Conceptual Tools for Thinking about Inter-teamwork in Clinical Gerontology

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Abstract

Frail elders with complex biopsychosocial and functional problems require the collaboration of many caregivers who are often working on different teams and may come from different organizations. The development and maintenance of collaborative alliances between caregivers working on different teams is the challenge of inter-teamwork. It is a challenge because, the quality of collaborative alliances in complex environments may predict outcomes better than the internal processes of individual teams, and because researchers and educators in gerontology have yet to address this important issue. In the present paper, business and small group research on collaborative alliances is examined and a familiar truth emerges. Just as putting individuals together to work does not necessarily make for effective teamwork, so putting teams together to work does not necessarily produce effective inter-teamwork. Several conceptual tools for thinking about inter-teamwork are explored. These include: a framework for understanding the impact of the diverse cultures of collaborating teams, a set of boundary-crossing functions to enhance inter-team linkage, an application from General Systems Theory which recognizes inter-team collaboration as a systems issue, and a set of outcome expectations emerging from inter-team experiences which feedforward and determine the quality of future collaboration. Throughout, the discussion of these tools will draw on illustrations from practise in clinical gerontology.
**Introduction**

Frail elders with complex biopsychosocial and functional problems typically need the help of many caregivers. These may include family members and lay caregivers in volunteer services and self-help associations; health professionals in hospital teams, clinics, and long-term care facilities; and social service and homecare professionals in social and community agencies. The provision of an effective continuum of care for frail elders requires high levels of collaboration not just between professionals on a single health care team, but between caregivers on several teams and often across organizational boundaries. We define the development and maintenance of collaborative alliances between teams of caregivers as the challenge of inter-teamwork.

Gray (1985) argues that five conditions require the development of collaborative alliances:
1) when the issues being managed are bigger than a single group acting alone can resolve, 2) when competitive methods do not work, 3) when teams must collaborate across organizational boundaries, 4) when resources are constrained, and 5) when the environment is changing and turbulent. If the collaborative caregiving required by frail elders is considered together with the socio-economic turbulence and constraint which presently characterizes hospital and community services, then Gray’s five conditions for inter-teamwork appear to converge. Yet with very few exceptions (see eg. Iles & Auluck, 1990; Oaker & Brown, 1986), inter-teamwork has not yet received a great deal of attention in health care or in clinical gerontology.

While inter-teamwork has not yet become a focus of attention in gerontology, the theoretical and empirical study of collaborative alliances in business and in small group research is active and the results of these studies can be extrapolated to our field. First, consider the reported benefits of collaborative alliances. In business, for example, inter-team, inter-departmental, and inter-organizational collaboration are seen as social and economic necessities (Trist, 1983)
fundamental to gaining access to new technologies, complementary skills, economies of scale (Ring & Van de Ven, 1994), and innovation (Gray, 1989). In the development of public policy (Gray, 1985; Roberts & Bradley, 1991) and environmental mediation (Bingham, 1986; Logsdon, 1991) successful outcomes are dependent upon the quality of the collaboration between the private and public sectors of society. In human service delivery systems, collaborative alliances are seen as an increasingly important correction to service fragmentation (Alter, 1990; Lawless & Moore, 1989; Rosenheck, 1988). Indeed, Ancona (1990) and Pfeffer (1986) argue that in environments requiring complex interdependency, the quality of collaborative alliances may predict outcomes better than the internal processes of the individual teams.

In addition to documenting the benefits of collaborative alliances, business and small group research also reveals several potential liabilities. Increased interdependence between teams may increase costs (Brown, 1983), prompt "social loafing" (McAllister, 1995), and decrease customer service and satisfaction (Ancona, 1990). Interdependence may heighten adversarial relationships (Gray, 1989), and even trivial differences between non-competitive groups have the capacity to prompt in-group bias (Brewer, 1979; Seta & Seta, 1992). Finally, while inter-teamwork is seen as a correction to human service fragmentation, intensely interacting systems may also be a cause of fragmentation (Rosenheck, 1988).

Clinical gerontologists need tools to help achieve the benefits of inter-teamwork while minimizing its liabilities. In what follows, conceptual tools for thinking about inter-teamwork are considered. First, diversity in the internal cultures of collaborating teams is explored, focusing specifically on diversity arising from the relative stages of development of collaborating teams and their mental models or constructions of reality. Second, a set of boundary-spanning functions is examined which describe the strategies teams use to develop and maintain their
relationships with other teams. Third, collaborating teams are considered as a system governed by general systems principals. Fourth, the effects of a set of expectations arising from inter-group experiences are discussed. Throughout, illustrations of these conceptual tools draw from practise in clinical gerontology.

**Inter-teamwork and the internal culture of teams**

When teams come together to work they each bring their own distinct culture. From an intra-team perspective, a distinct team culture reflects team cohesiveness and commitment. From an inter-team perspective, however, group distinctiveness is often a cause of in-group bias and inter-group rivalry (see, eg., Brown, 1983; Sherif & Sherif, 1953). How can we conceptualize the distinctive elements of team culture that will help us manage inter-teamwork effectively and minimize in-group bias and inter-team rivalry?

### Stage Models of Team Development

One determinant of the quality of inter-teamwork is the level of maturity of collaborating teams (Thalhofer, 1993). Level of maturity is also a strong determinant of team culture as Farrell, Heinemann & Schmitt (1986) reveal in their description of the distinctive leader and member behaviors, emotional climate, informal roles and rituals, and styles of humor characteristic which reflect team culture at different stages in team development.

The stage model of team development outlined by Tuckman & Jenson (1977) may be most familiar to gerontologists (see, eg., Drinka, 1991). In this model, a team begins its development with a "forming" stage in which team members seek leadership and direction in order to define their role and the teams tasks. This is followed by a "storming" stage in which team members resist leadership before developing their own rules in a "norming" stage which allows the team to optimize its performance in a "performing" stage. At any point a change in team membership or
task might occur prompting the team to "re-form" in an ongoing cycle. While the progression through these stages is by no means universal nor necessarily sequential, still, consideration of the stages of development of collaborating teams may provide a useful tool for thinking about issues in inter-teamwork.

Consider the following scenarios in which the members of two teams at different stages of team development meet to form a collaborative alliance. 1) If one team is in a "storming" stage and the other is in a "forming" stage, the anger and barbed humor which the storming team directs at its leader will likely alienate the members of the forming team who are looking to the team leaders for direction and order. 2) If one team is in a "norming" stage in which team members humorously deprecate their team through in-jokes signifying team membership, the humour may not be understood by members of the second team who will likely feel excluded. 3) In a "forming" stage, team members are typically dependent on a team leader and may have difficulty understanding the authority structure of a "performing" team where leadership is often dispersed. In each instance the differences have the potential to disrupt inter-teamwork.

We will consider the management of these differences later, but first let us examine the inter-team impact of another element of team culture - the mental models or constructions of reality which teams bring to their collaborative ventures.

Each team constructs a distinct model of reality

A second element of team culture which can help us to understand the formation of in-group bias and inter-team rivalry is the tendency of teams to construct conceptual models of the way in which the world is thought to work. Based upon each team's work experiences, these models
serve to select, filter, and organize information about the world in which the team functions (Hinsz, 1995; Porac & Thomas, 1990). Though seldom fully conscious to team members (see, eg., Argyris, 1994; Qualls & Czirr, 1988), the socially shared thinking that makes up a team's model of reality is another source of distinctiveness that can affect the quality of a team’s collaborative relationships (Fiske & Taylor, 1991).

What are the dimensions of a team's model of reality? Qualls & Czirr (1988) describe the intra-team impact of the mental models held by individual team members resulting from their distinct professional training and values, by conceptualizing models as sets of continua along such dimensions as "the focus of professional effort" and "the pace of action". We will use the concept of continua to help us think about team models and inter-teamwork. Our focus will be on six continua: the logic of each teams assessment, the breadth of focus of interventions, the perception of time, the location or place work, language, and style of documentation.

**The logic of assessment**

Collaborating teams frequently differ in the logic with they approach their client's problems. Qualls & Czirr (1988) describe a continuum ranging from the "ruling out" logic of a medical team's search for a definitive diagnosis by ruling out competing hypotheses to the "ruling in" logic of social workers and psychologists who typically look beyond the presenting problem. This continuum is even broader in the inter-team context where the "ruling out" logic of the medical team may be in stronger contrast to the "ruling in" logic of the community or family team concerned with a broad range of pragmatic issues. In between these extremes is the logic of rehabilitation or day hospital teams who seek a mix of diagnostic accuracy and functional breadth in their assessment. The potential for incongruence in the logic of assessment is therefore high.
Breadth of focus

Closely related to the logic of a team's assessment is the breadth of each team's interventions. The continuum here ranges between specialist and generalist perspectives. Differences in the breadth of focus of generalist and specialist teams and the attributions of status which arise from these differences are a frequent cause of inter-team conflict, even between teams from a single profession (Oaker & Brown, 1986).

A team's position along the generalist-specialist dimension can be quite relative. A team might see itself as generalist while being perceived as a specialist team by others. A chiropody team, for example, might pride itself on its broad holistic view of its customer, only to be treated with amusement by a community outreach team whose holistic view might, at times, include the elder, the family, the cats and even the bugs in the basement.

Sometimes a team may be perceived as generalist to one group but specialist to another. A hospital outreach team, for example, may provide a generalist perspective to internal hospital teams, while being valued by an even more generalist community case management team that values the outreach team's specialized skills. Like differences in the logic of assessment, attributions arising from differences in the breadth of focus of team interventions can be an unrecognized source of inter-team strain.

The perception of time

Teams differ in their perception of time, just as individual health professionals differ in their "pace of action" (Qualls & Czirr, 1988). At one extreme is the meaning of time for a trauma team where seconds might be the difference between life and death, and that of a team of family caregivers for whom time is a life-time. In between these extremes lie the meaning of time for
crisis management, acute care, day hospital, day program, community case management, and long-term care teams.

Complicating these differences in the perception of time is the feeling of "ownership" which teams develop during the time of their caregiving. So, for example, a community team, for whom time is defined in months or years, comes to feel that a client is "theirs". During a hospital admission, however, the acute care team, despite its episode of illness definition of time, claims "ownership" of the patient for that time, feels that it knows best, and finds opportunity to criticise the case management team for not having prevented the crisis from happening. Time may have different meanings in the models of reality held by collaborating teams and these differences can cause inter-team strain.

The location or place of work

A team's model of its world also includes the location or place of its work. The continuum here includes the home, the "community", and the hospital. It is difficult for a hospital based professional to understand, for example, that in community work an opening elevator, unlit hallways, and stairwells can be places of great danger threatening robbery and assault. In comparison, for community teams, the hospital is a seen as a safe environment where someone is always available to help. In the hospital, the next shift is always coming, while in the community, a worker with an elderly suicidal client is responsible and often alone.

At the same time, it is difficult for community workers to understand the stress of a trauma team transferring a patient in a halo vest when the screws pull loose and the transfer board is not to be found; or having a wandering patient with dementia lost in midwinter when six new admissions are arriving from emergency. In inter-teamwork, attributions arising from the location or place of each team's work can be an unrecognized source of inter-team strain.
Language

Through their collective experience the members of a group often develop a distinct language which reinforces their shared model of the world (McLuhan, 1964). Collaborating teams can have different words for the same thing or attach different meanings to the same word and these differences contribute to the process of inter-team bias (Perdue et al, 1990). Examples are everywhere. The person receiving care might be a "patient", a "client", a "customer", "Mr. Jones", or simply “Joe". The term "diagnostic workup" may be seen as an art form on one team and an expensive obfuscation on another. The title "doctor" may signify respect or domination. The terms "allied professional", "paraprofessional" or "layman" can be a comfortable designation or a patronising diminution of status (Stewart, 1990). The term "preventive care" is a golden grail for some a cynical devolution of responsibility for others. "Hospitals" are a symbol of caring and peace for some, disease and failure for others. Inter-teamwork will be compromised if we fail to understand the differences in the use of language on collaborating teams.

Style of Documentation

The final distinction in the models of reality constructed by collaborating teams that we will consider is the team’s style of documentation. Teams vary along a continuum ranging from excessive to minimal documentation. Health care teams, for example, are compelled by legislation to document in great detail, and hospital team members are likely to chart defensively in anticipation of possible legal action against them. On the other hand, community teams see often see documentation as an unnecessary invasion of client privacy, lay caregivers most
documentation is a distraction from caregiving, and for frail elders answering the same questions repeatedly becomes tiring.

Consider the following example. A broad spectrum community facility caring for elders, adolescents, and women in crises was given enhanced funding to develop a collaborative alliance with a medical team to provide care for frail elders. The medical team felt compelled to open medical files, while the community team maintained a relatively file free practice because it felt that routinely opening files would invade the privacy of some clients and deter them from help-seeking. An inability to resolve this inter-team dilemma which became focused on each team's style of documentation threatened the enhanced funding and the service. Difference in documentation style can become a significant element of inter-team strain.

Managing differences in team culture

To summarize, we have argued that differences in team culture strain the relationship between teams in collaborative alliances. As well, we have proposed two frameworks for understanding these differences: 1) the stages of development of collaborating teams, and 2) the models of reality that each team creates as a result of their specific logic of assessment, focus of intervention, perception of time, geography of work, language, and style of documentation. But how are these tools to be used to facilitate inter-teamwork?

Simply increasing the frequency of contact between collaborating groups has been proposed as one solution to dysfunctional intergroup relations (Allport, 1954; Miller & Brewer, 1984). Research on the contact theory suggests, however, that contact is a necessary but insufficient determinant of inter-group cooperation (Jackson, 1993). One of the reasons for this insufficiency is that, as we have pointed out, team members are typically unaware of their own team culture let alone that of another team. As Qualls & Czirr (1988) remind us, "with no
understanding of the models within which others work [we] are likely to make innacurate attributions about [their] motives" (p. 376).

Formal non-evaluative "differentiation" exercises have been developed to make group members aware of their own and other team's distinctive features and thereby reduce in-group bias and inter-team rivalry (Thalhofer, 1993). However, Hewstone & Brown (1986) caution that focusing on either intergroup differences or similarities alone has unpredictable consequences. They argue that focusing on both leads to more consistently positive out-group evaluations.

In this regard, Maznevski & DiStefano's (1995) research on managing cultural diversity may be instructive. Maznevski & DiStefano suggest that the negative effects of diversity within work groups may be moderated by focused training to not only recognize, but also to discuss and integrate both the similarities and cultural differences within teams. Perhaps this approach, borrowed from diversity research might help gerontologists manage in-group bias and inter-team rivalry arising from the diverse cultures of collaborating teams.

**Inter-teamwork and boundary-spanning functions on teams**

A second set of tools for thinking about inter-teamwork is found in the critical functions approach to understanding team performance. Critical functions are sets of behaviors that must occur if groups are to perform effectively. Since they were first described by Benne & Sheats (1948) the focus has been on two sets of intra-team functions: task functions and maintenance functions. Task functions such as giving information and clarifying direction allow the team to achieve its objective goals, while maintenance functions such as relieving tension and harmonizing build, sustain, and regulate the affective components of team life.
With the increasing focus on complex interdependency and collaborative alliances, attention is now focused on the critical functions necessary to maintain relationships across team, department, and organizational boundaries. A set of boundary-spanning functions has been developed which describe the behaviors necessary for maintaining these external linkages (Ancona & Caldwell, 1988) and these provide another tool for clinical gerontologists whose work with frail elders requires the development and maintenance of effective inter-teamwork.

Ancona & Caldwell (1988) describe three sets of functions that teams employ to maintain inter-team relationships: scout, ambassador, and guardian functions. The set of "scout" functions brings information and/or resources from the external world to the team. This set includes gathering external information and resources, modeling the external environment, scanning the environment for threats or opportunities, and soliciting feedback from outside the team.

"Ambassador" functions export team information and/or resources to the external world. This set includes opening up new channels of communication, coordinating and negotiating with other teams, and molding or influencing the external world to ensure more accurate perception of the team's own model of reality. Finally, the set of "guardian" functions buffer the team from external pressures through managing access to the team, translating external messages into the team’s language, and ensuring that legitimate requests from external teams are delivered.

Teams can enhance their inter-teamwork by asking whether and how well each of these boundary-spanning functions is being served by team members. In our own research developing a survey to measure health care teamwork (see, eg., Ryan, Robertson & Cott, 1994), we find that teams may differ significantly in the extent to which boundary spanning functions are performed. In particular, nursing teams tend to have fewer inter-team linkages than non-nursing professional teams. At the same time, our experience suggests that neither group is aware of the need for
routine analysis of these inter-team functions. While the research on boundary-crossing functions has arisen in business settings, the conclusions may well generalize to the inter-teamwork of those caring for frail elders: in contexts requiring collaborative inter-teamwork, teams that perform effective boundary-crossing functions will be the highest performers (Ancona, 1990).

**Inter-teamwork and general systems theory**

So far we have examined the inter-team consequences of team culture and team boundary spanning functions as if understanding each individual team would be sufficient to achieve effective inter-teamwork. But interdependent teams form a network or system, and systems have rules of their own (Buckley, 1968). General Systems Theory seeks to identify the rules governing system behavior (see, eg., Maruyama, 1968) and these rules may provide another tool for gerontologists engaged in the practise of inter-teamwork.

We will explore one general systems rule. This rule states that when information is exchanged across a boundary between sub-systems (in our instance, teams) which differ in their level of organization, the result is an increase in the level of organization of the more highly organized sub-system. This may be at the expense of the less highly organized sub-system (Margalef, 1975).

Consider the following applications of this rule in two situations arising in the author’s inter-team practise. A mature team with a well-developed set of norms was required to work with a new team that had not yet refined its goals and objectives. Both teams identified a need to improve inter-team communication. Whenever they met, however, discussion was dominated by the old team. Members of the new team felt that they were not respected, they did not trust negotiated agreements, and were concerned that they were unable to establish their own agenda. Over several months more communication was attempted but failed to resolve the dilemma.
Though counter-intuitive, the systems rule suggests that less rather than more communication might be desirable until the internal organization of each team approached equivalence. By providing a mediator for inter-team communication while facilitating development of the less well organized team, both teams were able to resume more constructive dialogue a few months later.

Similarly, an intensely fragmented nursing team felt unable to express itself in clinical rounds with a more highly organized multiprofessional team. The nurses felt that when they spoke up they ended up being told what to do. As a result nursing staff remained relatively quiet in team meetings. We applied the systems rule. Rather than bringing the two "teams within a team" together to discuss the situation, facilitation was focused on reducing the fragmentation within the nursing team. Five months later an examination of dialogue during clinical rounds revealed notable change: there were no differences in the level of participation of nursing and non-nursing professionals.

General Systems Theory allows us to understand the behavior of systems or networks such as the network of caregivers collaborating in the care of frail elders. The examples provided illustrate the potential value of general systems rules for thinking through issues in inter-teamwork.

**Outcome Expectations and Inter-teamwork**

The last inter-teamwork tool we will explore is a set of expectations which emerge during the development of inter-teamwork. Systems of inter-team collaboration have their own patterns of development. Ring & Van de Ven (1994), for example, describe an iterative sequence of negotiation, commitment, and execution in the development of collaborative alliances. Gulati (1995) describes a process of inter-team development in which mutual control through formal
equity sharing is a precursor to less formal controls based upon trust. For Tjosvold (1988), a set of equity based expectations arising from inter-team contact becomes a significant factor driving or inhibiting this development. An understanding of these outcome expectations, which arise almost unconsciously in the minds of team members (Kotter, 1973), provides gerontologists with yet another tool to guide their thinking about inter-teamwork.

Tjosvold (1988) describes three key expectations which sustain the development of collaborative alliances: 1) the expectation of a "win/win" outcome, 2) the expectation that scarce resources will be distributed equally, and 3) the expectation that the burden of work will be shared. Consider each of these expectation dynamics in the context of clinical gerontology.

"Win-win" expectations

Sustained collaboration between teams is predicated upon all participants expecting that they will gain from their inter-teamwork. Yet in many instances, teams focus on their own outcomes and one team's gain is another team's loss. "Dumping" of challenging patients is an all too frequent example of this threat to inter-teamwork. An elderly person with dementia, for example, is combative on an acute care unit. To relocate this person to a more appropriate long-term care setting the team downplays combativeness in the medical record and it emerges "unexpectedly" when the transfer is completed. Though the hospital team feels that it has won a discharge, from a systems perspective both teams have lost because the expectations arising from the exchange will compromise the development of future collaboration.

Expecting equitable resource allocation

The development of inter-team collaboration requires that participants come to expect equitable resource allocation. Unfortunately, inter-organizational contact has typically taken the form of competition for scarce resources rather than the equitable distribution of them (Trist,
Consider the following scenario. A hospital based geriatric assessment team and a community care team are jointly planning processes to ensure a seamless continuum of hospital and community care for frail elders. Independently, each team is training health care assistants to provide many elements of the day to day care of their customers. The collaboration progresses until the community team discovers that the hospital team is able to spend many times their budget for the assistant training. The planning process becomes bogged down until the two teams work through the resource allocation issue and combine their resources in a joint training program. The development of inter-teamwork is enhanced when teams expect that the equitable allocation of resources is an outcome of their collaboration.

**Expecting to share the burden of work**

Finally, consider the expectation of shared burden of work as an outcome of inter-team collaboration. Shifting rather than sharing the burden of work is a ubiquitous motif in personal and organizational life, prompting anger and competition rather than collaboration (Senge, 1990). Illustrations of shifting the burden in gerontology are not hard to find. When a multiprofessional team asserts that its members are not responsible for answering patient call bells, the burden of work is shifted rather than shared. Similarly, the burden of work is shifted when a primary nursing team tells a patient that he/she is "not their patient", or when a community support team brings a suicidal elder to an emergency team late Friday afternoon, or when a family "team" treats a day hospital team as a source of respite rather than an opportunity to develop improved caregiving. When the burden of work is shifted rather than shared during inter-teamwork, expectations develop which compromise future collaboration.

Following Tjosvold (1988) we have considered three expectations: the expectation of win-win solutions, resource equity, and shared burden of work which are significant elements in the
development of collaborative alliances. In the practise of clinical gerontology with frail elders the management of these three expectations will likely be significant factors in the development of the collaborative alliances we have called inter-teamwork.

**Summary**

Just as putting people together to work does not necessarily make an effective team, putting teams together does not necessarily lead to effective inter-teamwork. Yet the complex needs of our frail elderly clients and the turbulent nature of the present era confirm that inter-teamwork is an essential though overlooked area for gerontologists. We have shown that the collaborative alliances necessary for effective inter-teamwork hold both promise and liability and we have argued that without tools to guide our thinking about inter-teamwork we are likely to remain focused on the internal workings of our teams and fail our elderly customers and each other in avoidable ways.

Several conceptual tools have been examined which may help us to think more clearly about inter-teamwork in gerontology. We have considered two features of the internal workings of collaborating teams: their relative stages of development, and the mental models or shared social thinking about the world which each team creates. Both are a powerful source of differences which, in business and small group research, have proven a frequent source of faulty attributions giving rise to in-group bias and inter-team rivalry. We have pointed out that simple contact with other teams is not sufficient to overcome these problems. Methods adapted from diversity research in which teams are taught to recognize, discuss, and integrate both inter-team differences and similarities might prove useful to gerontologists practising in collaborative contexts.
We have examined a set of boundary-crossing functions which teams must use in order to link themselves to the external world. Similar to the task and maintenance functions familiar to most gerontologists, however, the boundary-crossing functions serve inter-team rather than intra-team development. We have suggested that teams should periodically review the ways in which they perform these boundary-crossing functions to enhance their capacity to provide seamless service to their elderly customers.

We have encouraged team members to think of their team as one element in a system of collaborative alliances that is governed, in part, by the general rules of systems. One general systems rule was examined in some detail, and the examples provided suggests that the General Systems Theory yields hypotheses which are both counter-intuitive and productive.

Finally, a set of expectations were considered which, though not necessarily common outcomes of collaboration, remain important elements in the development of inter-teamwork. Learning to facilitate "win-win" outcomes, equitable resource allocation, and shared burden of work is an important skill for gerontologists and yet another conceptual tool with which to think through the issue of inter-teamwork.

As Ancona (1990) and Pfeffer, (1986) assert, in environments that require complex interdependency, the quality of collaborative alliances may be better predictors of outcome than the internal processes of individual teams. Increasingly, the development and maintenance of collaborative alliances have become an essential feature of research and practise in business, public policy development, environmental mediation, and service delivery systems. Hopefully, the conceptual tools and the examples outlined here will encourage educators and practitioners in gerontology to take the lead in advancing knowledge and skill development in the teaching and practise of inter-teamwork in the care of frail elders.
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