

**Safety and Sanity**  
**in an**  
**Interdisciplinary Healthcare Team**

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Quality problems occur typically not because of a failure of goodwill, knowledge, effort, or resources devoted to health care, but because of fundamental shortcomings in the ways care is organized.

*Institute of Medicine, 2001*



## Abstract

If “health” is understood as “absence of disease,” then healthcare work is likely to be organized without strong collaboration. When professionals of various specialties work together, each will work on eliminating the diseases—or simple physical *differences*—that lie within his or her own professional purview. The systems that are created out of this understanding can have unexpected effects, including creating harm where only help was intended.

The World Health Organization defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” If we assume this broader, subjective understanding of health, then healthcare workers are likely to be organized in a very different way: as teams of professionals with complementary skills who incorporate the experience and perspectives of patients and work together to achieve a common purpose.

In this paper, I explore characteristics of a single interdisciplinary team that provides services for patients born with craniofacial conditions and their families. I conclude that psychological safety (the belief that the team is a safe environment for interpersonal risk-taking) is a requirement if the team is to collaborate to achieve a common goal: patient health in the sense of whole-life well-being.



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## Introduction

One evening when I was ten years old, my parents called me into their bedroom.

“Do you know why you went to the hospital and had [abdominal] surgery when you were eight? You were born with an *enlarged* clitoris. Doctors removed it when you were a baby. Do you have any questions?”

I didn't really know what a clitoris was, and their answer didn't make any sense. I didn't ask any other questions.

My parents never broached the subject again.

I now know that I was born with unusual sex anatomy, most obviously a dramatically large clitoris. If my family was like many families encountering this situation today, they must have felt confusion, fear, shame, and guilt. They sought the advice and care of experts in what is now known as disorders of sex development (DSD). Following common practice, these experts first looked for any threats to my physical health, and then they tried to eliminate the source of my family's distress.

From their point of view, as soon they made my genital appearance “normal” their job was over. For my family and for me, the real trauma was just beginning and took decades to play out.

What was done to me and my family was not a fluke or an error. It was common practice, rarely reflected upon until, in 1993, I became one of the first former patients to speak publicly about my experiences (Karkazis, 2008).

In 2006, fifty experts from around the world (including two patient advocates, of whom I was one) developed and published a formal consensus on improved care (Lee & Houk, 2006). An interdisciplinary team approach is a key element of the new consensus. Although it was

well received, no institution has yet implemented the new standard of care. As a result, I helped create Accord Alliance, a new organization which opened in March, to encourage and facilitate implementation of the comprehensive team-based care envisioned in the consensus (Accord Alliance, 2008).

Many of us who helped create the consensus believed only a high functioning team would be able to move beyond a reductionist focus on eliminating difference, recognizing that DSDs affect people in complex ways that require an attitude of humility and inquiry. Such a team would include patient and family, and would discover the challenges and problems actually experienced. It would creatively think together to come up with solutions that were not limited to surgery and which might include learning coping strategies for living with a sexual difference and any health problems arising from the underlying endocrine or genetic cause, rather than believing that genital surgery during infancy would eliminate all future problems. It would take a high functioning team environment to integrate hard technical skills such as surgery and endocrinology with specialties that are more subjective, reflective, and integrative, such as social work and pediatrics.

In this paper, I present a case study of a single interdisciplinary health care team. Because I wanted my research to avoid the distortions that might arise from my own complex reputation in the world of DSD, I chose to investigate a team that cares for families whose children were born with a congenital difference other than DSD. The team I chose provides services to families whose children were born with differences in their heads and faces known as craniofacial conditions. These differences are parallel in many ways to DSD: they are congenital (and typically unexpected); the powerful and challenging emotions they raise have a strong bearing on how well patients do; surgery is often involved; *some* of the decisions made on behalf of

children are cosmetic in nature, and they touch on issues of identity. The director of the team I investigated related how the face is connected to identity:

If I took a photo of your hand, and a photo of your shoulder, and a photo of your face, and I put them in front of you and I said “What are those,” you would say: “My hand, my shoulder. Me.” You would *not* say, “My face.”

The team I chose to investigate is one I became aware of several years ago, when I met some of their members whose thoughtfulness and ability to reflect impressed me. When I contacted a member of the team, she immediately expressed enthusiasm for my project. She was convinced her team was largely successful in holding a system perspective (“what problem is this causing”) rather than a reductionist perspective (“we have to fix this abnormality”). She shared my hope that my project would illuminate the unique factors that contribute to her team’s effectiveness, which might then be adapted to other settings, including disorders of sex development.

## Team Approach in Healthcare Today

Teams are recognized as a useful approach “when issues, needs, and problems are complex, chronic, and overlapping, and their resolution requires input from a variety of diverse perspectives” (Heinemann, 2002). The healthcare literature on teams is immense (Lemieux-Charles, 2006), and I found much of it to be filled with authoritative-sounding quantitative metrics and statistical analysis, but little understanding that the complexity of interpersonal dynamics is extremely context-dependent and not easily captured in quantitative measures.

Most of the more convincing work has examined environments involving high risk such as major surgery, and intensive care units. In a review article, Safran et al (2006) documented benefits of high-quality teamwork in these kinds of settings, including reduced mortality, improved functional health outcomes, shorter length of stay, improved workforce morale, and decreased turnover.

I was looking for a different kind of benefit: Authors (including myself) who contributed to the new consensus on improved care for DSD believed effective teamwork could help move a team’s attention from a narrow focus on pathophysiology and procedures to a broader understanding of whole-life well-being as the outcome of interest (Lee & Houk, 2006). Following the publication of the consensus, some groups of specialists who cared for children with DSD were calling themselves “teams” even though their level of collaboration was very low, and little change seemed to have occurred in their practice. Would I find the craniofacial team had a high level of team development? And if they did, would I also find a broad understanding of patient and family needs?

## What is a “Team?”

Katzenbach and Smith (1999) 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 hold themselves mutually responsible” (p. 45). In contrast, a *working group* relies “on the sum of individual contributions” (p. 85). They write:

By choosing the team path instead of the working group, people commit to take the risks of conflict, joint work-products, and collective action necessary to build a common purpose, set of goals, approach, and mutual accountability. People who call themselves teams but take no such risks are at best pseudo-teams. (Katzenbach & Smith, 1999, p. 85)

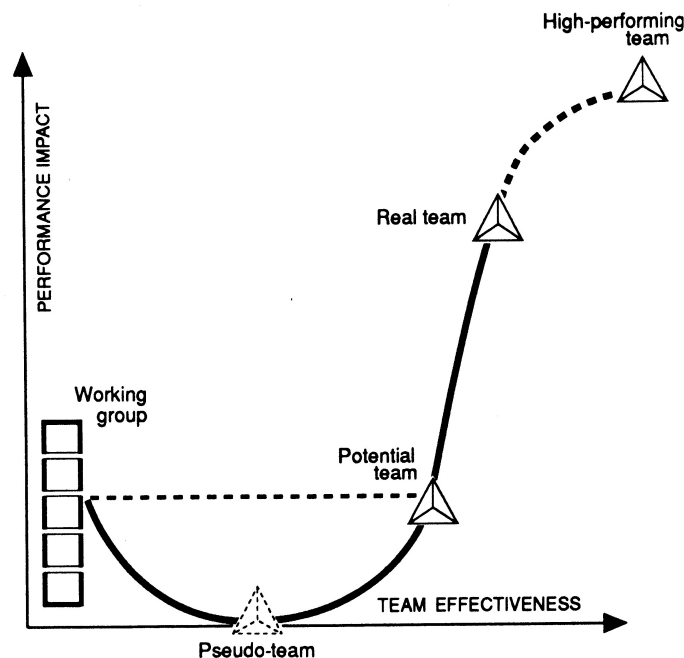


Figure 1. The Team Performance Curve (Katzenbach & Smith, 1999).

My interactions with professionals working to create DSD teams at several tertiary care institutions nationwide give the impression they better fit what Katzenbach and Smith call *working groups*, *pseudo-teams*, or *potential teams* than *real teams* or *high performing teams* (see Figure 1). Thus, they are not likely to realize improved performance without investing in greater team

development, and may even conclude (prematurely) that teams have a negative impact on performance.

## Methodology

I discussed my project with the team's director, and we agreed I would interview a subset of the team's 47 members (representing 19 disciplines). He encouraged his team members to meet with me and to be open and frank. With the help of one of the team's administrative program assistants, I scheduled hour-long interviews with twelve diverse team members, whose disciplines included surgery, pediatrics, nutrition, social work, speech pathology, and administrative assistantance. I interviewed individuals with and without MDs; members of short and of long tenure; members who exhibited an ease and willingness to reflect on the functioning of their team, and one who did not.

I arrived on Monday, and at the director's invitation, I observed the weekly team conference at 8:00 AM. He introduced me at the end of the conference, to avoid the possibility that awareness of an observer would alter the dynamics.<sup>1</sup> I then observed their weekly all day clinic, during which 68 patients and their families had over 200 appointments. I had clearance to view patient information, but I did not interact with patients or family members.

On Tuesday, I observed the weekly "staff meeting," in the team's own offices. At this meeting a subset of the non-MD staff discuss and problem-solve patient care issues, system issues such as patient and work flow during the clinic, interactions with other parts of the hospital system, compliance, and other topics.

Finally, the team dedicated their small library / conference room for my exclusive use, and I completed eleven interviews. I conducted these interviews in private, and I received written

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<sup>1</sup> In medicine, it is usual for such a team conference (also called a case conference) to be an open event, normally attended by quite a few outsiders, who are not individually recognized or introduced. Such was the case here. As a result, no one seemed to take note of my presence or wonder who I was until the director introduced me at the end of the conference.

permission to tape record and to use transcribed quotes. As I spoke with each interviewee, I referred to a short list of open-ended questions (using the list loosely, as a source of inspiration, rather than as a formula or protocol), and I took handwritten notes. See the list of questions in Appendix B: Interview Guide.



I transferred the audio to a computer, where I listened again carefully, and I transcribed portions. I worked with these partial transcripts and with my handwritten notes to create broad themes. Based on theme coherence, inter-relatedness, and discussion by most or all interview subjects, I selected the following themes related for analysis and discussion.

- Holistic perspective of patient and family
- Patient and parent involvement in decision-making
- Pediatric leadership
- Working together: conflict, competition
- Safety supports broad participation
- Sharing office space: “We got married!”

## Validity and Limitations

This is a case study of a single team. It's difficult to know how applicable my findings are to other teams. I spoke with only a minority of the team's members, and I did not speak with patients or families, nor with other stakeholders, such as hospital administrators, home departments of team members, payers, or regulators.

The people I interviewed work together. It is possible they allowed concern for their relationships with other team members to influence what they said. It is possible some may have withheld information from me that might reflect negatively on their team or their institution.

It is also possible the way I selected a group of team members to interview introduced bias. I spoke with the team's director and with one of the team's social workers, soliciting their opinions about whom I ought to interview, but I was given freedom to choose whomever I liked. The director suggested very diverse team members, and he strongly recommended I include the administrative program assistant. I was impressed he did not focus strongly on surgeons, or even on MDs. I was also impressed that one of the people he did recommend to me was a person who found my questions very difficult to understand or to respond to. Because he had recommended such a person for me to interview, I got the impression that the director was not trying to hide anything from me.

I developed feelings of admiration and affection for the team and its members, and felt an awareness, as I was writing of concern for how they would understand what I wrote. This may have caused me to focus more on positive than on negative findings and conclusions.

I have strong feelings about the working of healthcare systems, growing out of my personal experiences as a patient and as an advocate of change. I am a well-known and somewhat controversial figure in the world of DSD care.

I strove to minimize or contain these sources of potential bias:

- I investigated a field, craniofacial conditions, with which I have no prior personal experience, and where I am not known.
- I used open-ended interview questions.
- I provided an autobiographical sketch, to help the reader assess sources of bias.

I believe that what I have learned is useful and can serve as a source of inspiration for change in other interdisciplinary team settings; the reader may take into account these potential sources of bias in interpreting this study.

## Findings

### **Holistic perspective of patient and family**

The craniofacial team does indeed work hard to understand the needs of patients and families in a very broad sense. With each person, I mentioned that craniofacial conditions affect the patient's and family's life in many ways, and asked what part of that entire experience the team takes responsibility for. Every single member responded, "all of it." When I asked for clarification, they named educating the family, providing social support, advocating with social agencies, many logistical issues including finances and transportation and childcare for siblings, and providing the physical care that is needed. They emphasized that, because the needs for care are complex, it is their duty to schedule visits, investigations, and interventions in a way that minimizes the requirements for travel and disruption of the family's schedule.

Two of the team members were born with craniofacial conditions; one received some of her care from the team of which she is now a member, and her mother was an active participant in the team as a parent advocate. I suspect that having peer relations with adults who have experienced craniofacial conditions and their care may heighten the team's awareness of patients and families as "whole people," and of the goal of "a quality of life as close to equal to their normal peers as possible," but I did not develop this as a theme because it was mentioned by only one interviewee.

Surgeries can come to have a logic of their own, and genital surgeries are often justified simply because the anatomy is atypical. This team believes that it should make decisions about surgery based on functional goals, such as maximizing speech by kindergarten.

### **Patient and parent involvement in decision-making**

The team thinks of the family as members of the team. And, as the child grows up, they work to empower him or her to participate in decision-making.

About age 9, 8 or 9, depending on the kid, I start involving them in decision-making. I'll tell children, "You know what happens when you get to be about this age? What happens is that what *you* want is now more important than what your parents want."

Surgeries whose goal is to improve speech are evaluated by the speech pathologist rather than by the surgeon. At the same time, the team is aware that the patient or the family should decide whether or not the speech difference calls for surgery. A speech pathologist said, "When I say 'improve' I really mean based on the patient's perspective ... and not always "because I said" there's a speech problem."

### **Pediatric leadership**

The team's director is a pediatrician, and each family's case manager is a pediatrician. This contrasts with most craniofacial teams, which are led by surgeons. Team members explained this leads to better integration of care, because the nature of pediatrics as a discipline is to "put the child's development as a priority."

Surgeons take pleasure in exercising their technical skills, which may bias decisions in favor of surgery. With pediatric rather than surgical leadership, "It's about the whole child, the whole family really, versus focusing on a very specific procedure."

**Working together: conflict, competition**

In craniofacial care, surgical specialties overlap. Pediatric leadership helps reduce conflict that can arise from competition between surgical specialties. Because it would seem that this configuration would reduce surgeons' status, I was surprised that every surgeon mentioned pediatric leadership as one of the things they found particularly appealing about this team. They explained that turf conflict is minimized: the director cannot be suspected of supporting a decision because it will send work his way, and no surgeon can use a position of authority to support his case when there is a difference of opinion. Team members must instead share their reasoning, and decisions are usually made by consensus.

**Safety supports broad participation**

Members of the team feel able to participate freely in discussions and problem-solving. They don't feel constrained by status differences, or by concern that they will be made to feel wrong or foolish, or that they will be ignored. They feel able to speak even about patients who are not "their" patients.

I heard that the structure of case conferences, where they work together to understand and craft a plan for patients, and where decisions are made in the open and by consensus, contributes to this atmosphere of safety. Members emphasized the culture of open discussion and the value of bringing multiple perspectives to decision-making.

Psychological safety is by no means the norm in healthcare settings, where status differences based on discipline are frequent, with surgeons at the top of the hierarchy, generalists near the bottom, and professionals whose credentials don't include "MD" may even be required to

speak last, or sit against the wall rather than at a table.<sup>2</sup> Such status differences are minimized in this team, and members were aware that this sense of safety differentiated them from many other craniofacial teams. One pediatrician recalled that during her training “residents [were] terrified to speak in front of the attending surgeon.”

New members who join the team must be acculturated into this way of working together. One professional (without an MD credential) told me, “Even when I first started here, it was a little odd to just start talking in a meeting and not have your name called before you started talking.” This acculturation occurs by absorbing group norms, and sometimes through coaching by the leader.

### **Sharing office space: “We got married!”**

The team uses a wide variety of techniques to communicate with each other, including formal meetings, spontaneous and informal discussions during clinic and in their shared office suite, email, telephone, paper forms, reports, databases, and an electronic system for organizing their busy clinic days.

Two years ago most of the team moved into a shared suite of offices. Members of the team were enthusiastic about sharing space. “We got married!” one person told me.

This is surprisingly unusual in healthcare settings. “If you’re a medical person it is kind of odd, because usually [the] worlds [of surgery and medicine] are very very separate.” The director was delighted at the difference shared office space had made. “If I pick up a phone, I’m not a person. It’s very different when [we are] right physically here.” Another recalled that in his former team, the occasional team meeting was the only time that information was shared.

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<sup>2</sup> See, for example, Cashman (2004).

This team, in contrast, schedules only the most difficult discussions for team meetings, and “most discussions end up getting taken care of outside of that official team room.” Close proximity allows team members to put their heads together when an idea strikes them, without having to schedule a meeting “at the other end of the hospital or maybe even in another building.”



## Discussion

As I had hoped, I discovered that the craniofacial team takes a broad and subjective view of what patients and families need. They strive to focus on the actual challenges faced by each unique family, thinking of patients and families as having complex needs that evolve over time and can't be eliminated by surgery.

What allows the craniofacial team to work in this way? They are "equally committed to a common purpose, goals, and working approach for which they hold themselves mutually accountable" (Katzenbach & Smith, 1994).

The literature on teams shows that working in a real team requires individuals to take risks. Their fate is no longer in their own hands: the group makes decisions, and they will be accountable for the team's performance as a group. Furthermore, a real team requires significant investment in interpersonal process. Teams are able to improve only if they can obtain and process relevant data. Much of the data can only be obtained through "learning behaviors" such as sharing information, articulating differing opinions, asking for help or feedback, talking about errors and accidents, and experimenting. It is through these behaviors that a team can improve their collective understanding of a situation, or discover unintended consequences of their actions (Edmondson, 1999; Senge, 1990).

These behaviors entail risks such as loss of face and more concrete losses such as promotions, pay, and work assignments. The feeling of threat these behaviors evoke is specific to the group context, not solely to the individual: the culture of the group molds tacit individual beliefs about risk. When people expect these risky behaviors may be punished, they limit their behavior in a way that inhibits learning (Edmondson, 1999; Senge, 1990).

A belief that the team is a safe environment for interpersonal risk-taking is called psychological safety. This is quite distinct from team cohesiveness, or “getting along” (which can actually result from careful avoidance of risk and conflict). Psychological safety allows disagreement to be voiced. Divergent ideas—if they generate communication among colleagues—support the development of shared cognition (Van den Bossche et al, 2006), allowing the group to act in coordinated fashion, because they are all working to solve the same problem. Disagreement and conflict thus become sources of productive creativity.

Among members of the craniofacial team, I discovered a high level of psychological safety, and an awareness and pride that the team is unique in this way. The team creates and maintains this environment in several ways. The configuration of the team—with a pediatrician as team leader and pediatricians as family case managers—helps circumvent surgical competition and “turf wars” while supporting an integrated understanding of the goal of patient and family well-being.

Psychological safety is also supported culturally, through the action of established group norms (Schein, 1985). New team members learn from the weekly case conference that it’s OK to voice differing opinions, that “baring your soul” is the norm, that status differences don’t inhibit participation as they do in many other medical venues, that you can speak “out of turn” and that you can speak even if the patient isn’t “yours.” Making “fiery” decisions in the presence of the entire team at the weekly case conference helps reduce destructive surgical competition. The leader also exercises his influence to build psychological safety, coaching members as needed.

The team’s innovation of moving into shared office space supports a greater level of face-to-face communication by lowering the transaction cost. Face to face conversation is richer than

any other medium: it provides the cues of body language and tone of voice as well as immediate feedback. It is the medium of choice when communication is emotional, ambiguous, or equivocal.

We can infer a reinforcing loop, in which psychological safety permits team members to engage in risky learning behaviors, which in turn supports team learning, increasing the quality of decisions and thus team effectiveness, which increases self confidence, so psychological safety is reinforced (see Figure 2). This reinforcing loop acts in a context in which cultural norms, leader coaching, and pediatric leadership work together to support psychological safety.

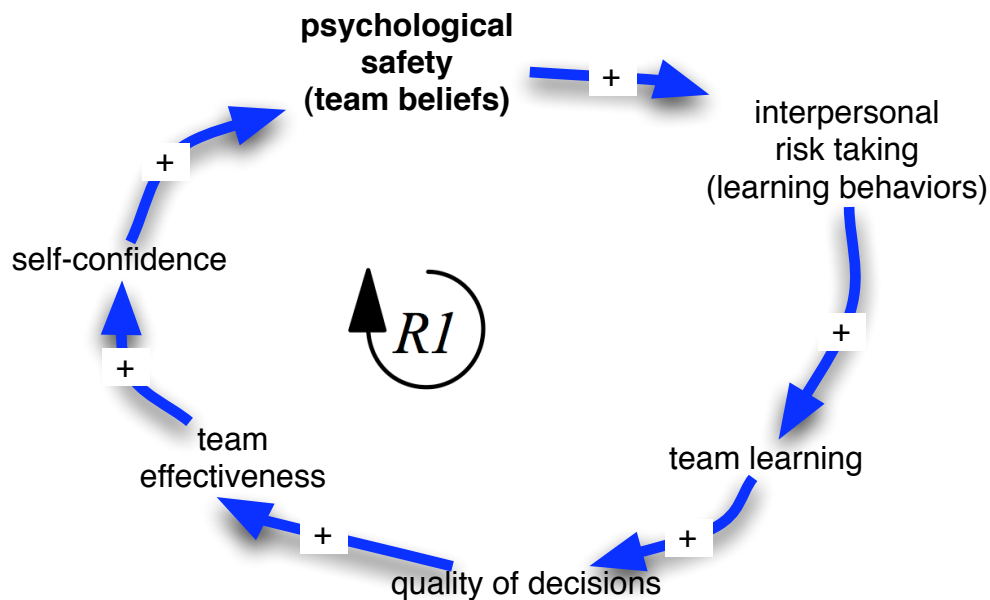


Figure 2. Causal Loop Diagram

How did this unusual system come into being in the first place? The director told me that an element of “magic” was involved. It seems that there is a certain aspect of “unconscious

competence” at work in the craniofacial team. Perhaps the cultural norms and work design create a self-organizing system that is dynamically stable.

## Implications

The culture of medicine derives from a rich tradition centered on the responsibility and achievement of the individual practitioner. Issues that extend beyond an individual practitioner's expertise are typically addressed by referral or consultation rather than through collaboration. Payment is based on interventions, not on time invested in team development or decision-making. This is a challenging environment in which to try to implement effective teams. Psychological safety is not a characteristic of an individual; it is an emergent property of a social system.

I believe that improvements in care and outcomes for DSD will come only if DSD healthcare teams can develop richer connections, relationships, and capacity for learning. What I've learned from the craniofacial team can provide inspiration and guidance for professionals working to improve DSD care.

## Conclusion

Medicine wasn't a safe place for me as a patient. Smart people were hampered—by deeply ingrained disciplinary assumptions, by inflexible work system designs, and by their personal biases—in ways that made it impossible to see what needs my family and I actually had, or how their interventions would actually affect us. They made decisions that violate common sense; that seem to me simply insane.

I've now come to understand that making sane decisions about patient care depends critically upon the psychological safety that healthcare professionals experience in their own work settings. Ironically, the harsh criticism of their practices and thinking which I helped to foment may have made it more difficult for professionals to change. I believe that improvements in DSD care are likely to result, not from debates about procedures and measurements, nor from any "evidence" to be obtained by studying patients or even provider-patient relationships, but by focusing first on improving the relationships among providers.

What's needed is cultural change, more than advances in diagnosis or surgical technique. Cultural change is unlikely to result from outside demands for change, or even from mandates from above. Rather, it is likely to arise as individual professionals embrace the vision of a new way to approach their work, and champion it within their own organizations. Carroll and Quijada (2004) describe Schein's paradigm of "cultural tilt" strategy (1992), in which the strengths of the existing culture are drawn upon and reframed to support new behaviors. Over time, if the new behaviors produce more satisfying results, the underlying cultural assumptions can be gradually shifted (see Figure 3).

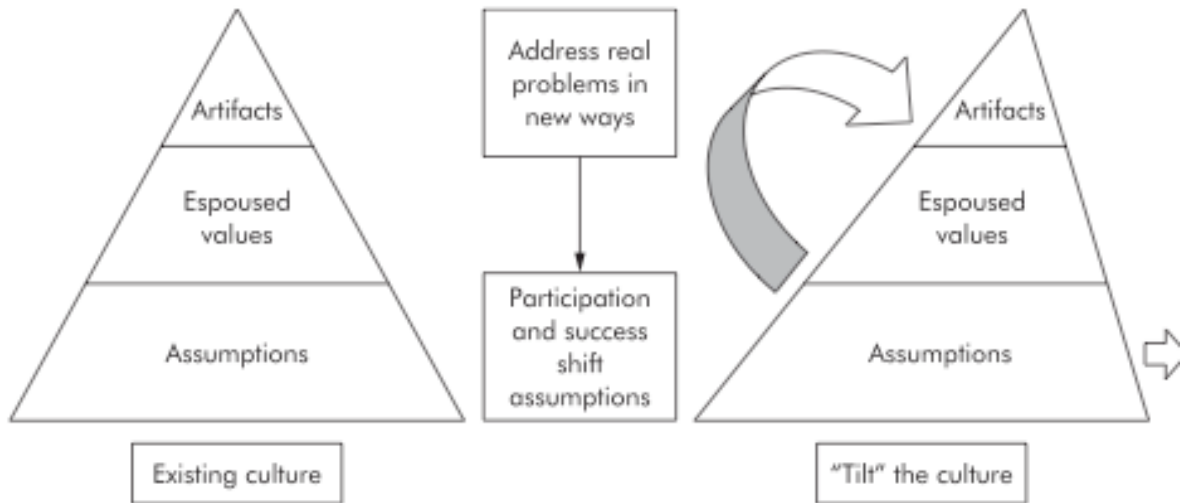


Figure 3. Culture change by “tilting” the culture (Carroll & Quijada, 2004 p.ii 17)

The future I now see for improved DSD care is one in which we at Accord Alliance articulate our vision of collaborative care and partner with those care teams who are eager to work with us. We plan to provide hands-on assistance for gradual cultural innovation. We also plan to act as a convener, creating connections between and amongst organizations and individuals engaged in change. Each institution is unique, but parties engaged in cultural change can benefit from sharing their learning, as well as new resources (patient education materials, justifications for investment in team development, outcomes research, etc.).

If we are successful, our model and our lessons learned are likely to be useful for any chronic condition with complex and evolving needs.

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## Appendixes

### A. Interview Guide

- How long have you been part of the team?
- What is your role in the team?
- What is your team's mission?
- How do craniofacial anomalies affect the child's and family's well-being?
- How do you understand what services will be helpful?
- What information do you rely on when considering what services will be helpful?
- How do you decide what services will be provided?
- Tell me about some times when there have been differences of opinion.
- How do you evaluate the outcomes of services provided?
- Do you depend on other members of the team in your work?
- How is your team different?
- Tell me about a time when you and your colleagues worked well together as a team, a story of good teamwork. What factors do you think helped you to perform well as a team in that instance?
- Tell me about a time when you and your colleagues worked poorly together as a team, a story of poor teamwork. What factors do you think contributed to performing poorly as a team in that instance?
- How is your team different when a member is absent? For instance, Carrie is absent this week.

## B. Interview Release Form

Dear Research Participant,

Your participation in this project is greatly appreciated. The purpose of this study is to produce a case study examining the functioning of a single interdisciplinary healthcare team. I am interested in the influence of team functioning on goals of service. I am excited by this topic and hope you will find our conversation useful, thought provoking and enjoyable.

With your permission, I will tape record our interview. If we speak by telephone I will use a digital telephony technique to record our conversation. I may also take notes. At the end of the interview, I will make sure to ask you if there was sensitive information you shared that you prefer not be included in my paper. Should you wish to not have your name and/or organization identified, I will assure your confidentiality.

Your participation is completely voluntary. You may ask any questions regarding the research and they will be answered fully. You may withdraw from the study at any time.

**If you agree to participate**, please complete the following:

I, (print your name legibly) \_\_\_\_\_, have heard and read the purpose of this study. Any questions I had have been answered to my satisfaction. I understand my right to withdraw my consent to participate at any time.

I hereby freely give my consent to participate in these aspects of the research project:

- Yes  No:          Permission to use my name and/or organization  
 Yes  No:          Recorded interview

NAME (Signature): \_\_\_\_\_ DATE: \_\_\_\_\_

Please feel free to contact me if you have any further ideas or concerns about the project. If you would like me to send you a copy of my final paper please indicate your request in the box below and provide an address or email for me to do so.

- Yes  No:          I wish to receive a copy of the final paper  
 Please send to the following address:

Thank you again for your participation,

Bo Laurent, Sonoma State University Organization Development MA candidate