

Effective Health Care Teams: A model of six characteristics developed from shared perceptions

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Abstract

This study into understanding health care teams began with listening to participants' teamwork experiences. It unfolded through a dialectic of iterations, analyses and critique towards a simplified model comprising six key characteristics of effective teams. Using the complementary theoretical perspectives of personal construct theory and inductive theory building, three research methods were used to collect a range of participant perspectives. A purposive sample of 39 strategic informants participated in repertory grid interviews and clarification questionnaires. A further 202 health care practitioners completed a purpose designed Teamwork in Healthcare Inventory. All responses were transformed through three iterations of interactive data collection, analysis, reflection and interpretation. Unstructured participant perspectives were qualitatively categorised and analysed into hierarchies to determine comparative contributions to effective teamwork. Complex inter-relationships between conceptual categories were investigated to identify four interdependent emerging themes. Finally, a dynamic model of teamwork in health care organisations emerged that has functional utility for health care practitioners. This Healthy Teams Model can be utilised in conjunction with a Reflective Analysis and Team Building Guide to facilitate team members to critically evaluate and enhance their team functioning.

Keywords: *teamwork, personal construct theory, health care teams, team building, inductive theory building, team evaluation*

Introduction

The use of health care teams, to achieve quality and efficient patient care, has become widespread. With the increasing costs and technological complexity of providing health care, and the resultant growth in specialisation of professionals, there is a need to co-ordinate scarce human and financial resources to maximise patient outcomes. As a consequence, there is an extensive literature defining and describing effective teamwork. The evolution of research into teamwork has moved from a broad socio-technical focus on optimising task and social goals during the 1940s and 1950s towards social psychology laboratory studies during the 1960s and 1970s, which examined the processes and impact of team interactions (Cummings, 1978). Since then, team research has become more interdisciplinary and pragmatic, and qualitative methodologies have been used to evaluate team performance.

Teams are often symbolised as complex open systems, which utilise resources, communicate within themselves and produce outcomes. Consensus generally exists about the descriptive taxonomies of characteristics of effective teams in the form of input conditions and preferred team processes (Mickan & Rodger, 2000a). Although team effectiveness has been strongly linked to productive team outcomes, there is increasing recognition of the need for team cohesion and individual viability (Hackman, 1987; Shea & Guzzo, 1987; Sundstrom, De Meuse, & Futrell, 1990). However, there remains a lack of robust predictors of effective teams and a growing demand for applied research to guide management practice (Guzzo, 1996).

Commonly, teams are defined as a small number of members with the appropriate mix of expertise to complete a specific task, who are committed to a meaningful purpose and have achievable performance goals for which they are held collectively responsible (Mickan & Rodger, 2000a). In order for teams to be effective, external structures and individual team members need to be aligned with internal structures and processes.

In general, internal aspects of teamwork are described in terms of agreed objectives and monitoring systems, shared and agreed responsibilities, defined roles and boundaries, pooled resources and shared learning opportunities. Specific team task behaviours often include co-ordination, organisation, decision making and problem solving skills. Processes of leadership and communication are often described in terms of the need for conflict resolution, cohesion and interdependence. These competencies are crucial in ensuring all team members contribute to the team effort, and trust and value their colleagues (Cashman, Reidy, Cody, & Lemay, 2004; Molyneux, 2001; Pethybridge, 2004).

Team members are required to be socially competent and willing to share information, negotiate decisions and solve problems. To communicate well and build up a sense of commitment, individuals need a certain level of self-knowledge and confidence in their own professional role and skills. Conversely, individuals also demand appropriate levels of respect, recognition and encouragement while working in teams (Molyneux, 2001; Thylefors, Persson, & Hellstrom, 2005).

However, as with any system, there are inevitable tensions between individuals, other team members and their organisation. The institutions in which teams exist need suitable and supportive organisational structures and rewards systems. There needs to be flexible, respectful and responsive workforce development opportunities if teams are to maintain their effectiveness (Cashman et al., 2004). To better define effectiveness, constructs of team efficiency and climate have been investigated. In a study of 30 Swedish health care teams, high levels of team efficiency were related to a supportive atmosphere, well-distributed activity amongst team members and encouragement for individual performance. Similarly, a good team climate was linked to having a common goal, satisfaction with team achievements, and having an adequate composition (Thylefors et al., 2005).

In addition to the many 'common sense' recommendations, there are an almost equal number of obstacles to effective teamwork. At the organisational level, the Audit Commission (1992) highlighted barriers of separate lines of control, different payment systems, diverse objectives, professional barriers and perceived inequalities in status. In relation to team processes, teams often take longer to make decisions, and are vulnerable to abuses of personal power, competition and social conformity. The many professional disciplines who work in health care differ in their education, status, language and theoretical orientations to teamwork. As a consequence, ignorance, competition and jealousy often reinforce inaccurate professional stereotypes, which ultimately limit effective teamwork, if left unchecked (Mickan & Rodger, 2000b).

Team members, patients and stakeholders often judge and prioritise team outcomes differently, such that effectiveness is both an empirical and political concept. These different

perspectives challenge research design. While systematic reviews often highlight inconsistent terminology and operational definitions, confounding variables plague longitudinal and interventional studies. Therefore, indicators of team effectiveness are often presented in terms of organisational, team and individual benefits. Using a constituency approach to evaluation, organisational benefits of teamwork have been described as reduced hospitalisation time and costs, fewer unanticipated admissions, better patient accessibility and improved co-ordination of care. Team level benefits have included efficient utilisation of services, enhanced communication and maximal diversity of professional expertise. Patients have reported enhanced satisfaction, awareness of treatment and improved health outcomes. Finally, team members report enhanced job satisfaction, greater role clarity and enhanced well-being (Mickan, 2005).

Rationale for study

Given the comparative scarcity of validated predictors for effective health care teams, this study adopted an alternative viewpoint from the predominantly positivist literature. A constructivist approach was chosen to encourage participants to value and reflect on their subjective perspectives and practical experiences of teamwork.

The first aim of this study was to gain a deeper understanding of what constitutes effective teamwork, from the perspectives of health care practitioners. This exploration was conducted without pre-supposed definitions of teamwork or measures of team effectiveness. A second aim was to progressively build a theoretical model from this collective understanding of teamwork, which had utility in health care organisations.

Conceptual framework

At a broad epistemological level, constructivist philosophy emphasises that individuals construe meaning from engagement in their individual and social worlds through both shared perceptions and multiple individual realities (Crotty, 1998). Personal construct theory was adopted to understand individuals' attitudes, beliefs and behaviours through their own cognitive frameworks for anticipating and interpreting situations (Wilson & Retsas, 1997). These frameworks are composed of hierarchies of bipolar constructs, which describe both similarities and differences. As individuals play roles in social processes, shared constructs develop from these experiences (Shaw, 1994). Inductive theory building was chosen to collect and organise both individual meanings and shared experiences (Crotty, 1998). Multiple iterations of reflection and analysis systematically refined the shared meanings of teamwork across participants' perceptions. Three research methods were adopted, within a mixed methodology, where quantitative analyses informed the qualitative process of inductive theory building (Morgan, 1998). This provided triangulation of data collection and analysis.

Methodology

This study comprised two stages.

Stage 1 participants

A purposive sample of 39 health care managers from a group of corporately managed metropolitan hospitals was identified for the first stage of this project. The Director of

Education identified 21 managers who had a leadership commitment to promoting teamwork. These strategic informants were identified as individuals with highly valued knowledge and experience (Smith, 1975). They were then asked to recommend colleagues with similar experience and abilities in promoting teamwork, (known as snowball sampling), to identify a further 18 participants (Portney & Watkins, 1993; Smith, 1975).

Participants included 15 doctors, 10 nurses, 7 administrators and 7 allied health professionals. They worked across primary teams designated as management, executive, clinical and research. All participants contributed from extensive personal teamwork experiences, with 18 participants (46%) having worked in more than 50 teams.

Stage 1 instruments

A structured repertory grid was designed to facilitate a deep understanding of individual perspectives and to enable consistent comparisons across participants (Shaw, 1994). It was presented to all 39 participants in a structured interview where, initially, they were asked to identify seven personal teamwork experiences, according to a structured template. Participants were then facilitated to describe similarities across two positive experiences and differentiate these from a third negative team experience, until they generated approximately 12 different bipolar constructs. They were instructed to rate all seven teamwork experiences against each bipolar construct and a given construct of effective / ineffective, using a five-point scale. Participants reviewed each emergent construct for its comparative importance to effective teamwork and they finally provided a written summary of their own perceptions of teamwork.

Following the administration and initial analysis of all 39 repertory grid interviews, a clarification questionnaire was designed to confirm individual perspectives. All 39 participants were asked to identify the comparative importance of 30 conceptual characteristics of effective teamwork and to verify four descriptive themes. Twenty-seven of the original 39 participants (69%) who participated in the structured repertory grid interview completed and returned this questionnaire.

Stage 2 respondents

To validate the emerging model with a greater number of people, maximum variety sampling was used to recruit a heterogeneous group of 202 health care professionals from the same group of hospitals (Morse, 1998). These 202 individuals were a similarly diverse group of health care professionals with varied professional backgrounds, ages and length of service. Most participants (76%) carried a clinical caseload.

Stage 2 instruments

A Teamwork in Health care Inventory (Mickan, 2002) was developed to ascertain a level of fit, credibility and relevance of the emergent theory to a broader group of health care practitioners. After categorising, analysing and interpreting results from the previous three research methods, 27 characteristics of effective teamwork were represented using both positively and negatively worded statements. The Teamwork in Healthcare Inventory was appended to a regular fortnightly newsletter to clinical and service staff, and it was attached to a group email to all heads of departments.

Results

An interpretive framework of three iterations (Table I) clarifies the transformative process of inductive theory building, through different levels of data analysis, reflection and interpretation using components of the three research methods.

Iteration 1: Qualitative categorisation

This iteration focused on qualitative content analysis of participants' repertory grid interviews. Individuals' bipolar constructs and higher-order qualitative summaries were coded to reflect separate units of meaning. The computer analysis package NUD*IST (Richards & Richards, 1998) was utilised to categorise, through constant comparison, the content of all repertory grid interviews into 30 conceptual categories, across four higher-level themes. These categories captured participants' shared understandings of teamwork, by summarising their elicited bipolar constructs and higher-order summaries (see Table II).

Iteration 2: Hierarchy of comparative contribution to effective teamwork

A hierarchy of comparative contribution to effective teamwork was developed, independently of the four themes described in the first iteration. Conceptual categories identified by participants most frequently were considered to be the most important discriminators of

Table I. Interpretive framework.

Iteration	Description	Component research method
1	Qualitative categorisation	Repertory grid interviews
2	Hierarchy of comparative contribution to effective teamwork	Repertory grid interviews Clarification questionnaire Teamwork in Healthcare Inventory
3	Emergence of common themes across conceptual categories	Clarification questionnaire

Table II. Summary of qualitative categorisation across four higher-level themes.

Team environment	Team structure	Team processes	Individual contribution
Organisational context	Purpose	Cohesion	Mutual respect
Team identity	Membership	Social fabric	Commitment
Mission	Goals	Communication	Flexibility
Hierarchy	Leadership	Managed	Recognition
Resources	Achievement	Problem solving	Maturity
Professionalism	Roles	Feedback	Personal benefits
	Meetings	Participation	
	Time lines	Support for change	
		Decision making	
		Planning	

effective teamwork. Results from all three research methods were utilised in this iteration; repertory grid interviews, the clarification questionnaire and the Teamwork in Healthcare Inventory

A consistent hierarchy of comparative contribution emerged across the repertory grid interviews. The frequency for each conceptual category was compared by identification in the repertory grid interview (identification), perceived importance to effective teamwork (priority) and higher-order summary. Higher frequencies are considered to distinguish effective teams. Figure 1 represents the cumulative frequencies for the top 15 conceptual categories.

A similar hierarchy of importance was generated from the ratings of 27 (69%) of the original 39 participants who completed the clarification questionnaire. Table III summarises the decreasing importance of the top 15 conceptual categories, using an aggregated score of all participants' importance rating.

The 202 respondents to the Teamwork in Healthcare Inventory used a six-point scale (where 6 indicated that this aspect was always essential for teamwork) to evaluate both

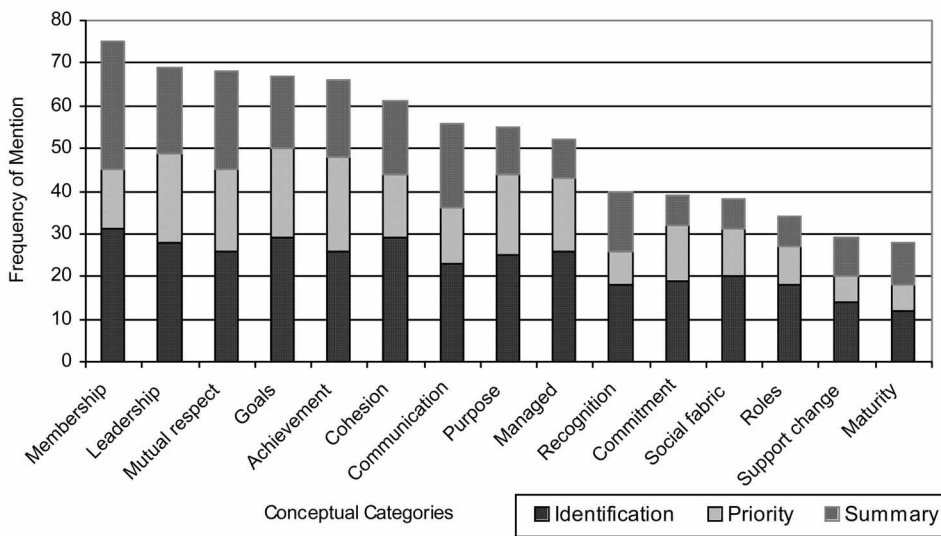


Figure 1. Cumulative frequencies for top 15 conceptual categories.

Table III. Participants' importance scores from clarification questionnaire ($n=27$).

Conceptual category	Total score (Max = 189)	Conceptual category	Total score (Max = 189)
Purpose	177	Cohesion	157
Communication	173	Support for change	157
Leadership	168	Maturity	157
Achievement	165	Decision making	156
Commitment	165	Mutual respect	153
Problem solving	162	Feedback	152
Goals	161	Planning	152
Participation	159		

positively and negatively worded statements for their comparative contribution to effective teamwork. Table IV describes the hierarchy of comparatively decreasing contribution of the top 15 conceptual categories to effective teamwork.

A clear hierarchy of contribution to effective teamwork emerged from these descriptive analyses. Six conceptual categories were consistently present in the top hierarchies of the analyses of all three research methods and it is proposed that they are most able to distinguish effective teams. These categories are: mutual respect, goals, leadership, communication, cohesion and purpose. Nine categories were evident in the top hierarchy of at least two research methodologies (achievement, commitment, social fabric, recognition, membership, support for change, maturity, participation, problem solving).

Iteration 3: Emergence of common themes across conceptual categories

This iteration focused on quantitative analysis of 27 participants' clarification questionnaire responses. Meaningful connections between conceptual categories were investigated through detailed analysis of participants' preferred allocation to themes. The way in which participants allocated 30 categories to four emergent themes is compared with the themes allocated by the researcher in the first iteration. While most participants offered definite preferences, several allocated categories to two descriptive themes. Table V represents the total allocations by all 27 participants for the 11 heavily cross-referenced categories, organised by decreasing frequency of mention. The highest allocation for each category is highlighted in italics.

There is consistency between the second and third iteration, where 11 categories are considered able to distinguish effective teams. However, the allocation of categories into emergent themes is not as convincing. It appears that these themes may be interdependent.

Discussion

A Healthy Teams Model has emerged to emphasise how six categories, which were most able to distinguish effective teams, are conceptually linked across four emerging themes. Each category can be described as a key characteristic of effective teamwork, which has relevance across several themes. The Healthy Teams Model allocates each characteristic to its most relevant theme and complementary interpretations are shaded (see Table VI).

Acknowledging the environmental context is consistent with open systems thinking in that teams interact with, and are influenced by, their external environments (Shea & Guzzo, 1987; Sundstrom et al., 1990). Participants emphasised the need for a clear purpose and an

Table IV. Hierarchy of respondents' ratings from Teamwork in Healthcare Inventory ($n = 202$).

Conceptual category	Mean (Max = 6)	Conceptual category	Mean (Max = 6)
Leadership	5.46	Mutual respect	5.22
Professionalism	5.46	Social fabric	5.12
Goals	5.44	Time lines	5.00
Cohesion	5.37	Participation	4.99
Purpose	5.33	Meetings	4.90
Problem solving	5.29	Membership	4.89
Communication	5.24	Mission	4.86
Recognition	5.24		

Table V. Participants' allocation of conceptual categories to emergent themes ($n = 27$).

Conceptual categories	Team environment	Team structure	Team processes	Individual contribution
Social fabric	16	3	2	6
Purpose	11	7	6	2
Membership	2	13	2	10
Goals	6	12	9	0
Achievement	3	1	19	4
Communication	5	2	18	2
Cohesion	5	8	12	2
Leadership	3	7	9	8
Mutual respect	5	1	5	15
Commitment	8	1	5	12
Recognition	7	3	5	12

Table VI. Healthy Teams Model.

Team environment	Team structure	Team processes	Individual contribution
Purpose	<i>[purpose]</i>		
Goals	<i>[leadership]</i>	<i>[goals]</i>	<i>[leadership]</i>
		Leadership	
		Communication	
	<i>[cohesion]</i>	Cohesion	
<i>[mutual respect]</i>		<i>[mutual respect]</i>	Mutual Respect

environment of mutual respect to align the team with the organisation's mission. In general, team structures provide the framework for patterns of co-ordination, control and specialisation (Gladstein, 1984). Team processes reflect the way that teams handle tasks and interpersonal dynamics. Participants in this study prioritised team process activities of communication, cohesion and leadership. Individuals approach a team with their personal strengths, needs and weaknesses, and their previous experiences, personalities and prejudices (Katzenbach & Smith, 1993). Therefore, these four emerging themes are relevant for understanding each of the six key characteristics.

Team characteristics

Participants described effective teams as having a well-defined and forward-looking *purpose* that was relevant to patients and linked with their organisation. Team members needed to generate the team's purpose to include collective interests and demonstrate shared ownership, both initially and regularly throughout the team's life. This is consistent with West (1990), who encouraged team members to work through differences in their expectations to find a consensually valued purpose.

Participants described *goals* as an intermediary link between the team's purpose and its outcomes. Goals focused on the team's task and specified how the team could achieve patient care outcomes. Participants emphasised the need for team members to agree upon and set goals collaboratively and to describe them in clearly measurable terms. Similarly,

Katzenbach and Smith (1993) suggested that clear team goals helped focus the development of strategies for their achievement.

Participants emphasised the importance of team *leadership* as influencing activities toward goal achievement. 'Good' leaders set and maintained structures for making decisions and managed conflict, shared ideas and information, co-ordinated tasks equally, provided feedback about the team's activity and were able to listen to, support and trust team members. Participants also emphasised the need for the team to agree and share leadership functions.

Participants described effective teams as having regular patterns of *communication* where all members shared ideas and information with each other quickly and easily. They emphasised flexibility of communication patterns to incorporate diversity of team members' interpersonal skills and preferred communication styles. Clear written records were recommended, as was sufficient time during meetings to reflect.

Participants described *cohesion* as the sense of camaraderie and involvement that was generated by working together over time. Through participation in team tasks and consistent communication networks, individuals built up a sense of commitment to the team and trust of other members. Cohesive teams had a unique and identifiable team spirit and individuals shared enjoyment and pride in their achievements. As a result, cohesive teams had greater longevity, because team members wanted to continue working together.

Participants described high levels of *mutual respect* between team members in effective teams, where individuals were open to the talents and beliefs of each person, in addition to their professional contributions. As team members accepted their diversity of opinions, they also developed respect for each member's expertise. Mutual respect was also described as a belief that working in a team was the best method for integrating the contributions of all members.

Evaluation of study

In this qualitative study, factors of credibility, dependability, confirmability and transferability are evaluated as alternatives to reliability and validity (Guba & Lincoln, 1998). Detailed triangulation of data collection, reflection and interpretation has enhanced the credibility and dependability of participants' shared meaning. The inherent complexity of teamwork was simplified within a purpose-designed interpretive framework that is potentially reproducible. Further, this content has been compared with the extant literature to confirm its alignment and accommodative ability.

There is conceptual and content support for the Healthy Teams Model across seven commonly cited theoretical models. All models simplified teamwork through identifying a small number of important characteristics and a range of complex interdependencies. Models were designed to be practical and to identify the most potent point of intervention for teams to enhance and maintain their effectiveness. Content similarities are summarised across the inclusion (or not), of each of the six key characteristics of the Healthy Teams Model in Table VII.

Collectively, the shared experiences of the original 39 participants and the later 202 respondents were sufficiently consistent to identify six key characteristics, meaningfully linked across four emergent themes, which are able to distinguish effective teams.

Reflective analysis and team development

Many health care teams become trapped in a vicious cycle of clinical work overload, which inhibits them from taking time out to determine priorities and evaluate their function (West,

Table VII. Content similarities between Healthy Teams Model and theoretical models.

Theorist	Healthy Teams Model					
	Purpose	Goals	Communication	Leadership	Cohesion	Mutual respect
Gladstein (1984)		✓	✓	✓		
Hackman (1987)	✓	✓				
Shea & Guzzo (1987)	✓	✓				
Sundstrom et al. (1990)	✓	✓			✓	
Fry et al. (1974)	✓	✓	✓	✓		
Anderson & West (1990)	✓		✓		✓	
Drinka & Clark (2000)		✓	✓	✓		✓

2000). However, teams require active design and maintenance to maximise their potential and ensure their success and survival (Hackman, 1987; Shea & Guzzo, 1987). The Healthy Teams Model provides a basis for individuals and organisations to reflect on, evaluate and develop teamwork knowledge and skills. It supports an alternative constructivist proposition that team members are best positioned to reflect on and identify shared meaning in their unique team environment.

To achieve this, a four-stage Guide for Reflective Analysis and Team Development is proposed to complement the Healthy Teams Model in promoting effective teamwork. This describes a practical system of reflection, planning and action, which acknowledges the complexity of team functioning in health care environments. It also recognises that effectiveness is a changing construct that is best understood by team members and stakeholders. This guide has been informed by the principles of reflection-in-action (Schön, 1983) and concepts of reflexivity (West, 2000) where effective teams reflect on their current status, plan and adapt to better meet changing environments.

1. Reflecting on current teamwork. The first stage emphasises the need for team members to understand the way in which teams work. The Healthy Teams Model provides a logical explanation of six key characteristics of effective teamwork in health care environments. It is a succinct way to enhance individuals' knowledge and understanding of teamwork. During this stage, individuals are invited to critically reflect upon their team's performance across each of the six key characteristics. Each characteristic needs to be interpreted in context, in terms of the team's stage of development, individual roles within teams, and patterns of professional socialisation. Team members need to be aware of team developmental patterns of change. Further, individuals bring to a team, professional and personal competencies, attitudes and behaviours from past experiences.

2. Comparative appraisal of team's performance. Through reflection, individuals are encouraged to form intentions, contemplate alternative courses of action and develop plans for implementation (West, 2000). Through critically considering how each characteristic applies to their team, individuals develop a holistic understanding of the team's comparative strengths and opportunities for improvement. In line with the constructivist nature of this study, self-reflection can be supplemented by peer reflection and objective observation. This model has the most powerful impact when utilised by a significant number of team members, who share, discuss and confirm personal reflections across each of these six characteristics

3. Planning team improvement strategies. In this stage, team members develop strategies to improve those characteristics that were considered to be least evident in their team. Based

on their enhanced understanding of the team, its structure, processes and environment, team members determine the need for educational or facilitation intervention to implement and manage their team's growth and development. Through their involvement in these discussions and decisions, individuals are empowered and more motivated to participate in these activities and the team is more likely to successfully achieve its goals (West, 2000).

4. Implementing and evaluating change. The final phase of action refers to the achievement of desired changes identified by the team. Given that change is a constant in health care organisations, it is important that teams incorporate the adaptive capacity of people, structures, processes and strategies. The Healthy Teams Model can provide a basis for regular appraisal and reflection of the team's progress. Over time, ongoing reflection could spark another iteration of the entire process at a different level of understanding of team function.

Applying the Healthy Teams Model in a health care environment

Reflection of a short case study is included to offer some insights into how the Healthy Teams Model can be used by individuals in health care organisations. Four purpose designed team-building workshops have been chosen to encourage readers to personally apply this understanding to their own experiences. These workshops were planned as a formal introduction for staff to a significant organisational restructure towards a cross-functional team based organisation. General information about the purpose and plan of implementation was disseminated hierarchically through the hospital. Approximately three months before implementation of the cross-functional teams, a full day workshop was planned for members of each of the four teams. A schedule of workshop activities was developed, based on the Healthy Teams Model, for repetition with each team.

The Healthy Teams Model was briefly summarised at the beginning of each workshop, to familiarise and enhance team member's understanding of teamwork. Team members were facilitated to reflect on their current situation, in terms of the need for and direction of proposed organisational change, through discussion with the executive director of the hospital. It became obvious for each team, that it was necessary to generate a shared purpose. A nominal group technique was used to facilitate a structured brainstorm with input from all team members (Roth, 1995). All team members reflected on their own expectations, listened to others' comments, and collectively summarised a single sentence shared purpose.

From this common introduction, team members selected and prioritised different strategies for the workshop, based on their comparative appraisal of their team's perceived strengths. Each team selected different strategies relating to the six key characteristics of the Healthy Teams Model. For example, one team moved straight into setting shared goals, by allocating sub-groups to achieve set tasks. Two teams wanted to better understand team roles and team members were facilitated to understand each other's preferences in order to develop mutual respect. The fourth team was most interested in determining communication strategies in great levels of detail.

Therefore, by the end of each workshop, every team had addressed all six key characteristics of the Healthy Teams Model, albeit at differing levels of emphasis. Use of the nominal group technique ensured all teams began by collaboratively developing a unique and clear purpose. All teams set some shared goals, with different levels of detail about timelines and team members required to achieve the goals. At least one goal for each team included clarifying and developing communication strategies, and each team adopted

slightly different strategies to reflect the interests and abilities of team members. All teams discussed the allocation of leadership, and nominated team leaders. Some nominated leaders began actively sharing leadership tasks across different goals. All teams, to varying levels, addressed the need to understand and respect personal and professional diversity. By the end of each workshop, there were high levels of cohesion amongst all team members, which were evidenced by alignment with a clear purpose, involvement in team goals and clearer perspectives of the expertise of their colleagues.

It is proposed that as individuals use the Healthy Teams Model to reflect on and critically evaluate their own team experiences, they will develop a greater understanding of teamwork that will enable them to contribute to the growing content and meaning of the model. The Healthy Teams Model inherently incorporates further creative, reflective analyses and interpretations, which enable a qualitatively new understanding of teamwork in health care environments.

Conclusion

It seems that the last 15 years of empirical research has not met the quest for a prescription for effective teams. The increasing recognition of the complexity of teamwork has made it difficult to design and implement validation studies in organisational settings. The Healthy Teams Model represents a relative accumulation of increasingly informed and sophisticated constructions of effective teamwork in health care. The personal experiences of health care practitioners, who have worked across a depth and breadth of different health care teams informed the emergent model. Collectively, their shared experiences were sufficiently consistent to identify six key characteristics, meaningfully linked across four emergent themes (environment, structure, process, individual contribution), which are able to distinguish effective teams. The Healthy Teams Model when used with the Guide for Reflective Analysis and Team Development has potential to assist teams engage in focused self reflection and highlights areas where teams could benefit from further input and team development activities.

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