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All professionals are equal but some professionals are more equal than others? Dominance, status and efficiency in Swedish interprofessional teams

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All professionals are equal but some professionals are more equal than others? Dominance, status and efficiency in Swedish interprofessional teams

This study explored status differences in interprofessional teams and their link with efficiency. In total, 62 teams (423 individuals) from occupational health-care, psychiatry, rehabilitation and school health-care responded to a questionnaire. Fifty-four of those teams (360 individuals) also participated in an observation session simulating problem-solving team meetings. Data were reduced to a number of indexes: self-assessed/perceived equality, functional influence and efficiency; and observed verbal dominance/activity and problem-solving capacity. Perceived status differences within the teams appeared moderate, irrespective of professional belonging. With respect to verbal dominance during meetings, however, the findings revealed a hierarchy with psychologists, physicians and social workers at the top together with special education teachers. No relationship was found between self-assessed efficiency and actual problem-solving nor between observed verbal activity and problem-solving. The findings suggest that different problems may demand different prerequisites to be solved effectively: successful solving of simple convergent problems correlated negatively with equality, whereas functional influence was a predictor of success with respect to divergent, complex problem-solving. The findings raise questions about leadership and procedures during team meetings.

Keywords: interprofessional teams, equality, status, verbal dominance, power, team efficiency, problem-solving.

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Introduction

Most arguments in favour of interprofessional team collaboration in human service organisations rest on a number of basic assumptions supported by research and/or common sense. For example, it is assumed that input from various professional areas is required to handle complex human problems. Way, Jones and Bursing (1) described this collaboration as 'an interprofessional process of communication and decision-making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided' (p. 4). Thus, interprofessional teamwork is a matter of joint problem-solving with dual elements: on the one hand, information must be asked for, listened to and taken into account; on the other hand, everybody also has to articulate their own views.

Equality among team members, with regard to influence on discussions and decisions, is recognised as a core component of collaboration (2, 3). Consequently, phenomena such as status, equality and power distribution have long been issues in the history of interprofessional collaboration (4), as well as in classic group theory (5).

In team settings, influence and impact are often defined in terms of communication time/space during team meetings, but also in terms of team members' own assessments. A relationship between formal status and verbal activity during team meetings has been observed in a number of early studies. In psychiatric care, for example, Moxnes (6) noted that '… verbal activity scrupulously follows the salary level' (p. 67). Thus, the higher the salary, the greater the frequency of verbal contributions – which implies a medical dominance. Doctors do not always dominate, however: in school planning teams, psychologists, social workers, counsellors and administrators scored higher on participation than medical staff (doctors and nurses) and teachers (7).

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The degree of professionalisation has relevance, as reflected in the findings of Bailey, Thiele, Ware and Helsel-DeWert (8): professionals exhibited a higher level of participation in interdisciplinary team meetings than did paraprofessionals and direct-care staff. Similarly, in a study of neuropaediatric teams, Thylefors, Persson, Price and von Wendt (9) found a professional hierarchy when team members' status was measured in terms of their ability to gain a hearing and respect for their opinions and to challenge others' opinions. Physicians followed by physiotherapists and psychologists/social workers had the most impact.

The work context has changed since the introduction of systematic interprofessional teamwork. Some factors have influenced the power balance between practitioners. An increasing number of occupations have acquired the status of a profession, and a deprofessionalisation has taken place simultaneously – a process resulting in a loss of autonomy and control (10). Also, a reprofessionalisation process is identified within health-care, resulting in new, more egalitarian roles (11). The general democratisation of working life and an emphasis on active co-workership are other factors likely to have an impact on status, influence and participation in teamwork. From another perspective, Øvretveit (12) suggested that the growing client/patient participation in decision-making will have a further equalising effect on traditional power relations within interprofessional teams.

Hierarchical and status differences still hinder team collaboration, however, as reported by Kvarnström (13) in a study of health-care teams. She identified a number of difficulties in interprofessional collaboration. Two of them focused on impact and status: (i) when knowledge contribution was not valued equally or put to use and (ii) when the organisation had hierarchical values that affected the experience of being appreciated. Several relatively recent studies confirm her findings. In an interaction analysis, Atwal and Caldwell (14) found that in geriatric care teams, occupational therapists, physiotherapists, social workers and nurses were too reluctant to voice their opinions compared with the consultants (physicians), and concluded that '…this type of professional hierarchy will not be able to contribute effectively to patient care' (p. 271).

Also, Blomqvist (15) revealed an imbalance in her analysis of psychiatric teams: 'the observed teams to a large extent did not view the patient in a multidimensional way' (p. 255). Irrespective of professional belonging, the social perspective dominated their discussions at the expense of physical and psychological perspectives. She also found that during meetings, psychologists, social workers and psychiatrists contributed more than the nursing staff. Likewise, in primary health-care, the dominance of physicians is reported as a crucial factor that interferes with successful teamwork (16, 17).

Studies on status and influence in interprofessional teams vary with respect to the professions included, organisational association and data collected. Despite these factors, the majority of studies in past years report a somewhat uneven distribution across different professions when it comes to influence and status, mainly explained by degree of professionalisation, length of professional education and formal responsibilities. There are, however, indications of differences between various care sectors; one and the same profession does not always dominate the stage. The a priori assumption about the positive correlation between an evenly distributed participation in team meetings and quality/efficiency in teamwork has seldom been tested. Most interprofessional teams are working within, or regulated by, the public health-care system. Within health-care, there is a long tradition of physicians being the dominant professional group, but less is known about teams outside the traditional health service system, such as occupational and school health-care teams. Those teams also have a broader mandate, whereby they have to pay as much attention to environmental factors as to individual problems.

This study is part of a research project focusing on work organisation, collaboration and efficiency in interprofessional teams in human service organisations. The overall aim of the project is to develop a teamwork model adjusted to different situations/demands, a situational model. The study explored two elements of collaboration in interprofessional human-service teams: (i) status in terms of perceived equality and functional influence and of observed verbal dominance and (ii) the relationship between these hierarchical aspects and team efficiency. Specific questions were the following:

- What are the team members' perceptions of equality/status in their team?
- Are there any differences between the professions in question with respect to verbal initiatives and impact in problem-solving situations?
- What is the relationship between, on the one hand, perceived equality/functional influence and observed verbal dominance, and, on the other hand, team efficiency?

Method

This study makes use of the same sample as the main project and parts of its questionnaire and observation data.

Sample

Teams from four care sectors are included in the project: occupational health-care, psychiatric care, rehabilitation (including rehabilitation, neuropaediatrics and hearing care) and school health-care. These sectors were chosen because they have a well-established team organisation

and teams dominated by members belonging to various professions. An invitation to participate in the project was distributed to teams in the western part of Sweden. All teams and individual team members participated on an entirely voluntary basis.

The sample consisted of 423 members from 62 interprofessional teams who responded to a questionnaire: subsequently 360 members from 54 of these teams also participated in an observation session (Table 1).

The teams generally had a predominance of females (78.5%), an average age of 48.34 years (SD = 9.80) and an average number of 8.85 members (SD = 3.56). The majority of the teams (73%) had a manager or coordinator within the team. The response rate to the questionnaire was 77%, and of the 54 teams invited to the observation sessions, 78% of the team members participated.

Questionnaire

An interplay between theory and field research/consultancy constitutes the base for the questionnaire items. The questionnaire was reviewed by a group of health-care managers and senior practitioners with respect to relevance. Except for background data, altogether 12 questionnaire items, reduced to three mean indexes, were used in this study.

Within a Weberian framwork (18), six items/statements on status were formulated. The items reflect two perspectives on status: the evaluation of various professions/team members (prestige) and the distribution of influence (power). The respondents could agree or disagree with the statements on a five-point scale as being characteristic of their own team (1 = not at all). The items were grouped into two indexes, supported by a confirmatory factor analysis explaining 62.33% of the variance. The Equality index was comprised of three items:

- No profession is more important than others in the team
- There are status differences between the team's various professionals (inverted scale)
- Everybody's contribution to the team is, in general, regarded as equally important

The reliability/internal consistency was estimated by Cronbach's alpha ($\alpha = 0.91$). As data were treated on a team level, also the intraclass correlation/interrater reliability was calculated (ICC(1,k) = 0.87) and the correlation, >0.60, justified a use of mean values as aggregated data on a team level (19) Also, the second index, Functional influence, was comprised of three items ($\alpha = 0.62$; ICC(1,k) = 0.62):

- The dominance of a profession depends entirely on the situation
- Depending on the character of the issue/task, the amount of influence varies among the team members
- The most suitable person at the time takes on the leadership responsibility

The Cronbach's alpha value, 0.62, is acceptable as it is sensitive to short scales. An alternative reliability measure, the mean inter-item correlation was 0.28, i.e. within the optimal range 0.2–0.4 (20).

A team efficiency scale with six items (21), each with five response alternatives (1 = to a very low degree), made up the Perceived efficiency index ($\alpha = 0.83$; ICC(1,k) = 0.82):

Table 1 Participants over professions and care sectors (observation sample in bold figures)

	Occupational health		*Psychiatry*		*Rehabilitation*		*School health*		*Total number*	
Care sectors/professions	%	%	%	%	%	%	%	%	*N*	*N*
Audiologist/audionom					4.7	**5.3**	2.0	**2.1**	7	**7**
(Mental) nurse assistant			14.4	**6.7**	1.6	**1.8**			26	**10**
Nurse	23.1	**19.8**	24.6	**24.4**	4.7	**4.4**	17.6	**21.3**	74	**60**
Occupational therapist	11.5	**4.9**	7.8	**10.1**	16.5	**15.9**			36	**34**
Psychologist	12.8	**9.9**	15.6	**16.8**	12.6	**14.2**	15.7	**12.8**	60	**50**
Physician	16.7	**16.0**	9.6	**10.1**	3.1	**1.8**			33	**27**
Physiotherapist/ergonom	20.5	**19.8**	4.2	**3.4**	15.7	**14.2**			43	**36**
Secretary/adm.assistant	7.7	**9.9**	10.8	**14.3**	5.5	**5.3**			31	**31**
Social worker	11.5	**14.8**	12.6	**14.3**	18.1	**18.6**	13.7	**12.8**	60	**56**
Special education teacher					11.8	**13.3**	43.1	**44.7**	37	**36**
Speech therapist					3.9	**4.4**	2.0	**2.1**	6	**6**
Technician/engineer	5.1	**4.9**			0.8	**0.9**			5	**5**
Other			0.6		1		5.9	**4.3**	5	**2**
Number of individuals	78	**81**	167	**119**	127	**113**	51	**47**	423	**360**
Number of teams	13	**13**	22	**14**	18	**18**	9	**9**	62	**54**

• To what degree do you consider all team members are working towards the same goal?
• To what degree are the efforts within the team of a high quality?
• To what degree does the work of the team meet the needs of users/clients/patients/pupils?
• To what degree does your team fulfil its goals?
• To what degree is the teamwork efficiently organised?
• To what degree do you have a high level of expertise within the team?

The Perceived efficiency index includes both items on internal and external efficiency. However, a factor analysis gave only one factor explaining 54.45% of the variance. The three indexes, operational definitions of Equality, Functional influence and Perceived efficiency, appeared as reliable with an acceptable construct validity confirmed by the internal consistency.

Observation of simulated teamwork

Every team was presented with three tasks/problems. All tasks were chosen/constructed to stimulate a collaborative discussion in situations where every participant's information and knowledge were necessary to complete the task.

The first task was the Zin Obelisk (test.trainingzone.co.ukmath) with each team member given unique information needed to determine on which day a building project would be finished. In the second task, a recruitment situation, the team had to select an executive manager for a fictitious care company. Only one of the seven applicants fulfilled all the specified demands. The team members were not aware that different versions of the information sheets existed. The sheets largely presented the same information, but also contained certain unique and necessary facts that only could be discovered by communicating and listening. The third task was a simulated consultation conference consisting of three short case descriptions, all with a multifaceted problem image and with elements relevant to all teams. The team task was to generate, and summarise in writing possible hypotheses about the clients' problems as well as recommendations.

Including feedback, the observation event lasted about three hours. The team tasks had an upper time limit of 95 minutes (20, 30 and 45 minutes). The first two problem solutions were assessed as either correct or incorrect (scale: 0–2, where 2 stands for correct solutions for both tasks). The suggestions from the consultation conference were evaluated on a five-step scale, where 1 stood for a contraindicated suggestion (harming the client), 2 for a dead end/repeating earlier measures, 3 for an overloaded list of unfocused measures that might be helpful, 4 for focused suggestions that would probably lead to correct diagnosis/explanations and measures and 5 for correct hypothesis and suggestions of adequate measures. A mean was calculated for the three cases (scale: 1–5). The evaluations were determined by two senior psychologists, in cooperation with one senior physician, all with relevant experience. Thus, the observation session gave two efficiency measures, problem-solving capacity (task 1 and 2) and case quality (task 3).

Response-initiative analysis. One expression of status in a group is an ability to initiate ideas and activities that are taken up by other members (4, 18). This ability was assessed by a modified Response-Initiative analysis (22).

The teamwork during the problem-solving process was observed for a total of five 5-minute sequences. Three types of individual verbal expressions were coded: (i) successful initiatives to influence the work process – Dominant Initiative [DI], (ii) unsuccessful initiatives to influence the work process – Initiative without Response [IwR] and (iii) verbal responses to initiatives – Response [R]. An initiative was coded as dominant when followed by a verbal confirmative or supporting response or by activities in accordance with the initiative. As a measure of impact on the work process, a Dominance Score, [DS], was calculated: DS = (2nDI + nR) − nIwR, where n stands for the number of initiatives and responses. Thus, successful initiatives were given twice the weight compared to responses with respect to impact on the process.

Besides three senior researchers/psychologists, a handful of specially trained students at the end of the 5-year psychologist programme participated as observers. Every team was assessed by two observers, and the mean of their estimates was used as a measure.

Realistic or not? Following the observation, but before being given feedback, all teams were asked this question: to what extent did the work process during the observation reflect your normal way of working together? The responses were summarised as 'as usual', 'better than usual' or 'worse than usual'.

Statistical analysis

Data were statistically analysed with SPSS 11.0.4 for Mac OS X (The Software MacKiev Company, Boston, MA, USA). Differences between subgroups were tested with ANOVA (Tukey's *post hoc* test), and correlations were calculated by Pearson's product moment correlation. Mean values were used as aggregated data on a team level.

Findings

To exclude possible interference of gender, age and formal leadership roles, those variables have been taken into account where relevant.

Perceived status

Both the Equality (M = 3.61, SD = 0.50) and the Functional influence (M = 3.20, SD = 0.34) indexes reveal a

perception of moderate status differences within the teams and professional association did not explain differences in team members' opinions. A comparison between the care sectors gave only one difference ($F(3,57) = 4.75$; $p < 0.01$): the rehabilitation teams scored higher on Equality than the psychiatric teams ($M = 3.86$, $SD = 0.48$; $M = 3.33$, $SD = 0.49$). No age or gender differences were found with respect to perceived equality and functional influence. Nor did team leaders differ from nonleaders in this regard.

Observed status

The majority of teams (80%) assessed their observed team meetings as being fairly realistic with the presented tasks eliciting the same dynamic and processes as in their regular meetings. Several teams felt that they worked even better during the observation, as being observed increased the discipline of their meetings. Only one team said that they performed better in their normal setting. Thus, the ecological validity seems good enough.

Initiatives and responses. Of the total amount of registered initiatives, 96% were successful, i.e. had an impact on the work process. A number of verbal responses followed the initiatives, but most responses were nonverbal and expressed in behavioural compliance. Only a few verbal responses had a questioning character.

All teams had the same opportunity for communication, and on a team level, as assumed, there was no correlation between the total amount of either verbal activity or successful/dominant initiatives and team size ($r = 0.00$; $r = -0.03$). On an individual level, however, total verbal activity, as well as number of dominant initiatives, did reflect the team size ($r = -0.47$ and -0.39, respectively; $p < 0.01$). The larger the team, the lower the degree of each member's verbal contributions.

Individual impact – professional differences. Depending on the team size, each individual's share of a team's total DS does not have the same value. Therefore, to compare individuals independent of team size, all individual shares were multiplied by the number of members within the team despite the fact that team size may affect the internal dynamics (Fig. 1).

Although large internal variations exist within each profession, there are some significant differences with respect to dominance scores ($F(12,352) = 7.45$; $p < 0.001$). The number of significant differences increases from task 1 to 3 (4, 9 and 15, respectively). Thus, the more familiar the task, the more differences. Nor in the case of verbal activity did team leaders differ from other team members, and no age or gender differences were noted.

To minimise the risk of Type 1 error in a comparison between professions, their number was reduced to five groups according to previous research and data in question: (i) psychologists, physicians and social workers; (ii) special education teachers; (iii) 'therapists', i.e. occupational therapists, physiotherapists, speech therapists and audiologists; (iv) nurses; and (v) paraprofessionals, i.e. secretaries/administrative assistants and assistant nurses. Owing to their small number, technicians and engineers were excluded from the sample.

The five groups of professions did differ from each other ($F(4,353) = 19.87$; $p < 0.001$). Physicians, psychologists

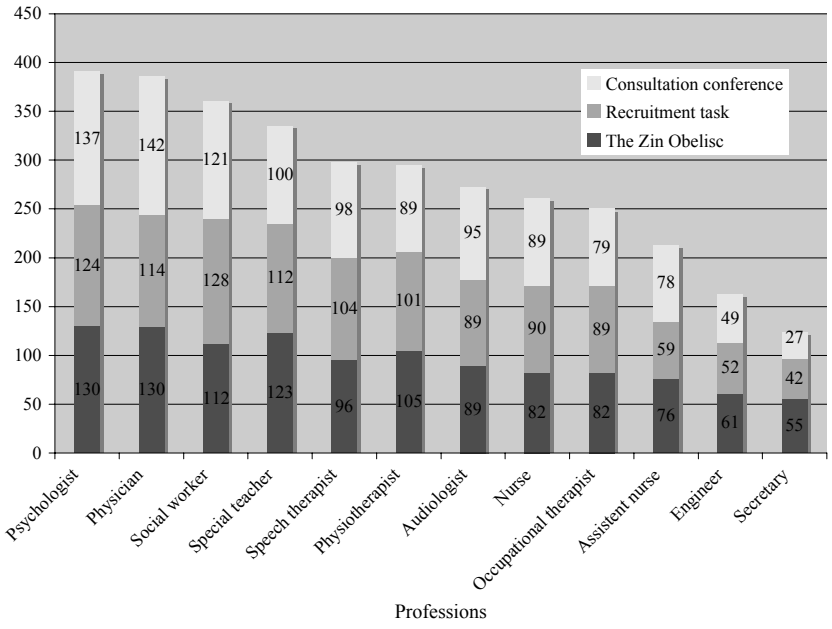

Figure 1 Share of Dominance Score x team size over professions (Figures are rounded to integers).

Table 2 Mean values (M), standard deviations (SD) and intercorrelations between status, observation and efficiency measures (N = 62/54 teams)

			Status		*Observations*		*Efficiency*		
Index/Measure	*M*	*SD*	*1*	*2*	*3*	*4*	*5*	*6*	*7*
Status									
1 Equality	3.61	0.50	1.00						
2 Functional influence	3.20	0.34	0.48*	1.00					
Observed verbal team activity									
3 Dominant initiatives[a]	62.93	34.58	−0.02	0.06	1.00				
4 Total verbal activity[b]	154.21	76.50	−0.06	0.15	0.89*	1.00			
Efficiency									
5 Perceived efficiency	3.86	0.41	0.45**	0.32*	−0.13	−0.16	1.00		
6 Problem-solving capacity	1.45	0.64	−0.30*	0.03	0.16	−0.02	−0.12	1.00	
7 Case quality	2.86	0.76	−0.02	0.32*	−0.17	0.03	−0.04	−0.09	1.00

*p < 0.05, **p < 0.01; [a]total number of dominant initiatives within the team; [b]total number of verbal initiatives and responses within the team.

and social workers scored higher (M = 373, SD = 185; p < 0.001) than 'therapists' (M = 277, SD = 133), nurses (M = 254, SD = 147) and paraprofessionals (M = 144, SD = 126) but not higher than the teachers (M = 325, SD = 113). The paraprofessionals scored significantly lower than all other professional groups.

The dominance pattern was about the same over the care sectors. Within rehabilitation, both physicians/psychologists/social workers and 'therapists' (F(4,106) = 2.47; p < 0.05; M = 318, SD = 93; M = 309, SD = 135) took more verbal initiatives than the paraprofessionals (M = 184, SD = 120). Also, within the psychiatric teams (F(3,116) = 11.36, p < 0.001), the same 'top trio' (M = 413, SD = 260) dominated over 'therapists' and paraprofessionals (M = 225, SD = 130, M = 130, SD = 14). Likewise, physicians/psychologists/social workers within occupational health-care (F(3,45) = 15.89. p < 0.001; M = 409, SD = 129) had a greater impact compared to nurses, 'therapists' and paraprofessionals (M = 244, SD = 100, M = 255, SD = 124, M = 147, SD = 79). In the school health-care teams, the teachers scored higher than the nurses (F(3,45) = 4.68, p < 0.01; M = 331, SD = 115; M = 181, SD = 71).

Considering all figures with respect to verbal dominance, three rather stable subsets emerge: the upper class (psychologists, physicians and social workers together with special education teachers), the middle class ('therapists', i.e. physiotherapists, occupational therapists, speech therapists and audiologists, and nurses) and the paraprofessionals (assistant nurses and secretaries/administrative assistants).

Status and efficiency

Does the perception of status and the observed verbal activity during team meetings matter with respect to team efficiency? All three efficiency measures suggested a moderate efficiency level, but they seemed to be independent of each other (Table 2). There were, on the other hand, positive correlations between the subjective assessments, Equality, Functional influence and Perceived efficiency.

With regard to observed problem-solving, the correlations carry a contradictory message: success on task 1 and 2 was negatively correlated with perceived equality, whereas the case quality assessment correlated positively with functional influence. Influence in the form of verbal initiatives, or activity, appeared to be unrelated to actual problem-solving. Thus, whether members of a team took many initiatives to affect the work process or otherwise had a high verbal activity appeared to be irrelevant to the outcome. The performance of teams with a formal leader participating in the simulated team meetings did not differ from that of those without a leader.

Discussion

Self-assessments and observation of simulated teamwork were used in this study. Both methods have their limitations. The first is 'a matter of perception' not, necessarily, 'actuality' (4, p.142). Whether the observations reflect 'actuality' may also be questioned. For example, only 25% of the communication was categorised and registered. Differences in team size and the number of individuals within each profession also caused a complication when the findings were interpreted. The study also shares a weakness with many team studies, the limited number of cases in spite of the number of individuals in the sample. This fact affects both statistical analysis and the generalisability of the findings. Thus, the findings ought to be regarded as indications which taken altogether might provide a relative picture of the situation. What do these indications suggest?

Independent of source, the data provide the same picture: there are certain, moderate, status differences

expressed in terms of equality and functional influence within the team and that perception is not linked to professional belonging. In the case of verbal dominance, however, a hierarchy related to profession emerges. In general, psychologists, physicians and social workers verbally dominated the team meetings and had the greatest impact on the work process and its continuous decisions. Those three professions represent different major disciplines (along with the special education teachers), with psychologists and social workers taking on complementary, not subordinated, roles in relation to the physicians, whereas nursing and the 'therapist' professions all originate from medicine (23). This origin contributes to a more subordinate role in relation to the doctors, an issue addressed in numerous studies (14, 24, 25). At the bottom of the hierarchy, the paraprofessionals are found. As in earlier studies, verbal dominance reflected the length of education or degree of professionalisation.

With respect to verbal influence during meetings, this study found a balance between the 'cornerstones' medicine, psychology, social work and, when relevant, education but also that some professions fall short in this regard. That psychologists and social workers were as influential as the doctors during the observed meetings may be a positive sign that foreshadows a greater equality in interprofessional collaboration.

The nonexistent connection between the amount of verbal initiatives/responses in the team and the objective efficiency measures is puzzling: teams with a high degree of verbal activity did not perform better than the more passive ones. Two explanations are feasible, an insufficient coordination and integration of individual contributions and/or the imbalance between professions, resulting in an omission of 'quiet competence' within the team.

The teams were presented with two types of problems: simple, 'convergent' problems with only one possible correct answer and complex, 'divergent' problems where the solution requires an intrinsic combination of different perspectives. Success in simple problems seemed to co-exist with some degree of hierarchy, whereas solving complex problems goes together with the existence of functional influence, the most competent members on an issue having the most say (cf. 26). The most typical result from the simulated case conference was an overloaded list of hypotheses and recommendations. This may be understood (supported by observations) as an expression of a wish to satisfy most members, and therefore every suggestion was accepted. Several motives may promote that attitude, such as conflict avoidance, time pressure or an excessive respect for others' expertise. The laboratory situation may also have played a role. In a real work situation, the teams have to take resource limitations into consideration and amalgamate their suggestions – but that amalgamation could lead to disagreements and negotiations.

The associations between self-assessed efficiency, equality and functional influence say nothing about direction of causality. Probably, there is a reciprocal interaction between these phenomena, and actually in this context, equality with respect to influence represents an aspect of internal efficiency.

The findings are built on data collected within four care sectors with similar working conditions: all teams delivered outpatient care, were mostly working with continuous, elective interventions and were taking relatively reversible decisions in relation to their clients. It is doubtful whether findings are transferable to other care contexts, such as emergency care, intersectional teams or inpatient care. Similarly, it should be noted that the study was conducted in a country with a relatively egalitarian culture (27), which affects the power distribution at work.

Thus, some professions are still somewhat 'more equal' than others. Are status differences justified or not? In literature, on interprofessional collaboration, two positions could be distinguished: one pleading for equality between autonomous professions (2) and one regarding teams as a means to extend the range of the doctor's work (17). The first position usually is favoured in areas with a long history of interprofessional team work while the other more often appears in primary health-care. One position is not necessarily better than the other. However, a physician-focused work organisation generally places unreasonable demands on the doctors and reduces input from other health professionals.

In contrast to, for example, acute hospital settings, all teams in this study worked within care services with an explicit holistic approach that requires a functional influence built on competence, not on formal status. Competence and expertise may, however, be exposed to form a power base (28). This means a shared responsibility in a team to achieve an appropriate balance of power – this is a concern both for high- and low-status members.

The reported findings and impressions captured 'between the lines' suggest that encouraging team members' verbal contribution during different meetings is not enough to improve efficiency. In general, team meetings would benefit from a more structured, active and integrative leadership – a leadership and a process adjusted to different kinds of problems. The findings also suggest the existence of a conflict–avoidant behaviour, resulting in an 'additive' instead of an 'integrative' attitude towards problems. This may save time in the interim, but in the long-term more structured procedures for negotiating, decision-making and conflict management will promote effective team functioning.

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Declaration of interest

The author reports no conflicts of interest and is solely responsible for the content and writing of this paper.

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