PERGAMON

Social Science & Medicine 50 (2000) 1403–1414

SOCIAL SCIENCE & MEDICINE

www.elsevier.com/locate/socscimed

Workforce diversity: implications for the effectiveness of health care delivery teams

Janice L. Dreachslin[a,*], Portia L. Hunt[b], Elaine Sprainer[a]

[a]*The Pennsylvania State University, Malvern, PA, USA*
[b]*Temple University, Philadelphia, PA, USA*

Abstract

This paper examines the implications of racial diversity for the self-perceived communication effectiveness of nursing care teams. An RN leads the nursing care team (NCT) and delivers care in collaboration with two or more nonlicensed caregivers. Overlap is intentionally designed into the roles of NCT members and the range of duties the team performs is generally expanded to include functions previously performed by personnel from centralized departments. NCTs are highly reliant on mutual respect and effective communication among team members. Team conflict and miscommunication can be exacerbated by the strong correlation between role on the nursing care team (NCT) and race. Verbatim transcripts of fourteen focus groups from two study hospitals were used to develop a grounded theory of the role that race plays in the self-perceived communication effectiveness of nursing care teams. Two themes that emerged from the focus group discussions constitute the overarching framework within which racially diverse team members evaluate team communication effectiveness: different perspectives and alternative realities. Three additional themes, social isolation, selective perception and stereotypes, that serve as reinforcing factors were also identified, i.e., these factors deepen the conflict and dissatisfaction with team communication that occurs as a natural consequence of the overarching framework of different perspectives and alternative realities. Leadership emerged as a powerful mitigating factor in the model of how race influences the self-perceived communication effectiveness of nursing care teams. Leaders who can transcend racial identity as evidenced by the ability to validate alternative realities and appreciate different perspectives appear to moderate the potential negative effects of racial diversity on team communication processes and strengthen the positive aspects of diversity.

Keywords: Nursing care teams; Self-directed work teams; Communication; Racial diversity

Introduction

As the racial and ethnic diversity of the population in the United States, Britain and other Western industrialized countries increases and social attitudes toward cultural diversity evolve from an assimilation model to one of valuing differences, enhanced attention is being directed at the role that workforce diversity plays in

* Corresponding author. Penn State Great Valley School of Graduate Professional Studies, 30 E. Swedesford Road, Malvern, PA 19355, USA. Tel.: +1-610-648-3269; fax: +1-610-889-1334.

E-mail address: jld13@psu.edu (J.L. Dreachslin).

0277-9536/00/$ - see front matter
PII: S0277-9536(99)00396-2

team processes for clinical decision making and health care delivery as well as in perpetuating or addressing well-documented disparities in access to care and patient outcomes (Perkins, 1993; Watson, 1994; Benzeval et al., 1995; Bollini and Siem, 1995; Dreachslin, 1996). Although the staff of health services organizations is characterized by racial and ethnic diversity, people of color predominate in low status and low salary service roles, while whites are concentrated in professional roles that offer higher status and compensation (Dreachslin, 1996). For example, US Bureau of Labor Statistics data reveal that, while 16% of hospital employees are black, blacks constitute only 8% of registered nurses but about 33% of nurses aides, attendants and orderlies. The situation is similar in Britain's National Health Service (Beishon et al., 1995). Frank Dobson, Secretary of State for Health, described the situation in the NHS as follows at the October 1997 launch of the NHS Leadership Challenge at the King's Fund headquarters: "The National Health Service would not function without the work of black and Asian staff. But they are not being treated fairly. Black staff are concentrated in lower levels of nursing and ancillary staff. Although there are a lot of Asian doctors few of them are in senior positions. This is wrong." The increasing significance of pervasive occupational stratification by race for the effectiveness of health care delivery teams is driven by two parallel trends.

The first trend is the population's increasing racial and ethnic diversity. Late in the twenty-first century, whites are projected to be a plurality not a majority of the United States' population. (Edmonston and Passel, 1994) Demographic trends are similar, although less pronounced, in Britain (Gillespie, 1993) where the National Health Service (NHS) is the nation's leading employer of people of color (Kline, 1994).

The second trend is health services organizations' increasing reliance on teams for the delivery of bedside nursing and personal care services to patients. Over half of hospitals in the United States are implementing team delivery of bedside care (Scherer, 1994a, 1994b) and the British NHS has implemented government-sponsored pilots of team-based bedside nursing care delivery (Hurst, 1996; Newman, 1997). In Britain, the current focus on primary care and disease prevention has contributed to a renewed emphasis on the team approach to health care delivery as well. (NHS Management Executive, 1993).

Nursing care teams (NCTs) constitute self-directed work teams, defined by Katzenbach and Smith (1993, p. 112) as "a small number of people with complementary skills who are committed to a common purpose, set of performance goals and approach for which they hold themselves mutually accountable". An RN leads the nursing care team and delivers care in collaboration with two or more nonlicensed caregivers. Overlap is intentionally designed into the roles of NCT members and the range of duties the team performs is generally expanded to include functions previously performed by personnel from centralized departments.

A significant body of research, reviewed in the next section of this paper, supports the proposition that team conflict and miscommunication can be exacerbated by the strong correlation between role on the nursing care team (NCT) and race. Conflicts that are framed as due exclusively to role status differences by one team member may very well be perceived as a racial conflict by another team member. These and other differences in perspective, if not reconciled, can interfere with the healthy expression and resolution of team conflict, contribute to pervasive miscommunication and consequently diminish team effectiveness in racially diverse NCTs.

Effective communication, widely recognized as key to high performing teams, occurs when sender and receiver share a common interpretation of the communication exchange, i.e., when the intended message and the received message are compatible. Effective communication is perhaps best viewed as an integrating mechanism (Maznevski, 1994) that unifies racially and ethnically diverse groups and, thereby, enables teamwork. Although communication as an integrating mechanism appears to be central to well-functioning racially and ethnically diverse teams, the process of communication in racially and ethnically diverse teams has not been the focus of group or team research. (Maznevski, 1994).

This paper address the gap in the literature identified by Maznevski (1994). Part of a larger qualitative research project to analyze the implications of team communication patterns and group composition for patient-centered care team effectiveness, this paper examines in detail the ramifications of racial diversity for the self-perceived effectiveness of communication in nursing care teams. Although multiple dimensions of diversity including gender, religion, age and sexual orientation were explored in the larger project, special emphasis was given to race due to its demographic and social significance. The project's database, consisting of verbatim transcripts of fourteen focus groups from two study hospitals, was used to develop a grounded theory of the role that race plays in the self-perceived communication effectiveness of nursing care teams.

Related literature

Diversity and group performance

Theory and empirical research support the con-

clusion that organizational diversity has the potential to result in both positive and negative outcomes. Williams and O'Reilly (1998, p. 120) systematically reviewed forty years of empirical research on organizational demography and diversity in organizations and work groups and summarize their findings as follows: "Consistent with social categorization and similarity/attraction theories, the preponderance of empirical evidence suggests that diversity is most likely to impede group functioning. Unless steps are taken to actively counteract these effects, the evidence suggests that, by itself, diversity is more likely to have negative than positive effects on group performance". A review of findings from empirical research studies that are relevant to the present investigation of the relationship between race and the self-perceived communication effectiveness in nursing care teams follows.

Based on their study of problem solving groups in an academic setting, Watson et al. (1993), conclude that, although diverse groups take longer to coalesce, their long term process and task effectiveness is not significantly different from that of racially and ethnically homogeneous groups. Heterogeneous groups in fact scored higher than homogeneous groups on two task measures in the study.

In McLeod and Lobel's (1992) comparative study of ideas generated by ethnically diverse and homogenous groups on a brainstorming task, diverse groups were found to generate higher quality ideas. On the other hand, Watson and Kumar (1992) found that racially and ethnically diverse groups experienced more conflict in group process that served to impede problem solving. Culturally diverse groups scored lower on all three factors that would facilitate group performance: communication and participation, expectation and integration and cohesiveness. In addition, the diverse groups score higher than homogeneous groups on the factor that would impede group performance: fight or flight. Watson and Kumar (1992, p. 61) conclude that, "Although culturally diverse groups have the potential to generate a greater variety of ideas and other resources than culturally homogeneous groups, they need to overcome some of the group interaction problems that make group functioning more difficult. To be effective, any work group needs to perceive, interpret and evaluate situations in ways that are comprehensible to all member and then agree on best decisions." Hoffman (1985) and Pelled et al. (1997) also found a significant association between diversity, group conflict and communication difficulties, with more diverse groups experiencing more conflict and miscommunication.

Milliken and Martins (1996), based on a review of recent management research on diversity, conclude that diverse groups have lower member satisfaction and higher turnover. Furthermore, group members who differ from the group leader on significant dimensions of diversity tend to receive lower performance evaluations. Baugh and Graen's research (1997) supports the contention that racially and ethnically homogeneous teams rate their own performance higher than do members of diverse teams. However, no difference in the ratings assigned to the performance of diverse and homogeneous groups by external evaluators was found in the study.

Mayo et al. (1996) report that group leaders' assessment of their own efficacy is lower for leaders of diverse groups than for leaders of homogeneous work groups. The practical significance of this finding is explained by the researchers as follows (1996, 279–80): "Research has shown that people who are low in self efficacy are less likely to take action to solve problems, feel that they have less control over the situation and believe they have less capacity to cope and be effective. ...The negative impressions and expectations of leaders of heterogeneous groups may become self fulfilling prophecies."

A related finding of the same study was that leaders of diverse groups also rate the group's performance lower than do leaders of homogeneous groups (Mayo et al., 1996). As the researchers (1996, 278) explain, "While the underlying logic was not studied explicitly, it is proposed that dissimilarity in demographic attributes such as sex, race and tenure decreases attraction and increases the potential for interpersonal conflict, misunderstandings and lack of trust. These negative processes are likely to reduce group performance outcomes. It could also be possible, however, that leaders' low evaluations of group performance reflect leaders' perceptual biases to see more negative performance in heterogeneous groups than homogeneous groups."

In one of the few studies of teams in a healthcare setting, Alexander et al. (1996) also conclude that team heterogeneity is associated with lower self-evaluations of team functioning. The researchers studied tenure, age, occupation and gender but not race due to confidentiality concerns expressed by labor union officials that represented many of the staff in the studied organization.

Maznevski (1994, p. 537), based on a review of the literature, observes that, "the common element in high performing groups with high member diversity is integration of that diversity. In all of these studies, diversity led to higher performance only when members were able to understand each other, combine and build on each others' ideas." Maznevski (1994) contends that effective communication serves as the integrative mechanism in diverse groups. Similarly, Williams and O'Reilly (1998), based on their comprehensive review of forty years of research into demography and diversity in organizations, conclude that it is crucial that organizations develop management interventions to

emphasize the positive aspects of diversity and moderate the potential negative effects of diversity. Maznevski (1994, p. 534) concludes that:

> The inevitability of diversity has only recently become apparent and simultaneously the synergistic potential of diversity has been recognized. To enable management teams to use their diversity productively, it is crucial that integration now be examined closely. ...One process... is an absolute prerequisite for integration: effective communication. The successful transmission of meaning as it was intended from each person to the other in the group is essential for any integration to take place. Unless group members are aware of and understand the different elements they have, they cannot combine the elements effectively.

Characteristics of high performing self-directed work teams

Cohen and Bailey (1997) in a comprehensive review of literature on team effectiveness research conclude that evidence supports the following with respect to self-directed work teams such as NCTs:

- Substantive participation in decision making improves team outcomes
- Cohesive teams are better performers
- Team autonomy results in higher performance
- Teams that collaborate and resolve conflict increase member satisfaction.

As the literature on diversity and team performance reviewed above indicates, high achievement on Cohen and Bailey's (1997) four team process indicators will be relatively more challenging for racially and ethnically diverse teams than for homogeneous ones. Cott's (1997) study of the structure of teams in a long term care facility in Metropolitan Toronto further highlights the challenges to high performance on Cohen and Bailey's (1997) four team process indicators that NCTs in traditionally hierarchical health services organizations will likely experience. Cott's (1997) analysis supports the conclusion that nursing teams involved in task oriented work, such as NCTs, continue to have a mechanistic and hierarchical structure for decision making and, consequently, such teams would tend not to reflect the four characteristics of high performing self-directed work teams identified by Cohen and Bailey (1997). Cott (1997, p. 1420) concludes that, "there is evidence of teamwork occurring within multidisciplinary long-term care teams, but the type of teamwork differs for different staff groups. The collaborative teamwork described in the literature is limited to the higher status professionals. The lower status staff are also involved in teamwork, but it is teamwork consisting of assisting each other with work tasks. The structure of the team acts to reproduce and perpetuate control of the division of labour within health care teams."

A review of the literature uncovered relatively few studies that evaluated the process and task effectiveness of NCTs specifically and the findings are somewhat inconsistent. However, results that have been reported in health services journals by early adopters of NCT redesign generally indicate that RN resistance and the need for training in leadership and interpersonal communication skills are often underestimated and costly side effects of NCT restructuring (Eubanks, 1991; Bernd, 1992; Borzo, 1992; Brider, 1992; Farris, 1993; Abts et al., 1994; Bernd and Reed, 1994; Bethel and Ridder, 1994; Bickler, 1994; Boston and Vestal, 1994; Clouten and Weber, 1994; Murphy, 1994; Murphy et al., 1994; Scherer, 1994a, 1994b; Tidikis and Strasen, 1994; Kirkhart, 1995).

Summary and implications

The literature reviewed above supports two seemingly contradictory propositions. The first proposition is that racial and ethnic diversity has the theoretical potential to enhance NCT performance. The second proposition is that, in practice, communication processes in racially and ethnically diverse teams are likely to interfere with the team's ability to tap the inherent potential in their diversity and will likely increase conflict, reduce self-efficacy and lower team performance.

This study addresses the gaps in the literature identified above by its focus on team members' perceptions of communication processes in racially and ethnically diverse nursing care teams. The study design is framed by Weber's definition of sociology (Mazlish, 1989, p. 231) as "a science concerning itself with the interpretive understanding of social action and thereby with a causal explanation of its course and consequence" and is rooted in the derived etic approach to epistemology as described by Ting-Tooney and Chung (1996). The derived etic approach focuses on the formulation of overarching common theoretical frameworks that can explain emic or culture-specific communication processes, including the process of cross-cultural communication. The use of focus groups as the data collection mechanism follows Ting-Tooney and Chung's (1996, p. 257) counsel that, "Intensive focus group interview method and ethnographic observation method can help us generated derived etic concepts of interpersonal relationship development". Study methods are detailed in the next section.

Description of methods

A focus group is a structured and expertly facilitated discussion by a small and homogeneous assembly of individuals of a series of pre-formulated open-ended questions which can be followed by additional spontaneous inquiries, as determined necessary and appropriate by the facilitators. Focus group methodology was selected as the data collection technique for this research project due to the match between the identified strengths of the methodology (Morgan, 1992; Krueger, 1994) and the purpose of the research.

Focus groups are a preferred data collection technique when certain circumstances prevail (Morgan, 1992; Krueger, 1994). Firstly, focus groups are an appropriate technique when the purpose of the research is to gain insight into the perceptions, attitudes, or opinions of the study's subjects and a natural environment in which the study subjects' influence one another is characteristic of the circumstance under study. Secondly, focus groups are a recommended technique when the research is action-oriented and is undertaken with the express purpose of influencing professional practice. Both circumstances prevail in the current study.

The focus groups were held in two hospitals which were selected based on availability and convenience from a larger cohort of facilities that indicated an interest in participation through responding to a mailing sent to all hospitals in a major metropolitan area in the northeastern United States. This approach to sample selection conforms to standard practice in qualitative research (Morse, 1998). As suggested by Krueger (1994) and Carey (1995), focus groups were held for each salient segment of the target population until theoretical saturation was achieved, i.e., until no new themes emerged. Consequently, a total of fourteen focus groups were held.

As discussed above, due to workforce demographics team role is strongly associated with race (in the present study, 90% of the RN team leaders were white, while 50% of the PCTs and 73% of the SAs were black). This demographic profile is not atypical for urban hospitals in the United States. Since race was expected to be a salient factor in care production team members' perceptions of communication effectiveness, separate focus groups were held for black and white employees in each of the three NCT team roles: The registered nurse (RN) who performs licensed nursing duties and leads the team, the patient care technician (PCT) who performs nonlicensed nursing duties and the support associate (SA) who performs housekeeping and dietary functions. Guidelines developed by Dreachslin (1998) for conducting focus groups in the context of diversity were followed.

A draft focus group protocol was developed after a thorough review of the literature on focus group methodology and patient centered care. Review by nurse leaders in patient centered care settings resulted in minor modifications to the original protocol, which followed the general approach recommended by Krueger (1994).

Description of results

All focus group discussions were audiotaped and verbatim transcripts of the discussions were analyzed. Transcript-based analysis was selected for its methodological rigor and, as recommended by Krueger (1994), the co-facilitators performed the analysis. Three questions in the focus group protocol dealt specifically with diversity. The first asked participants to discuss how similar or different their team's members were on a list of diversity dimensions that included differences such as race, ethnicity, gender, age, sexual orientation and marital status. The second question asked whether the diversity dimensions affected team communication and the third inquired as to the effects of diversity on patient care. Results specific to these three questions are summarized in a previous publication that presents a general analysis of the overall project's findings (Dreachslin et al., 1999). Seven general diversity themes emerged from that analysis: Gender was easier to discuss than race and ethnicity, opinions varied as to whether race is a relevant factor, participants emphasized diversity issues that affected them personally, when patients discriminate against males or blacks the team is affected, talking about differences improves teamwork, role in the team is an important dimension of diversity and clustering in identity groups inhibits teamwork.

Findings discussed below are based on a detailed re-analysis of the verbatim transcripts of all fourteen focus groups. The purpose of the re-analysis was to develop a grounded theory of the role that race plays in the self-perceived communication effectiveness of nursing care teams. Grounded theory differs from other qualitative methods due to its emphasis on theory development and the concomitant requirement that the researcher interpret and categorize respondents' answers into an overarching framework (Strauss and Corbin, 1994). The guidelines developed by Barnes (1996) for application of the grounded theory method with multicultural respondents were adhered to in this analysis and included relevant personal or professional cultural experience, familiarity with the professional literature pertinent to racial and ethnic diversity and (Barnes, 1996, 429), "constant comparison of emerging

concepts from the cultural perspective of the respondents".

Fig. 1 is a visual representation of the resultant theoretical model of how race influences the self-perceived communication effectiveness of nursing care teams. It should be noted that, irrespective of team role or race, NCT members were generally dissatisfied with the effectiveness of team communication. The NCT members who did characterize communication within their own NCT as positive saw their team's performance as not representative and acknowledged that communication within other NCTs was often fraught with conflict and misunderstanding.

Two themes that emerged from the focus group discussions constitute the overarching framework within which racially diverse team members evaluate communication effectiveness: different perspectives and alternative realities. Team members see the team's interactions from different perspectives or vantage points that are strongly influenced by each team member's racial identity and how he or she experiences that racial identity. When team members develop belief systems that are consistent with their perspective and incongruent with other vantage points, differences in perspective can result in alternative realities. Alternative realities encourage participants to attribute causation differently which in turn fuels team conflict and miscommunication by diminishing the team's ability to reach a common understanding of both the source of the conflict and the optimal path to its resolution through effective communication. For example, one team member may see a team conflict situation through the lens of race and attribute the incident to discrimination while another may attribute the same conflict to role differences. When team members' different perspectives harden into alternative and conflicting realities, team members' ability to validate perspectives other than their own is lessened and the team's capacity to coalesce around a shared approach to conflict resolution is concomitantly impaired.

Grounded theory analysis of the focus group transcripts resulted in the identification of three additional themes that serve as reinforcing factors, i.e., these themes deepen the conflict and miscommunication that occurs as a natural consequence of the overarching framework of different perspectives and alternative realities. As shown in Fig. 1, the reinforcing factors are social isolation, selective perception and stereotypes. Social isolation is driven by two related but different factors: voluntary clustering by racial identity groups for socialization and involuntary clustering by team role due to the systemic association between race and occupation. Since the lenses through which people filter their experiences and acquire beliefs about those experiences are developed through human interaction, social isolation serves to increase the potential for conflict by limiting opportunities for interracial contact and communication. Selective perception operates similarly through causing individuals to fail to perceive experiences that are incompatible with their belief system. Stereotypes further reinforce selective perception by their role as perceptual filters.

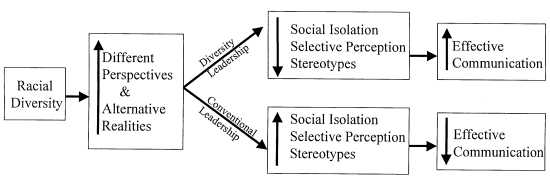

Fig. 1. Relationship between race, leadership and the self-perceived communication effectiveness of nursing care teams.

As Fig. 1 illustrates, leadership emerged as a powerful mitigating factor in the model of how race influences the self-perceived communication effectiveness of nursing care teams. While conventional approaches to leadership, i.e., approaches that deny or fail to address racial dynamics in NCTs, appear to contribute to the social isolation, selective perception and stereotypes that reinforce different perspectives and alternative realities, an alternative approach refereed to as diversity leadership (Dreachslin, 1996 for a thorough discussion of this approach) mitigates against these same three reinforcing factors and enables NCT members to find common ground and shared purpose within the overarching framework of different perspectives and alternative realities. Leaders who engage in diversity leadership can transcend racial identity, as evidenced by the ability to validate alternative realities and appreciate different perspectives and appear to moderate the potential negative effects of racial diversity on team processes and strengthen the positive aspects of diversity, as called for by Williams and O'Reilly (1998). A detailed discussion of results pertinent to each overarching, reinforcing and mitigating theme follows.

Overarching framework

Theme 1: different perspectives

As stated above, regardless of race, team role, or other dimensions of diversity, participants agreed that the communication process in the hospital's NCTs were often characterized by conflict and misunderstanding. Team members, however, offered very different explanations for the conflict and misunderstanding that was observed in the NCTs. These different explanations or belief systems were strongly associated with race.

Black participants irrespective of team role were more likely to identify race as a factor that exacerbated

team conflict and miscommunication, while white participants tended to attribute problems to role and status in the team and to identify race as coincidental and irrelevant. One black patient care technician zeroed in on this issue when he said, "I think that there is a race problem and I think that people are afraid to say it. White RNs treat white PCTs and black PCTs differently. White RNs think that black PCTs are lazier." However, some black participants contended that status or team role was a more central factor in conflict and miscommunication than was race.

Although white focus group participants did generally acknowledge that many of their black team members felt race was a significant factor in miscommunication and team conflict, it was not unusual for black team members' perceptions to be characterized as invalid or mistaken. For instance, a white patient care technician stated that, "There are no problems between people. Once an SA thought it was because of her race that a PCT asked her to do a certain task, but it was just because it's her job!" Some whites, however, did validate black team members' perceptions. For instance, one white RN team leader said, "A lot of black PCTs feel they're doing the dirty work for the white RNs. I'd feel that way too if I were treated like some of the white RNs treat the black PCTs." Another said, "You don't think about a color issue, but it ends up like that".

Theme 2: alternative realities

The different belief systems or lenses through which team members filtered their experiences often resulted in alternative realities. Participants were relatively more likely to question other's reality than their own. This tendency to discount other's realities fueled team conflict, leading many white and black team members to avoid discussions about race in an attempt to prevent conflict escalation. As one white PCT explained, "Sometimes you have to watch what you say about race". Some white team members expressed frustration with black team members who interpreted team conflict through the lens of race. Some white team members perceived that racial tension on the teams was escalating, attributing this to newly hired black team members who they perceived as more vocal about racial discrimination and more likely to identify racial prejudice as the primary cause for situational conflict or miscommunication among team members. Comments such as "I think the race issue has gotten bad in this hospital. I have noticed that a lot of the new people they are hiring have an issue with race." reflected this perspective. Race was often confounded with team role and socioeconomic status, challenging team members to reconcile different beliefs about the causes and solutions for team conflict and miscommunication. "Sometimes", a white PCT explains, "it's hard to tell why someone is treating you differently".

Thus, different perspectives and alternative realities defined the overarching framework within which team conflict, miscommunication and race were interpreted and experienced. The consequence for teams that did not discuss race was 'cold conflict', described by Fritchie (1995, p. 471) as, "a distinct lack of communication between the parties, no evident ideals and people are generally not very sensitive to one another. Rigid rules and procedures are often employed to avoid each other and the main players deny that there is any difficulty. They tend to be blind to the effect their behaviour has on other people. A cold conflict seems stuck and frozen with no obvious movement." Three reinforcing factors — selective perception, social isolation and stereotypes — served to harden racial division within nursing care teams, fueling an undercurrent of racial tension.

Reinforcing factors

Theme 3: social isolation

During break or lunch times, team members tended to cluster by role and race. Some team members said this was the cause of poor teamwork while others felt it was the consequence of poor teamwork. Comments such as "When lunchtime comes, white people eat in one area and blacks in another. Everyone is really segregated." and "There are people we've worked with for five years, but when it's time to go to lunch or whatever, everyone splits with their own background." are illustrative of the theme of voluntary clustering in social situations.

Focus group participants also acknowledged that team role was correlated with race and that this systemic association contributed to social isolation by race. A dialogue on this subject exemplifies this theme: PCT 1: "But if everyone gets along, why can't people just sit together?" PCT 2: "Because you are not working together."

The need to reduce social isolation and communicate across differences was widely identified. The following comments are illustrative of this theme: "I think the tension begins when people sit with their own race at lunchtime, discuss certain things and then come back into the workplace." and "I think that for us race is a big problem, but people are afraid to say it. The RNs are white and the PCTs are black."

Social isolation by race reinforces both overarching themes, i.e., different perspectives and alternative realities, because perceptual filters, shared beliefs and social reality are reinforced through interaction in social networks. Fewer occasions for interaction due to social isolation results in diminished opportunities to devel-

oped shared beliefs and a common social reality across racial groups.

Theme 4: selective perception

Selective perception served to reinforce different perspectives and alternative realities through its role in filtering experience. Fairly consistent patterns of perception that were associated with race emerged in the focus groups. Black team members were relatively more likely to perceive racial discrimination or racial stereotyping than were white team members. Comments such as "Patients will praise white caregivers and not blacks" and "I think that a lot of people treat people of color differently." and "There *is* racism here." were made by black team members, while comments such as "Our problems are more with status than race." were more illustrative of the perspective of white team members. Notable exceptions were also evident. Some white team members acknowledged the role of race in perception through observations such as, "A white nurse said that black PCTs are lazy and only white PCTs work." and "People will say that 'so and so' is or does certain things because he is a particular color". On the other hand, some black team members did not perceive race as a salient factor in team dynamics, expressing perceptions such as that voiced by a black SA, "We do not have any problems with race that I know of." or the black RNs who said, "Status is a bigger issue than race" and "I've seen white RNs treat both white and black PCTs badly".

Different perceptions of the role of the SA in the nursing care team are illustrative of the challenges faced in distinguishing between role dynamics and racial dynamics when role and race are strongly associated, e.g., nine of every ten RNs in the participating hospitals were white while over seven of every ten SAs were black. RN focus group participants did not generally identify SAs as team members unless prompted to do so by the facilitators, while focus groups of black PCTs were relatively more likely to identify the SAs as team members. Black support associates expressed feeling isolated and invisible, especially to the RNs. As one SA explained: "We (SAs) are not really teamed up. We are all just on the floor. I don't feel as if I am part of a team." SAs often bonded with one another, but not with the RN or PCT. When they needed help, they were more likely to go to another SA. The symbolism of having their name on the patient's board was important to SAs: "They (RNs and PCTs) will not write our names down on the patient's board. It's like we are not important so we should not be up there."

In general, black focus group members were more likely to state that they have seen incidents of racial discrimination while white focus group members were more likely to say that they had not. In this fashion, selective perception or the tendency to filter in data that support your own preconceived beliefs about reality and to filter out data that contradict those beliefs serves to reinforce the different perspectives and alternative realities that characterize the relationship between race and the self-perceived communication effectiveness of nursing care teams.

Some focus group members recognized the need to moderate their own tendency, reinforced by their racial identity group, to engage in selective perception. As one black PCT explained, "A few people (other black PCTs) told me that I was going to have a hard day because I had two Jewish patients. But I went in with a good attitude and by the end of the week the two ladies were asking for me."

Theme 6: stereotyping

Regardless of role, black team members were more likely than white team members to have observed or experienced discrimination that they attributed to racial stereotyping, i.e., a belief about an individual due to his or her racial group membership. Illustrative comments include the following: A black RN explained, "I have had a lot of problems with our Jewish patients. They don't want blacks taking care of them." While another black RN concurred stating that, "Our patients will think", "You are black, so you must be from housekeeping or dietary". Another said, "I will tell them I'm an RN. Then I'll get the courtesy of an RN." A black SA observed that, "Sometimes black PCTs get assigned more patients than white PCTs".

White team members were generally aware of incidents in which patients would express stereotypes about black team members, but they were less likely than black team members to characterize incidents of stereotyping or discrimination carried out by white team members as being racial in nature. As with selective perception, the tendency to perceive racial stereotypes and discrimination was associated with race and, consequently, served to reinforce the racial divide in nursing care teams.

Mitigating factor

Theme 7: leadership

Leadership style emerged as the key mitigating factor that can serve to either diminish or enhance the self-perceived communication effectiveness of racially diverse nursing care teams. RN team leaders as well as the patient care managers to whom the team leaders report were generally viewed as most effective at enhancing the self-perceived communication effectiveness of racially diverse teams when they openly encour-

aged and participated in discussions about race and other differences as well as listened to and validated different perspectives and alternative realities. In Fig. 1, this approach is referred to as diversity leadership and is contrasted with conventional leadership whereby leaders deny or fail to address racial dynamics in NCTs.

The theme that RN team leaders and patient care managers who encourage discussion about differences enhance the self-perceived communication effectiveness of nursing care teams is illustrated by comments such as the following: "A lot of people on my floor are in interracial marriages or are homosexuals. I think it helps my team communicate better with the patients who might be in similar circumstances. We ask each other questions about the differences." "Everyone seems to respect each other and get along. We talk about being Jewish or Baptist and go about doing our work. So far, we respect each other in these aspects."

Another team members who described her team's communication as highly effective explained, "We are always communicating about the different lifestyles and I think you grow from it". In the course of describing her satisfaction with interracial communication in her team one black PCT explained that, "We share recipes and bring in different ethnic foods". Not all team members or leaders were eager to engage in discussions about differences. As one team member explained, "I kind of stay away from talk about differences. I know that the conversations are there, but I won't seek them out." However, observations such as the following were more commonly expressed by focus group participants: "I would like to understand why people act the way they do and the differences in their cultures".

The leader's ability to validate the perspective, widely shared among black team members and acknowledged by some white team members, that racial discrimination is a real concern was especially important to black team members. One black RN complimented her white patient care manager on concluding that patients are relatively more likely to confer special praise on white caregivers and expressed her appreciation for the manager's resultant decision to downplay patient letters of gratitude in the review process. Another team member contended that her patient care manager's failure to validate the existence of racial discrimination exacerbated conflict in her NCT: "It is very difficult to work with someone who is going to treat you differently because of your skin color. That is horrible! We have a lot of this going around, but this goes right over my manager's head. She has no idea!"

Black participants in particular called for official policy on racial discrimination by patients. As one black RN asserted, "There are enough of us (black team members) here. There should be a policy!" Another black team member explained that stereotyping by patients is a challenge to black NCT members: "Patients think that blacks are only here to do the unskilled tasks. They call us 'girl'." White participants most commonly expressed feelings of embarrassment and shame when confronted with situations where patients refuse care from black team members.

Many black PCTs attributed ineffective RN team leadership to inexperience or naiveté and to the stereotypes that result from social isolation. For instance, one black PCT when expressing discomfort with what she perceived as inappropriate personal questions from RN team leaders added the observation that, "Seventy-five percent of RNs are white and some of them are experiencing other races for the first time. They ask me about certain things like my hair and what I do to make it straight." Other black PCTs and RNs contend that white RN team leaders often act based on stereotypes and unfounded assumptions. As one black PCT explained, "I live in the suburbs and a white RN just assumed that I live in the city". Another black PCT stated that, "I went to college. The white RNs assume that black people have no education and don't know anything. This prevents teamwork." A comment by another black PCT illustrates how a reduction in social isolation can produce a gain in understanding: "We had a white nurse who went to the funeral of a black patient. She finally realized that we were not having fun, but that we praised God in different ways. She was trying to explain it to the other white nurses."

The leader's ability to serve as a unifying force through transcending differences in perspective and validating alternative realities was seen as key to maintaining a positive diversity climate in NCTs. Leaders who reduce social isolation through creating opportunities for interracial social interaction and who, through example, demonstrate self-monitoring behavior that mitigates against selective perception and stereotyping increase communication effectiveness in NCTs. Diversity leadership thus serves as the mitigating factor in the relationship between race and the self-perceived communication effectiveness of nursing care teams.

Discussion

The findings reported above have important practical implications for health care delivery teams comprised of racially diverse team members. Since effective diversity leadership was found to be the significant mitigating factor in team communication effectiveness, increased attention to development of team leaders'

skills in managing diversity is strongly suggested by the study's findings. As recommended by Cox and Beale (1997), diversity training should be structured so as to move team leaders from awareness to understanding to action, thus emphasizing the transfer of concepts and skills introduced in professional development to the participant's actual behavior as a team leader. Additional issues related to the relationship between diversity training and diversity leadership are discussed by Dreachslin (1996).

Study findings also suggest that team members would benefit from similarly designed diversity training. Development of both team leaders' and team members' ability to understand different perspectives and appreciate alternative realities, as well as to lessen social isolation and engage in self-monitoring behavior that reduces the negative impact of selective perception and stereotypes, should improve the self-perceived communication effectiveness of racially diverse NCTs.

Kim's (1992) distinction between culture specific and intercultural communicative competence is a useful construct to consider in the design of diversity training for NCT team leaders, members and nurse managers. As Gerrish (1998, 118) observes, "Clearly there is a need to achieve a balance between culturally specific knowledge that can inform practice and the principles that are applicable in different contexts and recognize the changing and dynamic nature of ethnicity".

The grounded theory of race and team communication developed in this paper could serve as a framework for identifying generalizable skills that can improve NCT leaders' and members' intercultural communicative competence. The development of generalizable skills is of particular importance in the context of demographic and social attitudinal change since, "diversity may exist not only between cultures but also within a culture and between generations" (Gerrish, 1997, p. 361). Training that is chiefly focused on the development of intercultural communicative competence and that cautions participants against the wholesale or indiscriminate application of culture specific knowledge acquired in training should mitigate against the stereotyping that could potentially result from attempts to develop culture specific communicative competence. The reader is referred to Gerrish et al.'s (1996) discussion of training nurses for practice in a multi-ethnic society for a thorough review of a number of useful theoretical frameworks for viewing cross-cultural communication exchanges and for designing curriculum to develop competencies required for effective diversity leadership.

This study's grounded theory of the role that race plays in the self-perceived communication effectiveness of nursing care teams is perhaps best understood when viewed in the context of a number of existing theoretical frameworks. When interpreted in the context of neo-Weberian closure theory (1978), results lend support to the contention that effective communication is inhibited in part because the occupation of nursing is closed to outsiders. Consequently, RN team leaders may block effective communication with PCTs and SAs in order to maintain the preferred social status that the present closed system affords RNs.

However, occupational status differences alone do not explain the study's findings which support the contention that race itself operates similarly to occupation and that whites also can be viewed as members of a closed system that systematically limits or excludes the participation of people of color. It appears as well that, as Husband (1987) contends, the effects of race are not independent of class, gender, age, occupation or other aspects of social identity, but rather operate simultaneously as driven by individual consciousness, shaped by social identity development and reinforced through experience. Husband (1987, p. 329) explains, "Thus while racism, as a dominant ideology, *should* possess common core features, at the same time the unique multiple social identity of individuals makes the incorporation of the different elements of racist ideologies a unique configuration".

The traditional bureaucratic structure (Weber, 1947) of health care organizations themselves may also impede effective communication in NCTs through reinforcing rigid role definitions and boundaries among professions as well as between licensed and non-licensed or professional and non-professional caregivers. The movement to team based care delivery requires that the boundaries between licensed and non-licensed as well as black and white NCT members in health care organizations become more permeable. The result can be health services organizations with more positive diversity climates since, as Cox (1993, p. 213) contends, "Despite its strong points and continued influence, the bureaucratic model is, in many respects, antithetical to the needs of culturally diverse workgroups". However, as evidenced by this study's findings, attempts to change from a bureaucratic to a team-based model of organizational design are likely to result in backlash and exacerbate interracial conflict and miscommunication unless the mitigating forces of leadership are evident. Leaders must assume the role of boundary managers (Bruhn et al., 1993) through clearly evidencing the ability to validate the different perspectives and realities represented in NCTs and demonstrating a willingness to talk about differences.

Further research of both a qualitative and quantitative nature is suggested to test the validity of the theoretical framework for the role of race in the self-perceived communication effectiveness of NCTs that is proposed in this paper. Quantitative studies that employ stage models of racial identity development (Helms, 1984, 1990) are recommended to explore the

relationship between leader's stage of racial identity development and the self-perceived communication effectiveness of racially diverse nursing care teams. Ethnographic research that focuses on field observation of both racially diverse and racially homogeneous nursing care teams is proposed as an additional source of valuable data on the relationship between race, communication and NCT effectiveness. In addition, while grounded theories are more typically developed from interviews with single individuals, this study suggests that the use of focus group data to develop grounded theories of group interaction is a fertile alternative methodological approach.

Results of this study confirm the findings from the general management literature reported above that demonstrate a strong association between racial diversity and difficulties with communication and conflict resolution in teams. As both racial diversity and team approaches to service delivery are increasingly characteristic of health services organizations, this area of professional management practice and scientific inquiry is deserving of intensified and focused attention.

References

Abts, D., Hofer, M., Leafgreen, P.K., 1994. Redefining care delivery: a modular system. Nursing Management. 25 (2), 40–46.

Alexander, J.A., Lichtensetein, R., Jinnett, K., D'Aunno, T.A., Ullman, E., 1996. The effects of treatment team diversity and size on assessments of team functioning. Hospital and Health Services Administration 41 (1), 37–53.

Barnes, D.M., 1996. An analysis of grounded theory method and the concept of culture. Qualitative Health Research 6 (3), 429–441.

Baugh, S.G., Graen, G.B., 1997. Effects of team gender and racial composition on perceptions of team performance in cross-functional teams. Group and Organization Management 22 (3), 366–383.

Beishon, S., Virdee, S., Hagell, A., 1995. Nursing in a Multi-Ethnic NHS. Policy Studies Institute, London.

Benzeval, M., Judge, K., Smaje, C., 1995. Beyond class, race and ethnicity: Deprivation and health in Britain. Health Services Research 30 (1), 163–177.

Bernd, D.L., 1992. Patient-focused care pays hospital-wide dividends. Health Care Strategic Management 10 (12), 9–12.

Bernd, D.L., Reed, M.M., 1994. Re-engineering women's services. Healthcare Forum Journal 37 (1), 63–67.

Bethel, S., Ridder, J., 1994. Evaluating nursing practice: satisfaction at what cost? Nursing Management 25 (9), 41–48.

Bickler, B., 1994. Putting patient-focused care into practice. AORN Journal 60 (2), 242–245.

Bollini, P., Siem, H., 1995. No real progress towards equity: Health of migrants and ethnic minorities on the eve of the year 2000. Social Science and Medicine 41 (6), 819–828.

Borzo, G., 1992. Patient-focused hospitals begin reporting good results. Health Care Strategic Management 10(8), 1, 17-22.

Boston, C., Vestal, K.W., 1994. Work transformation: why the new health care imperative must focus both on people and progress. Hospitals and Health Networks. 68 (7), 50–54.

Brider, P., 1992. The move to patient-focused care. American Journal of Nursing, 27-33.

Bruhn, J., Levine, H., Levine, P., 1993. Managing Boundaries in the Health Professions. Charles C. Thomas, Publisher, Springfield, IL.

Carey, M.A., 1995. Comment: concerns in the analysis of focus group data. Qualitative Health Research 5 (4), 487–495.

Clouten, K., Weber, R., 1994. Patient-focused care: Playing to win. Nursing Management 25 (2), 34–36.

Cohen, S.G., Bailey, D.E., 1997. What makes teams work: Group effectiveness research from the shop floor to the executive suite. Journal of Management 23 (3), 239–290.

Cott, C., 1997. "We decide you carry it out": A social network analysis of multidisciplinary longterm care teams. Social Science and Medicine 45 (9), 1411–1421.

Cox, T., 1993. Cultural Diversity in Organizations: Theory, Research and Practice. Berrett-Koehler Publishers, San Francisco.

Cox, T., Beale, R., 1997. Developing Competency to Manage Diversity. Berrett-Koehler Publishers, San Francisco.

Dobson, F., Government Truly Committed to Equal Opportunities in the NHS, 21 October, 1997, Obtained from: http://www.coi.gov.uk/coi/depts/GDH/coi3644d.ok, 10 January 1998.

Dreachslin, J.L., 1996. Diversity Leadership. Health Administration Press, Chicago.

Dreachslin, J.L., 1998. Conducting effective focus groups in the context of diversity: Theoretical underpinnings and practical implications. Qualitative Health Research 8 (6), 813–820.

Dreachslin, J.L., Hunt, P.L., Sprainer, E., 1999. Communication patterns and group composition: Implications for patient-centered care team effectiveness. Journal of Healthcare Management 44 (4), 252–268.

Edmonston, B., Passel, J.S., 1994. The future immigrant population of the United States. In: Edmonston, B., Passel, J.S. (Eds.), Immigration and Ethnicity: The Integration of America's Newest Arrivals. The Urban Institute Press, Washington, DC, pp. 317–353.

Eubanks, P., 1991. Restructuring care: patient focus is key to innovation. Hospitals 65 (15), 26–27.

Farris, B.J., 1993. Converting a unit to patient-focused care. Health Progress 74 (3), 22–25.

Fritchie, R., 1995. Conflict and its management. British Journal of Hospital Management 53(9), 471, 473.

Gerrish, K., Husband, C., Mackenzie, J., 1996. Nursing for a Multi-Ethnic Society. Open University Press, Buckingham.

Gerrish, K., 1997. Preparation of nurses to meet the needs of an ethnically diverse society: educational implications. Nurse Education Today 17 (5), 350–365.

Gerrish, K., 1998. Preparing nurses to care for minority ethnic communities. International Nursing Review, 45(4), 115-6, 118.

Gillespie, R., 1993. Multi-cultural health provision. Health Services Management 89 (3), 24–25.

Helms, J.E., 1984. Toward a theoretical explanation of the effects of race on counseling: a black and white model. The Counseling Psychologist 12 (4), 153–165.

Helms, J.E., 1990. Toward a model of white racial identity development. In: Helms, J.E. (Ed.), Black and White Racial Identity Theory, Research and Practice. Greenwood Press, Westport, CT, pp. 33–48.

Hoffman, E., 1985. The effect of race-ratio composition on the frequency of organizational communication. Social Psychology Quarterly 48, 17–26.

Hurst, K., 1996. The managerial and clinical implications of patient-focused care. Journal of Management in Medicine 10 (3), 59–77.

Husband, C., 1987. British racisms: the construction of racial ideologies. In: Husband, C. (Ed.), Race in Britain Continuity and Change, second ed. Hutchinson Education, London, pp. 319–332.

Katzenbach, J.R., Smith, D.K., 1993. The discipline of teams. Harvard Business Review 71 (1), 111–120.

Kim, Y., 1992. Intercultural communicative competence: a systems theoretic view. In: Gudykunst, W., Kim, Y. (Eds.), Readings on Communication with Strangers. McGraw-Hill, New York.

Kirkhart, D.G., 1995. Shared care: improving health care, reducing costs. Nursing Management 26 (6), 26–32.

Kline, R., 1994. Discrimination right on your side. Health Visitor 67 (8), 278.

Krueger, R.A., 1994. Focus groups: A Practical Guide for Applied Research. Sage, Thousand Oaks, CA.

Mayo, M., Pastor, J.C., Meindl, J.R., 1996. The effects of group heterogeneity on the self-perceived efficacy of group leaders. Leadership Quarterly 7 (2), 265–284.

Mazlish, B., 1989. A New Science: The Breakdown of Connections and the Birth of Sociology. Oxford University Press, New York.

Maznevski, M.L., 1994. Understanding our differences: performance in decision-making groups with diverse members. Human Relations 47 (5), 531–552.

McLeod, P.L., Lobel, S.A., 1992. The effects of ethnic diversity on idea generation in small groups. Academy of Management Best Papers Proceedings, 227-231.

Milliken, F., Martins, L.L., 1996. Searching for common threads: understanding the multiple effects of diversity in organizational groups. Academy of Management Review 21 (2), 402–433.

Morgan, D.L., 1992. Designing focus group research. In: Stewart, M., Tudiver, F., Bass, M., Dunn, E., Norton, P. (Eds.), Tools for Primary Care Research. Sage, Newbury Park, CA, pp. 177–193.

Morse, J., 1998. What's wrong with random selection? Qualitative Health Research 8 (6), 733–735.

Murphy, R., 1994. Work reengineering: the benefits and the barriers, an analytical review. Journal of the Society for Health Systems 5 (1), 73–84.

Murphy, R., Pearlman, F., Rea, C., Papazian-Boyce, L., 1994. Work redesign: a return to the basics. Nursing Management 25 (2), 37–39.

Newman, K., 1997. Towards a new health care paradigm: patient focused care. The case of the Kingston Hospital Trust. Journal of Management in Medicine 11 (6), 357–371.

NHS Management Executive (NHSME), 1993. New World, New Opportunities. NHSME, London.

Pelled, L., Eisenhardt, K., Xin, K., 1997. Demographic diversity in work groups: An empirical assessment of linkages to intragroup conflict and performance. Working paper, School of Business, University of Southern California.

Perkins, J., 1993. Race discrimination in America's health care system. Clearinghouse Review 27 (4), 862–874.

Scherer, J., 1994a. Putting patients first. Hospitals and Health Networks 7 (3), 14–19.

Scherer, J., 1994b. Women at work. Hospitals and Health Networks 68 (18), 8.

Strauss, A., Corbin, J., 1994. Grounded theory methodology: An overview. In: Denzin, N.K., Lincoln, Y.S. (Eds.), Handbook of Qualitative Research. Sage, Thousand Oaks, CA, pp. 273–285.

Tidikis, F., Strasen, L., 1994. Patient-focused care units improve service and financial outcomes. Healthcare Financial Management 38-44.

Ting-Toomey, S., Chung, L., 1996. Cross-cultural interpersonal communication: theoretical trends and research directions. In: Gudykunst, W., Ting-Toomey, S., Nishida, T. (Eds.), Communication in Personal Relationships Across Cultures. Sage Publications, Thousand Oaks, CA, pp. 237–261.

Watson, W.E., Kumar, K., 1992. Differences in decision making regarding risk taking: a comparison of culturally diverse and culturally homogeneous task groups. International Journal of Intercultural Relations 16, 53–65.

Watson, W.E., Kumar, K., Michaelsen, L.K., 1993. Cultural diversity's impact on interaction process and performance: Comparing homogeneous and diverse task groups. Academy of Management Journal 36 (3), 590–602.

Watson, S.D., 1994. Minority access and health reform: A civil right to health care. The Journal of Law, Medicine and Ethics 22 (2), 127–137.

Weber, M., 1947. The theory of social and economic organization. (A. Henderson and T. Parson, Translators). Free Press, New York.

Williams, K.Y., O'Reilly III, C.A., 1998. Demography and diversity in organizations: a review of 40 years of research. Research in Organizational Behavior 20, 77–140.