conclusions which have important implications for health care teams. First, the researcher who studies collective responsibility and health teams needs to be cautious about theories which discuss responsibility as a separate metaphysical entity apart from persons who exhibit responsibility. Such theories have been of minimum theoretical value for practicing medical personnel and have left some of these same persons skeptical about the value of philosophy in application to medicine. I am not advocating the abandonment of metaphysics in medicine, only the abandonment of a particular theoretical research approach concerning teams and collective responsibility.

A second conclusion was that treatment teams are still in experimental stages concerning decision-making processes. Because personnel roles are in flux, workers are beginning to feel the need for a restructuring of the basic treatment team. Such restructuring, I suggested, necessitates recognition that no one member has special expertise when difficult moral dilemmas arise and decisions must be made. Clearly team members are trained medical specialists, but this does not necessarily qualify them as moral decision-making experts. If medical personnel were to take this idea seriously, then it would change the ways teams function during decision-making processes. Each member would have an equal vote on moral dilemmas. However,

given the conservative nature of present-day teams, where one person (usually a physician) is designated the leader and final decision-maker, it seems unlikely that this idea will be implemented in the near future. As mentioned in Chapter VII, it would be wrong to assume that team members would always vote according to their true convictions. They might give in to external pressures. The concept of voting equality for members is a progressive idea because it involves team members in decision processes who might otherwise take a back seat.

A third practical implication of this research was that it seems possible for treatment team members to be actively involved in choosing the decision-making structures for their teams. In our age we have the advantage of knowing basic structures, decision-making methods, values, and disvalues of many types of group decision processes. It seems important to apply this knowledge to treatment teams by allowing members to actively participate in the team's decision-making structure. As stated earlier, differently structured teams deal with responsibility in various ways. This would seem to indicate that responsibility is team relevant in the sense that it can be applied in various ways to suit team needs. It seems logical to believe that teams should be able to choose these decision methods and processes. Thus, members actively participate in the selection process and know, through the choices of particular systems, how blame and praise will be handled. There may be many limitations to this idea. Some boards-of-directors and medical personnel would

claim that it is impractical, medical workers do not want such freedom, that members could not use it, and that medical institutions cannot function with multiple decision-making team structures. These criticisms may be partially justified. However, little research has been done to support or refute these possibilities; and it is premature to make such judgements.

A fourth practical implication of this study was that in order for health teams to be more effective in their abilities to treat patients members must be better educated about the paradigms, incommensurabilities, and commonalities of understanding of the other members. By having a better understanding of the paradigms of other members, plus their own limitations and assets, respect can increase in a team and greater harmony can result. Whether this is possible, however, depends in part on current and future research. If medical education can include studies about the conceptual frameworks and treatment modes of other specialties in medicine, this could greatly increase the ability of students to learn how to work more creatively in health teams. Unfortunately, such knowledge is not available in an easily understood and coherent form for most students, but may be in the near future.

New research could, however, be immediately initiated to answer these questions. To initiate such research I propose that a bold project be started which would utilize practicing medical and allied personnel, plus educators, as researchers. Each specialist would be chosen for his or her abilities to carefully observe medical

personnel in various types of institutional settings. The purpose of these observations would be to determine (1) how medical education shapes the treatment views of workers, (2) how such views affect medical practice, (3) how the treatment views of differing specialists are similar and dissimilar, (4) how these different views preclude or include one another in joint treatment ventures, and (5) to pass this information on to medical students to broaden their understandings about the treatment views of other medical personnel. Researchers could begin to obtain what might be called a "cognitive portrait" for every specialization of medicine. This could be accomplished by observation, studying medical literature, and through personal interviews. In order to avoid conflicts of research technique, researchers would have to agree about how they would collect and evaluate data. If this cannot occur, then it may be impossible to coordinate and evaluate the collected information.

Once such observations were complete researchers could pool findings. It would probably be possible to then have a better understanding about which medical personnel would more likely have similar cognitive frameworks for patient treatment, how other personnel differ from them, and for what reasons. Such information could be valuable in the establishment of particular types of treatment teams where compatibility of treatment understandings would be an asset. Such information could be more valuable to interdisciplinary teams, for such information might be used to educate personnel about why particular types of conflicts occur, and how to avoid them. This

research knowledge could also be a valuable tool by letting other team members know the assets and limitations of workers to foster respect for the variety of treatment understandings.

No pretension is made that this type of a project would be easy to accomplish, but it is within the limits of present knowledge to initiate it, and to obtain valuable information.

Although this research has been extensive, it only begins to address many critical issues related to health teams and responsibilities. It was my intention, however, to create a project which could be used as a steppingstone for further research.

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VITA

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