

Interdisciplinary teamwork: is the influence of emotional intelligence fully appreciated?

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Aim The purpose of this study is to discuss how emotional intelligence affects interdisciplinary team effectiveness. Some findings from a larger study on interdisciplinary teamworking are discussed.

Background Teams are often evaluated for complementary skill mix and expertise that are integrated for specialist service delivery. Interactional skills and emotional intelligence also affect team behaviour and performance. An effective team needs both emotional intelligence and expertise, including technical, clinical, social and interactional skills, so that teamwork becomes greater or lesser than the whole, depending on how well individuals work together.

Key issues Team diversity, individuality and personality differences, and interprofessional safety are analysed to raise awareness for nurse managers of the complexity of interdisciplinary working relationships.

Conclusion If nursing input into interdisciplinary work is to be maximized, nurse managers might consider the role of emotional intelligence in influencing team effectiveness, the quality of client care, staff retention and job satisfaction.

Keywords: emotional intelligence, interdisciplinary teamwork, interprofessional safety, team diversity

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Introduction

The interdisciplinary team is defined as a group of health professionals from different disciplines, who work together sharing responsibility for collaborative decision-making and the outcomes of client-focused care (Liedrtka & Whitten 1998). Interdisciplinary teamwork raises questions about partnership working (Leathard 2003) and role understanding including transition and flexibility (Griffiths *et al.* 2004, Kneafsey *et al.* 2004, McLellan *et al.* 2005). Discussions of team types and efficiency (Thylefors *et al.* 2005) and the

characteristics of effective health care teams (Mickan & Rodger 2005) go some way to identifying specific indicators that promote interdisciplinary teamworking that supposedly improves the quality of care (Irvine Doran *et al.* 2002). To date, much of the focus has been on team effectiveness.

However, if nurse managers review team effectiveness in isolation from team process issues, a skewed picture of interdisciplinary practice results and fails to explain fully the complexities of teamworking. Although evidence of team effectiveness undoubtedly influences any health service manager wanting to know if interdisci-

plinary teamworking contributes to quality outcomes for clients, the extensive literature on the challenges of interdisciplinary working conveying another story (McCallin 2001). It is possible that another component of team effectiveness includes emotional intelligence, which has been given much less attention.

Emotional intelligence consists of four fundamental capabilities: self-awareness, self-management, social awareness and social skills (Goleman 1998). While the capabilities are usually considered in relation to individuals, Goleman *et al.* (2002) believe that they can apply to teams and have the potential to optimize a team's effectiveness. Emotional intelligence impacts on individuals managing interdisciplinary working relationships. Emotional intelligence influences excellence (Goleman 1998) and may affect quality care, staff retention and job satisfaction. While, intellect and expertise matter it is emotional competence that sets star teams apart from those that are less successful.

Teams and their managers striving for optimal effectiveness may need to review their level of awareness of emotional intelligence and expertise that includes technical, clinical, social and interactional skills. Working in a team is probably much more complex than expected but once the full dimensions of interdisciplinary practice are considered teamworking becomes greater or lesser than the whole, depending on how well individuals work together (Goleman 1998). Ideally, professional practitioners will balance emotional expressiveness and emotional restraint (Hawkins & Shohet 2000), as they focus on the client, bringing together skills and knowledge in collaborative working relationships. This view is consistent with Graham's (2003) observation that it is time for 'a more inclusive focus of process, purpose and people working together in an interdisciplinary fashion with the coordination, facilitation and integration of the work central to its goal and outcome' (p. 214).

It may be timely for nurse managers to consider the emotional aspects of interdisciplinary teamwork and reflect on how this idea influences interactions and behaviour. This is particularly important in the health care context where the quality of care is declining and the shortage of registered nurses continues to increase (Budnik 2003). In this study, two aspects of interdisciplinary teamwork, team diversity, including individuality and personality differences and interprofessional safety are discussed in relation to social effectiveness; some implications for nursing are offered. The ideas proposed are developed further from a grounded theory study on interdisciplinary teamwork in New Zealand (McCallin 1999a). The original research generated a

theory of pluralistic dialoguing that has been written up elsewhere (McCallin 1999b, 2003, 2004, 2005, 2006). The purpose of this study is to analyse the emotional component in interdisciplinary teamwork that not only impacts on team effectiveness, the quality of health and social outcomes for clients, but also influences job satisfaction and the retention of nurses.

The research

The aim of this grounded theory study was to discover the main concerns of health professionals working in interdisciplinary teams, and to explain the processes team members used to continually resolve practice problems in the workplace (McCallin 2004). Data, collected from 44 health professionals from seven disciplines in two major acute care teaching hospitals in a large metropolitan area, included 80 hours each of interviewing and participant observation. Data were constantly compared and analysed using grounded theory (Glaser 1998).

Findings suggested that team members were concerned about meeting service needs, and continually resolved their concern through the process of pluralistic dialoguing. Essentially, pluralistic dialoguing demonstrated how interdisciplinary team members changed their thinking by breaking stereotypical images, grappling with different mind-sets, negotiating service provision and engaging in a dialogical culture. Changing thinking also depended on several key variables that included competency, worldviews, information exchange, accountability, personality differences and leadership. In particular, personality differences had a significant effect on teamworking and it is this aspect that is analysed further in this study.

In the original research there was convincing discussion about personality differences and how individuals affected teamwork. While there was vigorous conversation about the disruptive and subversive attributes some individuals brought to teamworking it was also clear that personal idiosyncrasies were tolerated alongside troublesome behaviours. Nonetheless, personalities had an enormous impact on successful team functioning, or otherwise. Data suggested that much energy went into handling dysfunctional team members. These issues, highlight concerns about the emotional component underpinning teamworking.

This research on interdisciplinary teamwork emphasizes the cognitive aspects of teamwork, changing thinking. At the same time, psychomotor skills were fundamental to interdisciplinary work, as expertise and complementary skills were the basis of teamworking.

However, concentration on the cognitive and psychomotor domains of practice raises questions about the absence of emphasis on the affective domain of interdisciplinary practice, namely emotional intelligence. While professional competence was paramount in this study much less attention was given to emotional competence in the discussions of personality differences and interprofessional safety, suggesting that knowledge, skill and expertise were valued more highly than emotional intelligence. Team members focused more on tasks that made a team effective and were less likely to appreciate the importance of social factors influencing team process and outcomes.

Team diversity – individuality and personality differences

Team diversity is the basis for interdisciplinary practice. An interdisciplinary team is founded on the premise that different expertise and complementary skills, knowledge and disciplinary perspectives are required to deliver a specialist service for clients who have complex clinical and social problems. Team diversity assumes that if a team collects expertise, cohesive team practice will follow. However, expertise and diversity are interconnected. Diversity stems from individual difference that shapes expertise, which cannot be viewed in isolation. Expertise and cognitive function are intertwined, in turn impacting on the emotional component of teamworking. While individuals may be welcomed into a team because of their diversity and ability to carry out particular tasks, sometimes the overemphasis on expertise and skills is at the expense of interpersonal skills and personality differences that are just as important for effective team functioning (Katzenbach & Smith 1993). This is important for nurse managers selecting new team members. The key question, 'have we got the right fit?' needs to be asked. If the 'fit' is not right selection and appointment can be an expensive exercise.

Throughout this study there was substantial discussion about personality and individuality and its effect on teamwork. Discussion emphasized poor interpersonal skills, disruptive behaviours, sabotage and the use of power-coercive tactics, suggesting a low level of emotional intelligence. Team members described self-interested colleagues who were either engrossed in furthering their professional career, or were so taken up with personal problems that they lacked any awareness of their individual impact on team function. For example, the personality, who was an excellent clinician, preferably with an international reputation, was excused reasonable interactions with anyone on the

grounds that the team would cover all unfortunate lapses. Perhaps this illustrated well that although one high-IQ member is essential for a team that is not enough, particularly if that individual is socially inept and out of tune with the team feelings (Williams & Sternberg 1988).

Nonetheless, such behaviours stimulated subjective collegial responses and influenced team effectiveness. Diversity, conflicts and emotions were intertwined, supporting the notion that team members subjective experiences of diversity influence their cognitive appraisals of events and issues, and in turn, their experience of conflicts and emotions' (Garcia-Prieto *et al.* 2003, p. 420). Interestingly, while most participants accepted personality differences as a normal part of working with people, confrontation was carefully avoided, even though some personalities were apparently obstructive blocking any productive professional interactions.

On the one hand, team diversity was tolerated as an essential element of interdisciplinary practice yet, on the other hand, the emotions engendered by the wide-ranging differences were ignored altogether. Some people simply exited the team; others withdrew; a number denied the effects on team function and quality care; others became angry and anxious; and several attended counselling sessions. Job satisfaction certainly declined as professional practitioners were paralysed and unable to address problems at all. Whether conflict was task oriented or people oriented it had emotional and cognitive consequences for team effectiveness. Paradoxically, skilled practitioners, used to working with dysfunctional families, refused to recognize the emotional component of teamworking.

This is not surprising as some health professionals are educated to work therapeutically with clients but few are educated in the art of interprofessional relationships with colleagues. It is also possible that team members in this research were less comfortable supporting interdisciplinary colleagues. When this combined with reduced organizational resources and restructuring clinicians retreated into their own disciplines for encouragement, rather than discussing issues with the team. It may have been safer to express frustration, anxiety and anger in a familiar disciplinary group that communicated openly rather than reveal the emotions engendered working in a highly complex context that was subject to constant change. The notion that professional people will always respond objectively may be unreasonable when the pace of change is such that most people experience some sort of anxiety in interdisciplinary working relationships. In many respects,

emotional distancing acted as a safety valve in a potentially unsafe situation.

Interprofessional safety

Interprofessional safety assumed that because practitioners are professional people who are trained to work safely with patients, colleagues would work safely with each other. Yet, in this study, it was evident that new disciplinary alignments threatened psychosocial safety within teams. Alliances with other disciplines were unfamiliar, even risky, especially when some professions had a long history of authoritarian attitudes towards semi-professionals and allied health professionals, who were less used to seeing themselves as true partners in practice. Certainly, long-standing disciplinary dynamics, for example, between medicine and nursing, affected the emotional climate of practice and individual ability to work safely in the team. Although disciplines such as nursing have standards for professional safety with clients professional safety with colleagues is assumed making emotional safety across disciplines less well established. In this study, many participants, especially the nurses, were unaware, insensitive, or over-sensitive to safety issues as professional boundaries were blurring. Tensions though were subtle.

Many participants were clear that interprofessional safety was based on trusting interactions. Ironically, the intensity of interprofessional work in acute care meant clinicians had to form intimate, safe, trusting relationships, quickly, with strangers, clients. Yet, trusting colleagues was a very different matter. Initially, trust was based on competence that was confirmed once a team realized an individual had specialist knowledge and skill that was transferable into the team. Once clinical competence was confirmed colleagues listened carefully to each other and discussed client issues openly and honestly. Freedom of speech was evident, as colleagues felt safe and comfortable to challenge assumptions, and try out new ideas. Once professional competence was recognized an individual was more willing to take risks and when this happened, the team shared the understanding of risk by talking through issues and sharing in the problem solving.

Team effectiveness improved when colleagues were emotionally secure with each other. In these situations individuals offered and received input readily and candidly, putting personal defensiveness and value judgements aside in the interests of the client. Communication was direct and to the point. However, when the team scrutinized client management more vulnerable team members, possibly struggling to defend

professional competence and narrower ways of thinking, responded by becoming highly anxious and defensive. Despite the fact that perception of emotional safety was always individual, safety grew when the team accepted that no one person had all the answers and understood that all members had to change their thinking. Interprofessional safety developed better when individuals had the emotional intelligence to consider alternative points of view, and recognize the value of different disciplinary contributions that improved health outcomes for clients.

At the same time team leadership strongly affected interprofessional safety. Leaders set the tone of the team creating a secure, safe communication climate thus fostering the team spirit. Leaders encouraged colleagues to learn together by speaking up, raising ideas, questions and concerns (Edmondson 1996). This was especially important in these types of teams where traditional power differences inherent in the historical role of medicine increased risk. Edmondson (2003) argues 'the interpersonally safe route is to remain silent, but this poses technical risk if the context calls for learning. Not speaking up can protect individuals but harm the team' (p. 1422). Equally, Boyle *et al.* (1999) observe leaders that seek and value contributions from colleagues foster a healthy communication climate, which supports information sharing, decision-making and the expression of emotional intelligence. Team effectiveness was enhanced when colleagues felt safe to share power and control in problem solving and decision-making.

Discussion

It is clear so far that in interdisciplinary teams technical expertise and cognitive intelligence are not enough. Team members also need emotional intelligence to work effectively with colleagues as well as clients and families. Ideally, interdisciplinary teamworking in a rapidly changing, complex environment relies on broad synergistic relationships to integrate technical and interpersonal skills, which make client care possible (Baumann *et al.* 1998). In reality, it is apparent that the emotional aspects of interdisciplinary work, team diversity and interprofessional safety compromise team effectiveness suggesting that the intangible dimensions of practice may be isolated from the well-established emphasis on knowledge and expertise. When diversity is defined narrowly in terms of clinical expertise its impact on teamworking is less well understood as team effectiveness depends on how diversity impacts team processes and team management (Knight *et al.* 1999).

One possible explanation for the separation of the cognitive, psychomotor and emotional factors affecting the research results might lie with the research methodology. In symbolic interactionism that underpins grounded theory, the place of human emotions and social structure and their impact on social interactions and behaviour is not fully appreciated (Meltzer *et al.* 1975, Fine 1993). It could be that the constant comparative method influenced questioning so that the broader dimensions of interdisciplinary teamwork, namely emotional intelligence, was given less attention.

Another clue to the explanations may lie with the context of care that was dominated by health restructuring and change that may have increased individual anxiety and team conflict. If change is disruptive previously competent professionals may find themselves in situations in which they must practice differently. Too often, control that has previously underpinned professional practice is replaced by a lack of control and a sense of not knowing what you are doing at all. Gould (1993) suggests that individual tolerance for complexity, uncertainty and ambiguity will influence anxiety and emotional states.

It is hardly surprising that professional people who were educated in models of practice where there was one best way of doing things, feel uncertain, insecure and nervous of stepping into a new reality where everyone must learn to not only live with, but also integrate different points of view into working relationships. This requires an emotionally intelligent workforce so that various possibilities can be integrated with new approaches to practice.

Implications for nursing

Today many nurses work in interdisciplinary teams. Nurses are uniquely situated there and many will contribute significantly to team practice as practice leaders (McCallin 2003). Nurses are especially good at recognizing the emotional component of communication, having conversations with others and understanding that any informal exchange has the potential to change relationships and thinking. Nurses are well placed to manage many disciplines, coordinate client care, and to coach and mentor colleagues about emotional intelligence and its impact on team effectiveness, quality care and job satisfaction. Kerfoot (2002) observes that it is through our conversations and dialogue that people can explore differences and appreciate connections thereby discovering a shared commonality. It is in this process of 'becoming' that nurses gain attitudes, beliefs, knowledge and skills through both occupational and

educational experiences. Many nurses will be competent people managers, who can guide and coach colleagues further developing technical, social and clinical skills in the interests of the client, the team and the organization.

Conclusion

The interdisciplinary ideal continues to challenge health professionals. Today's health care environment requires leaders who are socially competent and engage in building teams that are individually and collectively responsible and accountable for their actions. It is about balancing a climate of teamwork and trust in the midst of complexity and uncertainty. Too often effective teams evolve because individual personalities gel at a certain point in time, not because team action makes attitude or behavioural change possible. While leaders set the tone for team effectiveness the team is also responsible for healthy interactions and may therefore need to look more closely at how individuals understand and manage emotional intelligence that impacts on social and team effectiveness and the outcomes of care. Self-awareness, self-management, social awareness and social skill are central to emotional intelligence that is the heart of effective teamwork.

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