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The rationale for using teams to care for geriatric patients is that teams integrate the efforts of the diverse professionals required to meet the complex needs of the elderly. Having professionals meet and exchange observations and information and coordinate plans of action, it is argued, results in better decisions and more efficient treatment and care than would be possible if each professional worked alone. Our previous research has led us to propose that the team approach does not always result in better quality care and decision making (Feiger & Schmitt, 1979; Farrell, Heinemann & Schmitt, 1986; Schmitt, Farrell & Heinemann, 1988). Teams may experience "process loss" rather than "process gain" (Hackman & Morris, 1983); that is, rather than synergistically enhancing performance, group processes, sometimes, can reduce the quality of judgements and the efficiency of team members compared to when each works alone.

The "groupthink syndrome" (Janis, 1982) is one type of group process that leads to mistakes in judgment and decision making. The following scenario illustrates a case in which groupthink may have occurred:

Mr. S was a 66 year old man with a severe form of arthritis of the spine which progressed to the point that it severed his spinal cord and resulted in paralysis from the neck down. After a stay in the hospital, he was discharged to his home to be cared for by his 57 year old wife and a hospital based home care team. In early discussions with Mrs. S, the physician on the team reiterated what she had been told in the hospital—that her husband was terminal and would need complete care for only a short time. In the meantime, he would be totally dependent upon her.
The team members (i.e., physician, nurses, social worker, dietitian and rehabilitation therapist) educated Mrs. S about her husband’s condition and taught her the skills and procedures necessary to maintain him at home. She learned quickly and rebuilt her life around his needs; however, after a year and a half of providing for him with no end in sight, she became distraught, and her feelings began to alternate between depression and rage. She told team members that she felt overwhelmed by the endless demands and asked them about the possibility of placing her husband in a nursing home. Fearful of being institutionalized, Mr. S refused to discuss the matter with her or the team.

Team members chose to ignore Mrs. S's pleas because they saw their mission as one of meeting the patient's needs and keeping him out of an institutional setting as long as possible. Mrs. S's frustrations and exhaustion continued to get worse. Gradually her relationship with Mr. S deteriorated to the point of shouting matches. Finally, she informed team members that she was leaving him.

In this case, the team continued on a course of action despite repeated feedback that the caregiver was overburdened and needed a respite from the heavy demands placed upon her. Team members ignored or discounted her concerns, and even when the couple's relationship deteriorated to the point where she was threatening to abandon him, the team did not respond. They justified their decisions and course of action by referring to their mission.

The purpose of this paper is to evaluate the relevance of groupthink theory to the functioning of interdisciplinary health care teams in situations similar to the one described above. The paper is organized in four parts: (1) a review of the theory of groupthink as proposed by Janis (1972 & 1982); (2) a review of research findings from studies in which facets of the theory have been tested; (3) a presentation of modifications to expand the theory; and (4) a discussion of the implications of the expanded theory for health care teams.

GROUPTHINK THEORY

Based on his analysis of case studies of decision making by political groups in the federal government (e.g., the evolution of the Marshall Plan under Truman, the Bay of Pigs invasion of Cuba under Kennedy, the Watergate break-in, and cover-up during
Nixon's administration), Janis (1972, 1982) proposed a theory about how highly competent members of a group might engage in information gathering and decision making in such a manner as to result in decision "fiascos"—disadvantageous courses of action that are continued even after the risks of disaster have become apparent to many members of the group. He defined groupthink as "a mode of thinking that people engage in when they are deeply involved in a cohesive in-group, when the members' strivings for unanimity override their motivation to realistically appraise alternative courses of action." (Janis, 1972, p. 9).

In response to criticism of his theory (Longley and Pruitt, 1980), Janis (1982) reconceptualized groupthink as "premature concurrence seeking" in which members of a group suppress disagreements and commit themselves to a course of action without adequately considering all relevant information, alternative courses of action or risks of failure if the current course of action is taken. In this state, members withhold information or doubts about a course of action not because of fear of retaliation in a hostile climate, but because of a reluctance to disrupt the illusion of harmony in the group.

**Symptoms of Groupthink**

Premature concurrence seeking is accompanied by a set of eight symptoms according to Janis. These include:

1. an illusion of invulnerability or an overinflated view of the competence of group members and the leader;
2. a belief in the moral rightness or ethical superiority of the group members compared to anyone who might challenge their course of action;
3. post hoc selection of facts and arguments that rationalize a course of action already chosen;
4. disparaging stereotypes of any opposing persons or agencies;
5. self-censorship by group members such that doubts are not publicly shared;
6. an illusion of unanimity;
7. attacks on dissenters and demands for conformity; and
8. "mind guards" or members who keep from the group expert information that might call into question their course of action.
Group cohesiveness is maintained at the expense of a decline in effective intake and sharing of relevant information, a decline in efficient reasoning and moral judgement and ultimately, a decline in the quality of decision making. As Janis stated:

"Concurrence seeking and the various symptoms of groupthink to which it gives rise might be best understood as a mutual effort among the members of a group to maintain emotional equanimity in the face of external and internal sources of stress arising when they share responsibility for making vital decisions that pose threats of failure, social disapproval and self-disapproval. The eight symptoms of groupthink form a coherent pattern if viewed in the context of this explanatory hypothesis." (Janis, 1982, p. 256.)

Conditions Leading to Groupthink

Janis proposed that groupthink is more likely to occur in decision making groups with certain properties. The first of these is high cohesion such that members feel honored to be part of the group and are reluctant to burst the sense of like-mindedness and good feeling among members. It seems counterintuitive to argue that a group could be overly cohesive; yet, Olson, McCubbin and associates (1983) have suggested that this same property is detrimental to family functioning as well. According to family systems theory, highly cohesive families are believed to undermine individuation in members; in groupthink theory, Janis proposed that highly cohesive task groups undermine information sharing as well as the expression of disagreements and doubts about decisions.

A second set of conditions predisposing to groupthink is comprised of structural properties of groups: (1) the insulation of the group from experts, critics or information that might challenge group members' thinking or course of action; (2) a directive leader with a preferred course of action; (3) the lack of norms for methodically processing information in preparation for decision making; and (4) homogeneity of members' social backgrounds and ideologies.

Finally, a third set of conditions predisposing to groupthink includes situational properties--(1) high stress in the group due to pressures for action because of perceived emergency or demands of authorities and (2) low self-esteem among group members due to recent failures, overwhelming task demands or an unresolvable moral dilemma.

According to Janis' theory, these conditions lead to the symptoms of faulty decision making presented in the previous
section of this paper. Members selectively process information and fail to carry out a complete survey of their objectives as well as the alternative courses of action to reach the objectives. Once a course of action is chosen, they fail to seek out information that might lead them to reconsider, and they are uncritical about the risks of failure. Finally, they fail to reappraise the rejected alternative courses of action and have no contingency plans should their course of action fail. These faulty decision making processes lead to risky decisions with low probability of success.

Tests of Groupthink Theory

Since Janis' initial formulation of the theory, there have been relatively few attempts to test hypotheses about the conditions under which groupthink occurs. The paucity of research is due to the complexity and ambiguity of the theory, which make it difficult to operationalize the full array of variables in a single study. The dependent variable, the groupthink syndrome, has been measured in several ways. To measure information sharing, some researchers have distributed unique facts to each group member and observed how frequently the facts emerged compared to how frequently they were withheld during discussions. As an indicator of suppression of doubts, other researchers have compared groups on their rates of expressed disagreement. Finally, researchers have had experts rate the quality of groups' decisions in order to discern faulty decision making. Antecedent variables examined in research include level of cohesion, directive versus open leadership and presence versus absence of decision making procedures.

Four studies are presented and discussed in this section. They are Flower (1977), Courtright (1978), Callaway and Esser (1984), and Leana (1985). Flowers (1977) compared groups in which leader and members were strangers (low cohesion) and groups in which leader and members were acquaintances (high cohesion). Group leaders were instructed to be either directive or open. Directive leaders stated their preferences early and discouraged participation of members. Open leaders were impartial and encouraged members' participation. Within each group, members were asked to role play a school superintendent, a principal, a counselor and a school board member. Twenty-seven facts were distributed among the members; one indication of groupthink was how little members shared the facts they were given. Flowers also examined the number of facts that surfaced before and after the decision. Facts that emerged afterward were assumed to rationalize a decision already made.
Contrary to Janis' theory, Flowers found that the degree of cohesiveness in the groups had no effect on indicators of groupthink; in support of Janis, she found that when the leader was open, a greater number of solutions were proposed, a greater number of facts emerged before the final solution and a smaller percent of the group perceived the leader as the most influential group member. In summary, Flowers' two main findings were: (1) cohesion is unrelated to groupthink and (2) highly directive, authoritarian leadership is likely to generate groupthink processes.

Courtright (1978) varied the degree of cohesion and the directiveness of the leaders in groups. His manipulation of cohesion was weak in comparison to Flowers' in that he simply varied whether a group had time to warm up before carrying out the task and whether members believed they had similar values. Content analyzing interactions, he found that in the high cohesion and directive leader condition, members disagreed less; however, when he counted the number of solutions proposed, the number of statements negatively criticizing or praising the final solution and had experts evaluate the quality of solutions, he found little overall support for groupthink theory.

Callaway and Esser (1984) varied cohesiveness and the degree to which members adhered to decision making procedures which Janis suggested reduce groupthink. Cohesion was varied by deceptively informing certain subjects that they were matched into congenial groups on the basis of completed personality tests. When this measure of cohesion had no effect on groupthink, the researchers reexamined their data and rank ordered the groups on cohesiveness based on the amount of disagreement observed in the groups and how congenial members perceived their groups to be. In the procedure's present condition, members were instructed to: (1) consider fully all alternatives; (2) encourage constructive criticism as well as differences of opinion; and (3) make decisions by consensus rather than majority rule. The groups were assigned two problems—The Horse Trading Problem, in which they calculated a horsetrader's profits in a series of transactions, and The Lost at Sea Problem, in which they rank ordered fifteen items in terms of their usefulness to survivors of a shipwreck. In the latter problem, rank orderings by group members were compared to those of experts.

Findings from the first problem showed decision making to be unrelated to either degree of cohesion or the presence/absence of decision making procedures in the groups. With regard to the second problem, findings revealed that, overall, groups with a medium degree of cohesion had the best solutions to the problem or made the best decisions, and the highly cohesive groups with no decision making procedures had the worst solutions. This
latter finding was not significant, but approached significance, $p = .08$. Thus, when rules for decision making were present in a group, the members were more likely to disagree and deliberate longer and make better decisions (i.e., groupthink was reduced). These findings lend some support to groupthink theory; however, the post hoc manipulation of cohesion raises doubts about the findings until more replications are reported.

In Leana's (1985) test of the theory, she varied cohesion by having two sets of groups, one consisting of strangers (low cohesion) and one consisting of persons who had worked together on assignments for 15 weeks (high cohesion). In the high cohesion condition, the leaders were chosen by group members; in the low cohesion condition, they were selected randomly. For half the groups in each condition, leaders were instructed to be impartial to suggestions and encourage open discussion; in the other half, they were instructed to be directive and to state their positions early in the discussion. The groups role played company executives faced with cutbacks in operations. Members had to rank six employees in the order they should be layed off. Each group member received four pieces of information not available to other members.

Once again and contrary to Janis' theory, more of the hidden bits of information surfaced in the high cohesion than in the low cohesion groups; however, cohesion did not affect the number of solutions proposed or have a systematic effect on the actual decisions made. The leaders' behaviors did have strong effects on the interactions in the groups. When the directive leaders stated their preferences early, most group members accepted these preferences as final decisions. Yet, post session questionnaire results indicated that members tended to "go along" with directive leaders even though they did not agree with them.

In summary, research findings both support and refute facets of Janis' groupthink theory. Contrary to the theory, high cohesion did not lead to groupthink, but was either unrelated (Flowers, 1977; Courtright, 1978; Callaway & Esser, 1984) or inversely related (Leana, 1985) to it. Members of cohesive groups were less likely than members of noncohesive groups to engage in self-censorship of privately held information. In support of the theory, findings consistently demonstrated that directive leadership increases the changes of groupthink. In groups where leaders stated their preferences early, discouraged disagreements and dominated the interactions, members withheld information, suppressed doubts and disagreements and arrived at premature concurrence. Additionally, findings emphasized the importance of methodical procedures for decision making to allow for more openness and disagreement in groups.
Modifications/Expansion of Groupthink Theory

In part, because so little research has been conducted to test this theory, a number of criticisms have been leveled at it. These include an inadequate definition of groupthink, a negative bias related to groupthink (i.e., the assumption that early concurrence always results in poor decisions) that ignores the type of issue under consideration by a group, and the lack of a logical relationship among the theoretical processes and their causal sequences (Longley and Pruitt, 1980). Janis attempted to address most of these criticisms in several restatements of his theory (Janis & Mann, 1977; Janis, 1982).

Framing and Group Polarization Theories

Whyte (1989) noted that the theory does not explain adequately why groups tend to make excessively risky decisions or reach consensus around a particular decision choice. He suggested that groupthink theory incorporate research that has demonstrated how group processes can distort judgment in groups. In an attempt to build a more comprehensive theory that includes an explanation for risky group decision making, Whyte (1989) utilized framing and prospect theories and findings from group polarization research.

Drawings on framing theory, Whyte argued that the framing of a decision may be a factor that influences the degree of risk individuals and groups will take in making decisions. (For original accounts of the development and application of framing theory see Tversky & Kahneman, 1981; Eraker & Sox, 1981; Fiegenbaum & Thomas, 1988.) Framing refers to the perceived context in which a decision is made. If a group sees itself as fighting a losing battle, it will be more risky than if it sees itself in a winning situation. That is, given a decision choice between a small loss now or a risky course of action that could result in either a greater loss or recovery of some of the small losses, the group fighting a losing battle will more likely make the risky choice. If a group sees itself as gaining ground or in a winning situation and is given the option of making a risky choice that should gain even more ground, it is likely to reject the risky choice.

Knowledge of initial preferences is necessary if group polarization is to be integrated into the theory. Group polarization is the tendency for decisions based upon group discussion "to magnify the dominant initial inclinations of group members" (Whyte, 1989, p. 41). Findings from group polarization research have demonstrated that group decisions, compared to decisions made alone or prior to group discussion, tend toward the extremes of risk or caution. That is, group discussion tends
to polarize decisions such that individuals move toward the more extreme positions. Evidence has suggested that this effect is due to both social comparison processes and persuasive information. Thus, when individual members of a group are disposed to risk prior to discussion (i.e., the decision choice has been framed as one between losses or the group sees itself as fighting a losing battle), the decision of the group will be even riskier than that of the average group member.

Group Development Theory

In their critique of groupthink theory, Longley and Pruitt (1980) suggested that there are different types of cohesion present at different stages of a group's development. They argued that premature concurrence is likely to occur in the early stages of group development when members are insecure and uncertain about their roles and status. During this time, members experience a "false cohesiveness" because they suppress and avoid disagreement with the leader and with one another. Kennedy's advisors during the Bay of Pigs fiasco, when a newly formed group gathered around an idealized leader, is an example of a group in the early stages of development and prone to "false cohesiveness". Under these circumstances, members exhibit concurrence seeking and prematurely commit themselves to a course of action suggested by the leader. In contrast, members of groups in later stages of development feel enough security to challenge and disagree with one another, consider multiple sources of information and courses of action and arrive at consensus through open, straightforward discussion.

In our previous research (Farrell, Heinemann & Schmitt, 1986), we expanded group development theory and applied it to health care teams. We argued that the quality of functioning in health care teams is affected by the stage of the team's development. In the first stage, Dependence and Orientation, members are directed and influenced by one leader. The other team members are less active and abdicate responsibility for group actions and decisions because they are insecure and uncertain about what is expected of them. At this stage, the team is characterized by what Longley and Pruitt refer to as "false cohesion", and tendencies toward premature concurrence seeking are high. In stage two, Conflict, the team becomes polarized around those who support and those who feel oppressed by the existing structure. A number of informal roles emerge (e.g., Clown, Hatchetman, Scapegoat, Caring Ear, etc.) to absorb and channel the rising tensions in the team. Subgroups become preoccupied with scoring points against one another, which undermines open communication and careful task-oriented deliberation. As a result, cohesion is lowest at this stage, and the animosity between subgroups predisposes the team to faulty
decision making. In the third stage, Cohesion and Consensus, the group forms a Coalition of Colleagues such that members come to respect, trust and value one another's skills and abilities and work together to clarify expectations, establish a more rational division of labor and establish group norms for decision making. Cohesion is moderate to high in this stage, and groupthink becomes less problematic. In stage four, Functional Role Relatedness, the Coalition of Colleagues goes through repeated cycles of work and reintegration as work is allocated on the basis of members' expertise. Cohesion and quality of decisions are highest at this point in the team's development.

Leanna's (1985) previously discussed study, in which she observed groups that had worked together for 15 weeks and compared them to groups of strangers, also suggests the importance of group development theory in understanding groupthink. She found that the more developed groups (i.e., those whose members had worked together for a longer period of time) were also more cohesive, had more democratic leadership and had fewer groupthink tendencies.

Implications for Health Care Teams

While groupthink theory has been used to explain faulty group decision making in government and industry, implications of the theory have not been applied to health care teams. Yet the variables Janis identified certainly are pertinent to these teams. In our observations of and research on health care teams, we have documented teams with varying: (1) levels of cohesiveness among members; (2) numbers of leaders and styles of leadership in the team; (3) degrees of formalizing and documenting procedures for operating; and (4) degrees of insulation from other teams and health professionals in the work environment. Additionally, health professionals are often assigned to teams by supervisors in a haphazard, random fashion such that the sociodemographic composition of any given team varies from homogeneous to heterogenous. Finally, given that the team approach is most appropriate for patients with multiple, chronic and/or complex health needs and problems and that proper staffing is often problematic in health care settings, teams certainly qualify, at some time or other, as decision making groups that "experience external and internal sources of stress as members share responsibility for making vital decisions that pose threats of failure, social disapproval and self-disapproval" (Janis, 1982, p. 256).

Returning to the scenario presented in the introduction of this paper, we can identify some of the antecedent conditions of an expanded groupthink theory that might have predisposed the team to poor decision making. At the time that Mr. S was being
managed by the team, it was functioning in stage one or early stage two of development (i.e., between the Dependence and Orientation Stage and the Conflict Stage). The team had two very directive leaders—an extremely competent Wonder Woman and an authoritarian with high external professional status. Most of the other team members did not participate actively in the team's deliberations or decision making.

Team meetings were characterized by discussions between the two leaders with others listening or making only occasional comments that were directed to one or both leaders. Serious disagreements were rarely discussed in team meetings, but seemed to be "argued out" by the two leaders outside of meetings. This type of meeting structure permitted self-censorship of members' doubts and mind guarding by the leaders. Furthermore, it set the stage for a false sense of cohesion, suppression of disagreement and an illusion of unanimity among members. The stage of the team's development and its meeting structure also indicate that the team had not developed any formal procedures for group decision making.

While team members were reasonably heterogeneous with regard to background (i.e., professional status ranged from physician to licensed practical nurse, a range of social classes and minority status as well as both genders were represented on the team), the team was not able to capitalize on this diversity, possibly due to the similarity in background and ideology of the two leaders.

Team members perceived the team as "well functioning" at this time (possibly as a result of false cohesion), and they had refused to participate in a team building educational program because they felt they did not need it. This illusion of invulnerability was maintained and encouraged in the team by the energy, enthusiasm and skill of the leader in the Wonder Woman role. As stated earlier, team members did feel that their mission provided a moral rationale for their inaction. The mission assuaged their doubts and justified limiting their attention to the patient's needs and viewing placement in a nursing home as a failure of the team.

Team members tended to stereotype negatively other professionals outside the team, other departments and programs within the hospital and especially the nursing homes in the area. Some of this negative stereotyping could have been related to the team's insulated location within the hospital. Team members' offices were in close geographic proximity to one another and relatively isolated from other hospital activities. The fact that team members spent much of their time making home visits to patients increased insulation. This insulation also reinforced team members' low self-esteem because it limited the amount of positive feedback the team received from others in the hospital.
Finally, because Mr. S was a patient with very complex health problems and needs and a poor prognosis, it was easy for the leaders to frame decision choices about his treatment and care as choices between losses. The two directive leaders stated their preference for continued home care forcefully and early in team meetings, and the team, ultimately, gambled that Mrs. S's health would not deteriorate as a result of continued full-time caregiving, that she would not actually carry out her threat to leave her husband if he continued to remain at home in her care and that Mr. S would not require repeated hospitalizations that would be financially burdensome to this medical center.

The presence of these antecedent conditions inhibited the team's ability to consider other alternatives (e.g., a paid caregiver for Mr. S during the day, short-term respite for Mrs. S provided by other family members, etc.) or to view nursing home placement as a positive outcome (i.e., Mrs. S might have been able to reestablish a meaningful, satisfying relationship with her husband if she was not so overburdened by his care and could have more time for herself and her own needs).

Given that health care teams do not have the power to overcome all of the conditions predisposing them to groupthink (i.e., members may have little input into selecting new team members or determining the location of their offices within a large hospital), what precautions can teams take to minimize poor decision making? The following guidelines are suggested along with the type of condition predisposing to groupthink (in parentheses) each should prevent or minimize.

1. Scheduling informal social activities for team members where they can get to know one another better both personally and professionally and begin to identify shared interests in order to facilitate true cohesiveness within the team (level of cohesion/low or false cohesion);

2. Participating in educational programs on team development that (a) facilitate team development to stages three and four where groupthink becomes less problematic and (b) teach team members about the conditions predisposing to poor decision making and how to identify them in their own teams (level of cohesion/low or false cohesion, situational properties/low self-esteem, negative effects of framing and group polarization).
3. decentralizing leadership by identifying various types of leadership necessary to the team's functioning and practicing different leadership roles in the team (structural properties/directive leadership);

4. establishing mechanisms for referring patients to the team and for linkages with relevant consultants, service units outside the team and hospital supervisors and administrators to reduce insulation (structural properties/insulation);

5. capitalizing on diversity in the team by sharing in group discussions the discipline-specific skills and abilities as well as personal and professional values systems of team members (structural properties/homogeneity);

6. scheduling regular administrative meetings, especially for teams in the early stages of development, where team members formulate in writing a mission statement, goals and procedures for operating and for orienting new team members (structural properties/lack of norms and procedures);

7. scheduling regular administrative meetings, especially for teams in later stages of development, that include reviewing and/or updating: (a) mission statement, norms and procedures; (b) discharge planning and the ratio of patients served to team members; (c) linkages within the hospital; (d) group process and team functioning; and (e) quality assurance and outcomes of team care (structural properties/insulation, lack of norms and procedures, situational properties/high stress and low self-esteem);

8. role playing decision making scenarios (e.g., selecting a restaurant for dinner that is acceptable to all team members) in which team members practice brainstorming to identify options, prioritizing the options and coming to consensus on a final decision (structural properties/lack of norms and procedures, negative effects of framing and group polarization); and

9. formalizing and rotating the role of devil's advocate among team members during discussions to develop alternative plans of action in case a particular decision
proves to be inappropriate or too risky (structural properties/lack of norms and procedures, negative effects of framing and group polarization).

While these guidelines are not meant to be exhaustive, we believe they can be useful to teams that want to reduce the chances of groupthink and overly risky decision making.
References


