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Team effectiveness in academic primary health care teams

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Abstract
Primary health care is undergoing significant organizational change, including the development of interdisciplinary health care teams. Understanding how teams function effectively in primary care will assist training programs in teaching effective interprofessional practices. This study aimed to explore the views of members of primary health care teams regarding what constitutes a team, team effectiveness and the factors that affect team effectiveness in primary care. Focus group consultations from six teams in the Department of Family Medicine at Queen's University were recorded and transcribed and qualitative analysis was used to identify themes. Twelve themes were identified that related to the impact of dual goals/obligations of education and clinical/patient practice on team relationships and learners; the challenges of determining team membership including nonattendance of allied health professionals except nurses; and facilitators and barriers to effective team function. This study provides insight into some of the challenges of developing effective primary care teams in an academic department of family medicine. Clear goals and attention to teamwork at all levels of collaboration is needed if effective interprofessional education is to be achieved. Future research should clarify how best to support the changes required for increasingly effective teamwork.

Keywords: *Teamwork, primary care, interprofessional education*

Introduction

Primary health care is undergoing significant organizational change in the Western world in order to provide cost-effective comprehensive care (Wilson et al., 2004). The introduction of Family Health Teams in the province of Ontario, Canada represents one such organizational change, the goal being to develop interdisciplinary health care teams that work effectively to improve the delivery of primary and preventative care (Ontario Ministry of Health and Long Term Care [OMHLTC], 2004). D'Amour and colleagues (2005) describe interdisciplinary teams as groups of professionals who work collaboratively to develop processes and plans for patients as opposed to multidisciplinary teams in which health care professionals work independently and then share information. Concurrently, there is increasing interest in developing interprofessional education for collaborative patient-centered practice. Without practice settings that demonstrate and explicitly articulate the factors that contribute to effective collaboration, preclinical interprofessional education will be a theoretical construct that is not experienced in the workplace. Family Health Teams have the potential to provide settings for learners to experience collaborative practice.

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The OMHLTC framework documents provide guidance on the structure and characteristics of well-functioning teams (OMHLTC, 2004). It is not known how effectively these initiatives will be implemented or whether they are appropriate for the primary care setting (Canadian Association of Occupational Therapists, 2005). The simple provision of guidelines does not change behaviour and the introduction of new contractual arrangements may not consistently improve teamwork (Davis, 2006; Cabana et al., 1999; Shaw et al., 2005).

Much of the theory regarding well functioning teams originates in the organizational literature. Beatty (2003) suggested there may be common characteristics in high performance teams. Lemieux-Charles and MaGuire (2006) reviewed the literature on health care team effectiveness and found that little is known about the transferability of findings across different contexts. For example, intensive care unit teams have much shorter work cycles, and team membership is unstable. These teams work in an environment considered to be complex and highly uncertain. Such teams have very different characteristics and processes than primary care teams which may be highly stable with team members working together over long periods, dealing with a broad scope of activity. Lemieux-Charles and MaGuire (2006) also argued that the multiple and changing membership of teams threatens the stability of team culture boundaries. The distinction between core members and extended members of the team, and how these identities affect team processes has not been well studied. The OMHLTC guidelines define a team as: ''a small number of people with complementary skills who are committed to a common purpose, performance goals, and approach for which they are mutually accountable'' (Katzenbach & Smith, 1993). Others view primary care practices as local professional complex adaptive systems which work in larger networks of health care providers (Miller et al., 2001; Naccarella & Sims, 2003). Thus a deeper understanding of primary care teams is needed to provide support for effective family health team development.

As the Department of Family Medicine (DFM) at Queen's University embarked on the introduction of Family Health Teams, we became interested in understanding the current conceptions of teams and team function in the academic teaching practice and whether there was a suitable tool to measure change as the new models were introduced. The Team Survey® developed by Millward and Ramsay (1998) is based on cognitive models involving metacognitive factors and motivational factors that underlie effective team self-regulation. As we pilot tested the tool for face validity in Canada, we explored through focus group discussion perceptions of teams and teamwork in an academic primary care setting.

Aims

Through focus group discussions with members of primary care teams practicing in an academic teaching centre we explored members' perceptions of teams and team effectiveness and the factors that influenced how they functioned as a team. With this information, we hoped to understand the complex relationships that promote team effectiveness and the factors that may be necessary to promote the establishment of effective interdisciplinary teams in primary care.

Methods

Setting

The DFM at Queen's University has six teaching practices or teams, each composed of two to three physicians working with a nurse, a shared receptionist and two or three learners,

either first year residents or medical students. The Department included four allied health professionals; one dietician, one nurse practitioner, two social workers and two part-time consulting psychiatrists. Secretarial and management assistance was provided for both the clinical and academic duties of the faculty. The clinic has functioned since 1974 and the study took place prior to official transition to a Family Health Team model.

Participants

All permanent members ($n = 50$) of the DFM were invited to participate. Teams identified themselves, thus providing ''naturally occurring'' focus groups. Nine teams participated and the recordings of six focus groups were of adequate quality for transcribing. Four of the teams were multidisciplinary teaching practices. Inclusion of residents, secretaries, float/replacement nurses, nutritionists, social workers, and administrative staff varied among these teams. Two teams were uni-professional: an administrative/management team (four members) and a nursing team (nine members). Of the 42 participants 34 were women and four were family medicine residents.

Data collection

The focus groups were conducted following a pilot test of the Team Survey® (Delva & Jamieson, 2006). Participants provided informed consent and completed the surveys individually in the group setting. Upon completing the questionnaire, the research assistant explained the purpose of the focus group, obtained consent to participate, ensuring voluntary participation, and no anticipated harm to subjects, integrity and confidentiality. The research assistant recorded and facilitated the focus group discussion. The data collection period was from December 2004 to January 2005. The Research Ethics Board of Queen's University approved the study protocol.

Data analysis

Focus group data analysis methods were used (Krueger & Casey, 2000). Naturally occurring focus groups in team research allow observation of interactions and shared conceptions. The study of fragments of interactions and the relating of comments by participants to events in their shared daily lives may approximate naturally occurring data. (Kitzinger, 1995). Participants may challenge or encourage the elaboration of events, ideas and attitudes among members. Challenges in focus group analysis include the coding of talk between participants that could be labeled visiting, the redirecting of discussion by interruption and the overriding of comments by other participants.

Thematic data analysis was used to explore the attitudes and perceptions of the team members. The Team Survey® tool set the stage for the discussion, addressing dimensions that were theoretically based but not explicit to the participants. Content analysis was conducted without reference to the Team Survey®. The recorded focus group discussions were transcribed by one investigator (ML) and verified by the research assistant. The revised transcripts were read and reread to search for themes that were consistent within and across transcripts. A coding system (Appendix 1) that best reflected the themes was developed and Nvivo 2.0 (QSR International, 2002) was used for systematic data analysis and to identify key quotes reflecting themes. A second investigator (MJ) independently reviewed the transcripts and analysis. Discrepancies were discussed and consensus reached. After this process a third investigator (DD), familiar with the workplace, provided clarification of organizational

relationships that may have influenced the discussion. Finally, the data was compared with other frameworks to determine fit or differences with current theories of team functioning.

Results

The data presented some challenges that are common to focus group work. Social chat and interruptions prevented development of some ideas. The voice recording method was unclear in some sections and identification of speakers was unclear when a number of participants were speaking at once. With these limitations, an inductive approach was taken to analyze the data. In the following quotations participants are identified by the participant code (e.g., *P37*).

Educational and clinical obligations

Members of the DFM perceived themselves as fulfilling two main functions: meeting patients' clinical needs and educating future health care workers. A number saw the fulfillment of both functions as a challenge and that for some members to meet their dual obligations, others members' role obligations could be compromised.

> See, the problem I have thinking about teams is that we have two functions that I often have trouble putting together and that's the role of teachers and the role of practitioners . . . I mean the needs of one don't always meet the needs of the other. (*P37*)

Others ranked the functions, believing that the education of future physicians was the purpose of the DFM.

> It's like every four months, you meet young people that rely and share with you. And if you can contribute to their career, it goes far . . . I think the reason we are here is for the residents in the program. I mean the bottom line is and it will always be that or the funding won't be there. (*P24*)

Purpose, motivation and team goals

Participants believed that patient care was the goal common to all teams in the department and some recognized that training the family medicine residents was also a major goal.

> Patients are the . . . . , we don't realize it, but they are the substrate for our teaching . . . (*P29*)

Motivation for teaching residents could be altruistic or pragmatic.

> Anybody can look after those patients, right? But not everybody could show the residents. (*P33*)

Team membership

Variation in perceptions of team membership was reflected by the participation of members in focus groups and through focus group discussion. Only two of the clinic focus groups included residents, although two-three learners were part of every teaching practice. Occasional members, such as float (i.e., replacement) nurses, attended only some of the

focus groups for the teams that they supported and no allied health professional apart from nurses participated in any of the focus groups.

Members questioned how much interaction was required in order for someone to be considered a team member. The membership of transient members seemed to create the most confusion.

> Some of these team meetings we're included and others we're not. So it kind of makes you feel like you are not really part of the way things go or whatever. (*P25*)

Perceptions on the team membership of float support or consulting allied health professionals varied from skepticism that they were true team members, to consideration of how to include them more effectively, to indifference about their membership status.

> When certain things come up, certain issues present themselves or certain times of the year where we might need their assistance or vice versa. But other than that, you guys kind of do your thing and we do our thing. (*P21*)

Residents who attended the focus groups perceived that they were truly included in their teams and chose the setting for this reason. Permanent members questioned whether residents were true team members.

> Because they rotate every few months. I just wondered how does their role within the team . . . it must change as each person changes. (*P26*)

An understanding of members' roles

Appreciation of team members' roles varied. Some expressed confidence in knowing how to take on each other's roles and were certain that members could share certain responsibilities or duties. Some understood that each team member had a different role within the team, but their shared goal brought the team together. Some expressed a desire to learn more about other team members' roles. Knowledge of some colleagues' roles was "sketchy" because they did not all interact to the same extent with each other. The orientation of new members provided an opportunity for detailing the different roles and responsibilities of each team member. The focus group proved to be another such opportunity for some teams in this study.

Power differences

Physicians were perceived to hold more power in teams due to access, the perception that work must be adjusted to their requirements, and the cancellation of clinics without regard to the impact on the staff.

> When you are working with three physicians, each of those physicians do things differently and that makes it difficult because you have to remember if you are dealing with an issue as to who is in the clinic, how do you deal with that problem? (*P5*)

Receptionists identified their stress when a clinic was cancelled:

> So it basically falls back to us to deal with the patients saying: "well I'm sorry, yes she/he is here but he isn't going to see you because he is not going to see patients this week." And

> patients don't understand that and quite frankly, a lot of times, I don't either. [. . .] The patients can be very upset about it . . . . yet when they come in to see you (i.e., the physician), they are not going to tell you that because they are very happy to be here. But they have no problem telling us. (*P6*)

Adjustment and problem-solving as a team

This theme concerned the perceptions of how teams and/or the department to which these teams belonged responded to the need for change.

> It's like pulling teeth to get little changes. [. . .] Let's face it: everybody hates change. But, sometimes we discover that there is a better way to do things and through team-building and brainstorming, we can find our way to doing it. (*P21*)

It was perceived that teams reacted to crises rather than planning change.

> Everybody would prefer to be proactive rather than reactive. And I think that being reactive has been the norm around here for a very long time. (*P21*)

Teamwork process

Despite the challenges of teamwork, some valued the experience of being part of a team, emphasizing the importance of relationships.

> Our team works really well together and we communicate and we work hard. We have fun. You know, we can have a laugh and still get our work done and we support each other and I think that's very important. (*P24*)

Some considered teamwork was necessary to get their work done and some thought it was inherent to some disciplines.

> Nursing has always thought of itself as being a profession that's team players because that works well in the work place. (*P3*)

Communication

Effective teamwork relied on team communication based on respect and feelings of comfort with other team members.

> You don't feel like a dummy and you are more comfortable asking what you need to know. [. . .] I mean you have to have that communication in order to work effectively anyway. (*P6*)

Good relationships among team members not only aided communication but facilitated the degree to which team members could help each other. Communication barriers with physicians were thought to be due to conflicts in schedules and roles. For nurses, the building layout was deemed responsible for lack of interaction between different teams. Information from team meetings was inconsistently shared or was incomplete and this

hindered performance. Variations in operational approaches used by the different teams were also problematic.

> When things might go on that we may not know about, you know, from different areas or how they want things done. We do the best we can with the information we have but every area operates differently. (*P25*)

Suggestions were made to distribute minutes and to create an electronic bank of policy information. Secretaries were thought to be central to facilitating communication since they interacted with all team members. For some teams, communicating immediately when problems arose and being aware of other team members' needs enabled effective working relationships.

Recognition

Others reported that their teams pulled together when times were more demanding.

> I think given the fact that we're a very busy area that we do remarkably well. You know, to keep up with the load and meet the needs that have to be met. I think we do very good [sic]. (*P19*)

The focus groups allowed recognition of others, in particular the float nurses who were uncertain of their team membership.

> I think J... and R... are probably the biggest team players in the nursing group because they do help everybody all of the time. (*P13*).

Receptionists were also appreciated as the ''keys to continuity'' and ''critical points of contact'' for the team. The challenge of their role was acknowledged.

> If someone is upset, you guys get hit first. Even though you can pass it along, you still have got that initial front to face. (*P29*)

Support

Support from fellow team members was also valued, particularly when the support made the teamwork fun.

> You know, we can have a laugh and still get our work done and we support each other and I think that's very important. And we all react under stress and depending on the day, could be under more stress than others but I think we understand that about each other and we don't hold that grudge that ''oh she snapped at me today''. (*P24*)

Support was thought to be strongest between longstanding team members but new team members reported that they especially valued team support.

Overcoming barriers to effective teamwork

Participants identified a number of barriers to team effectiveness including: absenteeism, disorganized teams, too little time for team building and unwillingness to accommodate a

fellow team member. The focus group setting allowed discussion of strategies to address barriers.

> People have very specific roles but if there is not good communication and understanding of the roles between members of the team, then things don't work. (*P29*)

A strong commitment to meet role obligations was critical.

> Falling behind and not pulling your weight creates bad feelings . . . (*P44*)

A willingness to expand one's role obligations when the team was under pressure was identified as a strategy.

> When the nursing team as a whole is in trouble or has a gap because of whatever . . . . I know that members have even broadened the scope that they were going to do that day; what their focus was or they just adjusted the specifics of what they were doing that day in order to cover the patient care. (*P26*)

Governance

The Department of Family Medicine is governed by the university and is located on hospital property. Physician faculty members are appointed by the university and the other staff are hospital employees. This division was perceived to cause organizational conflict as a result of inappropriate systems and inefficiencies.

> You are spending huge amounts of time and that has to do with the system again. It's designed for somewhere else, not for here. It's designed for the hospital and it doesn't function here. (*P2*)

Certain hospital rules and regulations were thought to inhibit effective teamwork:

> So there are rules and regulations that are constraining how we function; probably almost without realizing it. (*P37*)

The lack of communication of hospital news and events and a lack of consistency in the hospital's application of policies were problems. Inconsistencies in the demands that team physicians placed on other team members was attributed to lack of interaction among team physicians.

> It's just unique to the way this centre is organized because the physicians are just never in the clinic at the same time, by design. (*P2*)

Team meetings

The purpose and timing of team meetings varied. Meetings were held to introduce new members, review professional expectations and guidelines, review patient progress or for problem-solving. Meetings might be formal or informal and varied in frequency from none

to one per month. Participants expressed a desire for more team meetings but recognized barriers:

> It (meetings) meets with resistance because the people with whom you are trying to talk to about it are too busy. So, we don't have the time to devote. (*P21*)

Ineffective team meetings were discouraging:

> There was a lot of bickering rather than problem solving. It was more accusation than anything else. [. . .] The same thing just always seemed to be discussed and never a solution and a lot of blame. (*P6*)

Discussion

Several themes emerged that relate to how the teams functioned and to the factors that influenced effective teamwork in this primary care setting with responsibilities for both patient care and education. Three topics stand out that have relevance for teamwork and the introduction of interprofessional education in the practice setting. These are: (a) the dual goals of education and clinical care; (b) team membership; and (c) team functioning.

The DFM exists as a training practice and although all team members perceived clinical/patient care as a common goal/obligation, only some perceived education to be an obligation/goal. This discrepancy led to the perception of roles being compromised if clinical care was delayed as a result of competing obligations on faculty. Dual governance contributed to the issue as faculty members are university employees and other members are hospital employees. The strain on team function was expressed in the concerns about the care of patients and the perception that the hospital-imposed practices were not relevant to the practice setting and its dual mandate. Dual governance acts as a barrier to effective team functioning, confusing roles and accountability (D'Amour & Oandasan, 2005).

Determining whether a group constituted a team and its membership challenged some participants. The frequency of interaction seemed to be critical to determining team membership for transient members, although residents perceived themselves as members of the team despite the doubts of others. Lingard (2007), building on Engestrom and colleague's work (2003), examining collaboration by viewing the patient as a boundary object (i.e., the focus of interest that crosses boundaries between teams), proposes that researchers might view the learner as a boundary object. As education is increasingly dispersed into clinical settings, team investment in collaborators and learners may vary considerably, depending on how frequently the individuals come in contact, how often they change, as well as the effect of varying personalities. Bleakley (2002) has noted that unassertive learners may not be included in team discussions or be perceived as contributing members to the team. In an effort to understand learning in the workplace, Bleakley (2006) proposed that sociocultural learning theories might provide better frameworks to explain learning in clinical teams. Newer theories that view clinical teams as unstable complex systems in which ''new knowledge is produced and held collaboratively'' may be needed to understand the complex relationships needed for collaborative care and learning in these environments (Bleakley, 2006). The addition of interprofessional learners with different learning needs may add to confusion over goals and priorities. The development of Family Health Teams in Ontario has not yet led to a shared conception of interprofessional education (Soklaridis et al., 2007). We did not set out to explore these questions, but our data provide evidence that interprofessional education is a complex undertaking.

How learners fit into the team and the perceptions of the team on the roles of learners, teachers and health care providers may influence learning in this environment.

In a review of primary care teams, Xyrichis and Lowton (2008) identified that both team structure and team processes affect interprofessional teamwork. The distinction between interprofessional teams and ''uniprofessional'' teams was highlighted by the nurses. They indicated that as a nursing team they supported one another in their roles across clinical teams. Identity with like professionals continues to challenge the elimination of silos in health professional education. The reason for the nonattendance of allied health professionals in the focus groups in our study is unknown. We speculate that they were not perceived as team members or did not perceive themselves as team members. An observational study following patients to determine how the professionals interact might clarify the roles of allied health professionals in this setting (Engestrom, 2000).

The allied health professionals at the DFM might be considered members of a multidisciplinary team as defined by D'Amour and colleagues (2005). Interdisciplinary teams with a greater degree of interdependency, developing processes and plans collaboratively have been shown to improve certain patient outcomes (Grumbach & Bodenheimer, 2004; Triolo et al., 2002). Understanding how to effectively integrate allied health care professionals into the interdisciplinary team may present the greatest challenge in developing Family Health Teams.

Much of the literature on interprofessional education and interdisciplinary teamwork focuses attention on the professionals. We included the views of support staff who have clear opinions and important roles in the teams. Receptionists play a vital role as front line members of the primary care team affecting access to care, the approach to preventative practices and the success of research in primary care studies (Carnegie et al., 1996; Dixon et al., 2004; Eisner & Britten, 1999; Gallagher et al. 2001). The receptionists' concerns regarding access to care were important factors in their perception of team effectiveness. Secretaries played important roles in effective team communication in this setting.

Much of the discussion focused on team functioning, an area deemed fundamental to team effectiveness (Lemieux-Charles & MaGuire, 2006). Overall, team members valued teamwork and considered their team necessary to getting the work done. They also valued effective team work and described their teams in ways that suggested positive team functioning, for example the high level of comfort that existed between members, communication based on respect, members that pull together in time of greater work demands, a sense of fun, and the recognition of members and their contributions. They acknowledged that shared goals brought team members together.

The data also suggest that teams struggled. Some seemed unsure about what their colleagues did and linked this to infrequent interaction. Challenges were presented by: conflict with physician schedules; the layout of the building interfering with communication, the limited recognition of transient members such as floating nurses; and too little time to build teams. Our study was not designed as action research, yet some teams used the focus group as an opportunity to engage in team building, recognizing and valuing other team members, and suggesting improvements to team functioning.

D'Amour and Oandasan (2005) proposed that alignment between the system, organizational and the practice/interactional levels is essential to support effective teamwork. Laying this framework over our findings, participants often attributed barriers to effective teamwork to the system and organizational levels. The dual governance created conflicts on roles, goals and obligations. Power differences were attributed to the hierarchical organization of the hospital system with its policies lacking in relevance to the primary care setting and the traditional power held by physicians. Few barriers were described at the practice/interactional

level and only in general terms. Participants may have been reluctant to risk interpersonal relationships in the focus group setting by discussing conflict, feedback or decision-making.

Many of the guidelines for the development of interprofessional teams provided by the OMHLTC and the constructs of the Team Survey® tool are supported by the themes that emerged in this study. (Millward & Jeffries, 2001; OMHLTC, 2004). The Team Survey® tool likely influenced the focus group discussions leading to themes of communication, problem solving, support and recognition (Millward & Jeffries, 2001). The four dimensions of team processes in the Team Survey® align with our findings: well functioning teams pulled themselves together in a crisis, (team potency) supported new members (team identity), shared goals and recognized the roles of each member (shared mental models) while being flexible in adapting roles in stressful situations. Team goals and the potential tensions over the dual obligations would fit with the fourth construct of meta-cognition.

We did not measure whether the teams were effective and it is interesting to note that the teams generally viewed themselves as functioning well. No mention was made of audits or quality assurance indicators. Grumbach and Bodenheimer (2004) suggest that the use of audits may represent both a systems issue and a cultural shift for primary care teams. It is not clear whether the survey prompted thinking away from a discussion of quality assurance issues or whether this is a cultural issue.

Both the absence of certain issues deemed important by other investigators and the effect of the research to prompt team building in the focus groups suggest that the study of teams requires robust models that take into account complex adaptive systems (Miller et al. 2001). Bleakley (2006) suggests that predicting learning in these environments will need new models of learning that take into account distributed knowing, learning through time and space, and the complexity of the learning environment including relationships between persons and artifacts and building on complexity theory. In our study, the investigators were influenced by a number of concurrent events: the introduction of organizational changes, the shift to considering interprofessional education models and the search for a measurement tool that might reflect the understanding of teamwork in an academic setting. Further research is needed to determine how interprofessional teams can not only explain how they work collaboratively, but effectively include learners in their systems.

Limitations

The study took place in one academic setting and may not be representative of other primary health care environments. The size and organization of the group is larger than many primary care teams but similar to that proposed by the initiatives in Ontario for Family Health Teams (OMHLTC, 2004). Non-participants may have more negative views of their team and some participants might have withheld negative views to preserve their relationships with their teams. The strengths of natural focus groups are balanced by the limitations experienced in our data, such as gaps in statements due to poor recording, interruptions or too many people speaking at once, social visiting and straying from the topic. Furthermore, points that were accepted without question, not clarified or not developed limited our analysis. Methods of observation using cultural-historical activity theory linked to objective outcomes of team effectiveness might yield further valuable data.

Conclusion

Within the limitations of the data, our findings provide insight into the opportunities and challenges faced in developing effective primary care teams in an academic department of

family medicine. Cultural shifts in primary care that embrace all team members (i.e., professional and support staff) *and* learners will be important if interprofessional teamwork is to be modeled and learned in academic practice settings. Further research based on modern concepts of complex adaptive systems is needed to determine how best to support the changes needed to implement effective teamwork in primary care. This study provides some possible directions for research in how best to develop appropriate settings for interprofessional education.

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Appendix 1

Team and Teamwork

(1) Purpose, motivation, team goals: What the team is there to do. What the team is working for. What their priorities are. Who they serve. Why they do their work.
(2) Member roles: Accounts of the roles members have on the team. Not including strategies and barriers related to this.
(3) Power differences: Relating to some members being dependent on others. In other words, leadership or importance of some members over others.
(4) Team member inclusion\exclusion: Ways of defining who should or should not be a member of a team. Discussions about the artificiality of the existence of some teams.
(5) Team meetings: How often team meetings are usually held.
(6) Organization: How the hospital\department\setting influences or affects the team.
(7) Adjustment\problem-solving: The process of change or making changes within the team.

(8) Barriers: Explicit factors that inhibit the team from functioning optimally (excludes communication and role-related barriers).
  (8a) Role-related barriers.
  (8b) Communication barriers.
(9) Strategies: Explicit ways or things done which help improve or maintain team dynamics. Approaches taken for team-building (excludes communication and role-related strategies).
  (9a) Role-related strategies.
  (9b) Communication strategies.
(10) Teamwork process: What members get out of being on the team. How members experience membership of the team. What collaboration brings to them as individuals.
(11) Communication: How, what, why members communicate. Not including communication strategies and barriers.
(12) Recognition: Reflections on the accommodations team members make for each other. Recognizing how aspects of some members' jobs can be trying at times, but very helpful for the team in general.
(13) Support: How the team members support each other. Concepts of: comfort, fun, continuity, etc.

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