Power and conflict and the performance of medical action teams: a commentary

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In this issue of *Medical Education*, Janss *et al.*¹ address the need for medical team training and suggest that knowledge available from both social and organisational psychology might be used to guide the development of a training intervention. The differences in the interpersonal dynamics of ad hoc medical action teams are well described in this article, as are specific needs for the management of conflict and other issues that arise as a result of power struggles within these types of team. The authors¹ propose that using available theories from social and organisational psychology will allow the medical community to develop tools and methods with which to train ad hoc medical action teams in a manner that will improve team performance.

In reviewing the social and organisational psychology literature with reference to the types of conflict that exist (i.e. task, relationship and process conflict), Janss *et al.*¹ suggest that negative emotions arise more dramatically from relationship and process conflict rather than from conflict about tasks. However, in a recent study conducted in the setting of the operating room (OR), Rogers *et al.*² discovered that task conflict can transform into relationship conflict very easily. This suggests that the most appropriate management strategy for conflict in medical practice is one that assumes that all types of conflict will exist and should be managed actively.²,³ This then implies that conflict of any type should be addressed and that tools should be developed and conveyed in a way that will allow all members of the team to feel safe to openly communicate, especially with reference to issues of patient safety.³,⁴

The process of addressing the power struggles that exist in the medical culture will require a particular skill set. If all team members are not aware of each team member’s roles and abilities, it is difficult for the medical action team to coordinate effectively. If the leader does not understand and respect each team member’s contribution, it will be nearly impossible to effect permanent change. In particular, Rogers *et al.*³ suggest that an effective method of creating an environment in which surgical team members feel sufficiently safe to contribute starts with training the surgeon in leadership. The surgeon who can remain calm and demonstrate expert problem-solving skills and superior communication skills is one who can effectively manage conflict.

Since the highlighting of the importance of communication errors,⁵⁻⁷ a number of efforts have been directed toward ameliorating this problem. Perhaps most significant in North America is the collaboration between the US Department of Defense and the Agency for Healthcare Research and Quality to develop and implement the TeamSTEPPS® (strategies and tools to enhance performance and patient safety) curriculum, which was introduced in 2005. This curriculum includes a number of elements that are oriented toward improving team communication, coordination and adaptation. The competencies of TeamSTEPPS® are defined as leadership, situation awareness, mutual support and communication.⁸ This TeamSTEPPS® curriculum has been incorporated by many postgraduate training programmes as an adjunct to teaching the teamwork ethic to residents. TeamSTEPPS® has been taught successfully as early as in Year 4 of medical school. Its hypothesis is that if team training is initiated in medical school, it will help to prepare trainee doctors for their increasingly team-oriented future work environment.⁹

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As Janss et al. point out, debriefing may be one of the most useful and effective methods for managing team conflicts and power struggles. We know that structured debriefing after simulated trauma resuscitation is effective in improving team competencies and team function. It allows each member to discuss his or her roles and responsibilities in the ad hoc team and provides a safe forum for open discussion that might prevent unproductive future conflict. Overall, Janss et al. offer a more complete basis for developing future training programmes by their inclusion of theories from both social and organisational psychology. No matter how much theory is in place, we still need to generate a product that can be used in the clinical setting. Although it is very difficult to measure the effectiveness of any team-training programme, the important work in this regard will only be completed when we can demonstrate that improved team function results in improved patient outcomes.

**Structured debriefing after simulated trauma resuscitation is effective in improving team competencies and function**

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**REFERENCES**

Enculturation to medicine: power for teachers or empowering learners?

Jennifer Cleland & Peter Johnston

According to a classic formulation by Peacock, ‘culture… is a name anthropologists give to the taken-for-granted but powerfully influential understandings and codes that are learned and shared by members of a group’.1 The concept of culture has been, and continues to be, hotly debated by anthropologists, but is frequently understood to refer to the tacit knowledge or ‘webs of meaning’ through which people in specific social settings interpret their existence.2

Numerous studies have examined the ways in which medical students and doctors undergo processes of socialisation that promote particular norms and behaviours, thereby transforming students into experienced professionals.3 That enculturation is the outcome of social interactions is unarguable,4 but it is time to explore fully both the elements of the learning environment that contribute to enculturation and the impact of this process.

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In this issue of Medical Education, two papers explore enculturation into the medical profession of medical students and doctors. Phillips and Clarke gathered student views of negative role-modeling and the messages of the hidden curriculum in a Canadian medical school.5 They describe how students do not challenge discordant values and attitudes, sometimes absorb new messages and at other times are not swayed by them.5 A second paper, by Gordon et al., explores the process of enculturation after graduation in a diverse group of hospital doctors.6 The authors found that medical enculturation is achieved on a continuum, which plays out over time and is influenced by personal values, such as the desire for work–life balance.6

The two studies align broadly in terms of messages for medical education. They make explicit: (i) the importance of role-modelling in the professional enculturation of medical students and doctors, and (ii) the need to organise and support specific opportunities for learners at all career stages, and from different generations, to reflect on both positive and negative messages and experiences.

Phillips and Clarke’s study5 identified negative role-modelling and the communication of poor attitudes towards patient ‘shortcomings’, such as obesity, to students. Medical teachers and trainers are members of society and hence are likely to share, at least to some extent, the wider social, political and philosophical norms of that society, whether these are flawed or not. It does not seem unreasonable, however, to expect a degree of self-awareness and intentional role-modelling in medical educators,7 particularly given that the evidence suggests role-modelling is at...