

Groupthink: What's So Great About Teamwork?

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Introduction

"She's a great team player," a common accolade, may not always be a good thing. Working in groups is neither inherently good nor successful. When effective and efficient, group processes facilitate problem-solving and decision-making and are vital to achieve success.¹ Working alone deprives an individual of collaboration, input, validation, and varied knowledge.

This commentary explores how interactive, small-group processes in Medicine, as in other disciplines, can also have negative effects leading to impaired learning and sub-optimal decisions. Applied to educational and clinical settings, poor group dynamics can increase medical error and poor patient outcomes. Our discussion will focus on small teams, work or study groups, committees or panels that approach a specific problem.²

Why can small groups or teams lead to poor decisions?

Successful groups typically use collaboration, open communication and shared decision-making; ideally, each member has a voice. However, group interactions tend to favor clear, harmonious choices. At times, teamwork may deteriorate into an artificial homogeneity. Groupthink is a group conformity bias where pressure from oneself, peers, or leaders to produce consensus may limit discussion because potential dissenters self-censor, change or suppress a contrary opinion or evidence despite actual underlying disagreement.³ The result can limit group performance by generating fewer and less creative ideas.⁴ Perhaps surprisingly, the factors that affect idea generation, such as trust in teammates, group stability, cohesion and shared brainstorming can accentuate groupthink.⁵

What aspects of collaboration facilitate groupthink?

Group membership can be a powerful trigger to go along with the crowd. Peer pressure to achieve a consensus in homogeneous groups may influence a team member to endorse ill-formed opinions of other members. Insecure,



new or lower-status members may focus on inclusion, friendship, acceptance and self-esteem conferred by group affiliation. Thus, non-conforming individuals may modify or censor their opinions to avoid group rejection, stigma and feelings of inadequacy. In a simple example, Nobel laureate Daniel Kahneman reported studies demonstrating that when a line of individuals incorrectly answers an easy problem, such as medical students measuring

blood pressure, the next student is more likely to mimic their mistake rather than respond correctly, termed a herding or bandwagon effect.⁶

'Wisdom of the crowd' versus individual judgment

In 1906, Francis Galton collected individual responses for a 'guess the weight of the ox' competition, an example of "Wisdom of the Crowd," a belief that the aggregate of solutions from a group of individuals is a superior problem-solving strategy than the majority of individual solutions. The median guess, 1,207 pounds, was less than 1% off of the actual weight of 1,198 pounds.⁷ But, wisdom of the crowd is most accurate when applied to numerical estimates with a correct response such as the number of jelly beans in a jar. The cognitive process in such estimates or specific fact-based questions is not analogous to typical medical decision-making. Aggregate wisdom can be inappropriately applied to complex group decisions which lack a precise answer. We must also note that collective wisdom strategies can work. For example, in Medicine, selecting the diagnosis of a majority of individual dermatologists or radiologists typically outperforms individual diagnoses in mammographic screening and skin-cancer detection.⁸

Groupthink is often resistant to logical reasoning or specific de-biasing training. These predispositions, which can distort communications, are frequently unconscious and automatic contributors to sub-optimal judgment.⁹ (Table 1).

Groupthink is not static or immutable. Its expression may be magnified by contextual influences during the work day which may be ignored, undetected or downplayed (Table 2).

Table 1. Cognitive influences facilitating Groupthink^{1,3,9,10}

Cognitive Bias	Description
Conforming bias	Low status, new or insecure members may stifle opinions to avoid stigma, group rejection.
Herd effect	Group behaviors relying too easily on opinions of teammates speaking early or assertively.
Halo or authority bias	Uncritical acceptance of opinion of senior or experienced member.
Social loafing	Less effort if individual accountability is absent or goal viewed as unimportant.
Bystander effect	If responsibility is unclear or group too large, individuals decide someone else will act.
Sunk cost fallacy	Unwillingness or inability to modify course when too much has been invested.
Decision inertia	Successful groups tend to repeat past decisions.
Motivational blindness	Judgment impaired by self-serving individual, group or institutional conflicts.
Longevity bias	Homogeneous, long-standing or unchanged teams risk becoming echo chambers of like-minded members.
Inbreeding	Groups trained at the same institution risk homogeneity of opinions.
Organizational silence	Potential dissenters self-censor. Silence interpreted as consent.
Team-based burnout	Emotional contagion. Individual's burnout contaminates other members.

Table 2. Contexts facilitating Groupthink

Fatigue, sleepiness (<i>impairs mood, cognition, performance</i>)
Physical and cognitive overload (<i>commitment and focus lag</i>)
Overlong session, time pressure (<i>interest and attention decrease</i>)
Poor leadership – unskilled, bad agenda-setting, unclear aims, authoritarian
Decision fatigue (<i>cognitive exhaustion after tough, stressful day</i>)
Unclear or unshared mental models
Distractions, interruptions (<i>force attention to shift from discussion</i>)
Burnout – individual or team-based
Sub-optimal meeting space (<i>noisy, wrong size or shape, lack of inclusive seating</i>)
Inability to embrace creative aspects of uncertainty or conflict

Embracing dissent in teams

Group conflict or uncertainty may disrupt, distract or poison individual and collective success.¹¹ But, striving for consensus or unanimity can undermine healthy skepticism by undervaluing the benefits of inter-member disagreement. By avoiding conflict, groups may never ask “what are we missing?” Conflict may foster creative ideas by expanding the range of options. Comfort expressing non-conforming ideas thrives when individuals feel safe despite heated debate. Conflict can destroy groups or be a productive, energizing source of learning, leading to superior outcomes.¹²

Conclusion

Medical education and clinical medicine occur frequently in small groups or teams. Collaborative decision-making most frequently leads to better choices. Familiarity with negative consequences of potential group conformity biases can facilitate better group dynamics and improve group decisions. We must be wary that groupthink exists. Sometimes, teamwork can and does fail.

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Physician overextenders

JOSEPH H. FRIEDMAN, MD

I RECENTLY LEARNED FROM a scheduling secretary that my new patients frequently ask, “Am I going to see Dr. Friedman?” She told me that patients often find themselves referred to specialists by their primary care physician (PCP), only to see physician extenders and not the physician. Many patients also tell me they’ve never even seen their (PCP), only the physician assistant (PA) or the registered nurse practitioner (RNP).



a particular joint problem or set of joint problems might explain a peculiar gait. I consider myself a clinical gait specialist. I have given medical grand rounds at other universities on assessing gait disorders. I give a talk every year to geriatric internal medicine fellows, and occasional gait lectures

to other groups. Gait disorders may be complex and I am often stumped, and therefore request opinions of others, who I believe will have more knowledge or experience in some aspect of the problem, since walking problems are often due to more than one contributing problem, like a brain disease plus bursitis. Most physicians, including neurologists and orthopedists, are uneasy assessing gait disorders. So, imagine my surprise to see my referral addressed by a PA. I’ve seen patients referred by a neurologist to a neurosurgeon, who saw only the neurosurgeon’s PA who then sent the patients to me. The first neurologist would have sent the patient to me directly if he wanted my opinion. He wanted the neurosurgeon’s, which he never got.

I sent a patient to a spine specialist because I wanted to be sure that her scoliosis was due only to Parkinson’s disease and not to an intrinsic spine problem. The patient told me that the

PA told her that she had degenerative joint disease and scoliosis due to Parkinson’s disease, which is what I had thought, but I wasn’t sure if this assessment was correct, which is why I sent to patient to the orthopedist in the first place, and without an orthopedist’s opinion, still don’t know if it is correct. I wouldn’t have thought twice about it if I knew this was the spine specialist’s opinion. I sent a letter to the spine orthopedist to ask if I needed in the future to specify that he needed to see the patient! Not only that, but the same day I asked a patient why he limped after his hip replacement. He didn’t know. “Didn’t the orthopedist who operated on you say something?” “I never saw the orthopedist.” “Never?” “He came to the emergency department before the operation, but I never saw him again.” In seven months! Luckily, this has not been the experience of most of my patients who have had hip or knee replacements, but the fact that this was deemed acceptable behavior was a surprise to me.

I understand the need for physician extenders and have worked with them. When I worked with RNPs, I used them only to see patients who I had first evaluated, and I considered relatively stable. If the patient was found to have not been stable, the RNP would get me so that I could review the case, at that time. I can’t imagine why a fellow physician would refer a patient for a non-physician evaluation. I’ve had patients tell me

they were referred by a rheumatologist to an orthopedist and saw the health “extender.” Imagine, a doctor, possibly a specialist in a related discipline, sends a patient to another specialist in a closely related discipline and sees someone, perhaps a PA with 2 years of training, for an opinion. Aside from betraying a profound lack of respect for the referring physician, it displays one of the many weaknesses in our health care system. We train too few doctors, burden them with time intensive requirements that are not reimbursed and then use less well-trained health professionals to help compensate. This allows more patients to be seen in a timely manner, but for consultations, it may actually delay being seen, since the patient may have to wait again, several weeks, or months, to see the doctor.

It upsets me to think that my surgical colleagues think more of their PAs than they do of their medical colleagues or me. I am generally not keen to refer my patients to newly graduated surgeons,

since they lack much experience. Why would a PA or an RNP be an appropriate substitute?

I now have my patients check to make sure they will see the doctor, and call me for an alternative referral if not. I may lose doctors I’ve dealt with over the years but why tolerate a drop in quality?

I am further asking you, the reader, to do the same. Physician extenders have a major role to play in health care. They can provide special services, like follow-ups after an operation, learning to identify danger signs so that they can call the doctor on call, to change dressings, reassure the patient and further supplement the routine care that used to be provided by registered nurses. They can likely sew up some lacerations, apply casts, assist in the interventional radiology suite, insert canulae and catheters, and follow patients in the office who have well-defined problems. If they can substitute for the doctor completely, why not get rid of the doctor and save a lot of money? ❖

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Helping Prevent Unintended Teen Pregnancy in Rhode Island Impacts All of Us

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IN THE LATE HOURS OF A BALMY SUMMER night in Pawtucket, our patient pushed hard, cheeks puffed out and red with effort, beads of sweat at her temples. Her baby boy was delivered, dried off, and wrapped in a blanket before being handed to her. She held the crying newborn, visibly overcome with exhaustion and fear. At 16 years old she was scheduled to start her junior year that fall. Parenthood was not a part of her immediate plans. Now, as a new mother with limited support, life would have to wait.

Having easy access to a low-cost clinic with confidential services that addresses unintended pregnancy and reproductive health is essential to improving the health of teenagers in Rhode Island (RI), according to the Rhode Island Department of Health (RIDOH), and helps them meet their educational and economic goals.¹

Fortunately, there are three such clinics in the state, housed within public high schools in Woonsocket, Central Falls, and West Warwick. These provide a range of low-cost and confidential reproductive health services, including contraceptive services and supplies, to teenagers, thereby reducing barriers to care. These clinics provide these services under the federal Title X program that awards nearly 1.2 million dollars to RIDOH, the state's Title X grantee. The majority of funds are distributed to eight community-based clinics throughout RI.² Under Title X, teenagers who may not otherwise seek care due to financial barriers or fear of parental notification can access affordable, confidential, reproductive health services.

However, federal Title X funding is at its lowest in nine years.³ Additionally, new regulations from the U.S. Department of Health and Human Services (HHS) eliminate the requirement that Title X sites offer a broad range of medically approved family planning methods and nondirective pregnancy options counseling including the discussion of abortion.⁴ These regulations have been challenged by groups including the American Medical Association⁵; however, if these rulings are enforced by the HHS, this action will restrict teenagers' access to clinics with comprehensive contraceptive and family planning services and would have important repercussions on teenage health in Rhode Island.

There is a great public health need for these services. About one in four high school students in Rhode Island report that they are sexually active.⁶ Of those teens who are sexually active in RI, 88% depended on at least one form of birth control during their last reported sexual encounter.⁷ In RI, there are approximately 20 teen girls out of 1000 every year who experience an unintended pregnancy.⁸

These pregnancies have long-lasting impact. Unintended teen pregnancy is linked to greater risk of future disadvantages in education, employment, housing and family structure.⁹ Only 50 percent of teen mothers have a high school diploma by age 22, versus 90 percent of women who do not give birth as a teen.¹⁰ Ensuring that teens have access to birth control is one of the best strategies to boost the graduation rate.

Providing publicly funded contraception to one female teenager costs \$239 a year; researchers estimate a savings of approximately \$6 in medical costs for every \$1 spent on contraceptive services.¹¹

Title X-funded school-based clinics in RI make a difference in helping prevent unintended teenage pregnancy. Based on our analysis of publicly available data from the Rhode Island Department of Health, teen pregnancy and birth rates were significantly lower over time in Woonsocket, where a Title X-funded school clinic has existed for several years. Central Falls, which has the highest teen pregnancy rate in the state, saw an overall decrease in teen pregnancy rates after the introduction of Title X-funded programming at the high school's clinic.

To address the shortfall in federal Title X funding, we urge the Rhode Island House of Representatives and Legislation to appropriate state funding to Title-X funded school-based clinics to allow them to continue providing fundamental reproductive health care, including a full range of contraceptive services and supplies. Specifically, we urge the House to reconsider H7928, introduced by Representative Kazarian last January, which would annually appropriate state funds for contraceptive services; we also ask that they reconsider and include school-based clinics in this appropriations bill. This action will save millions in taxpayer funds and would contribute to the goal of our state's teenagers fulfilling their potential. ❖

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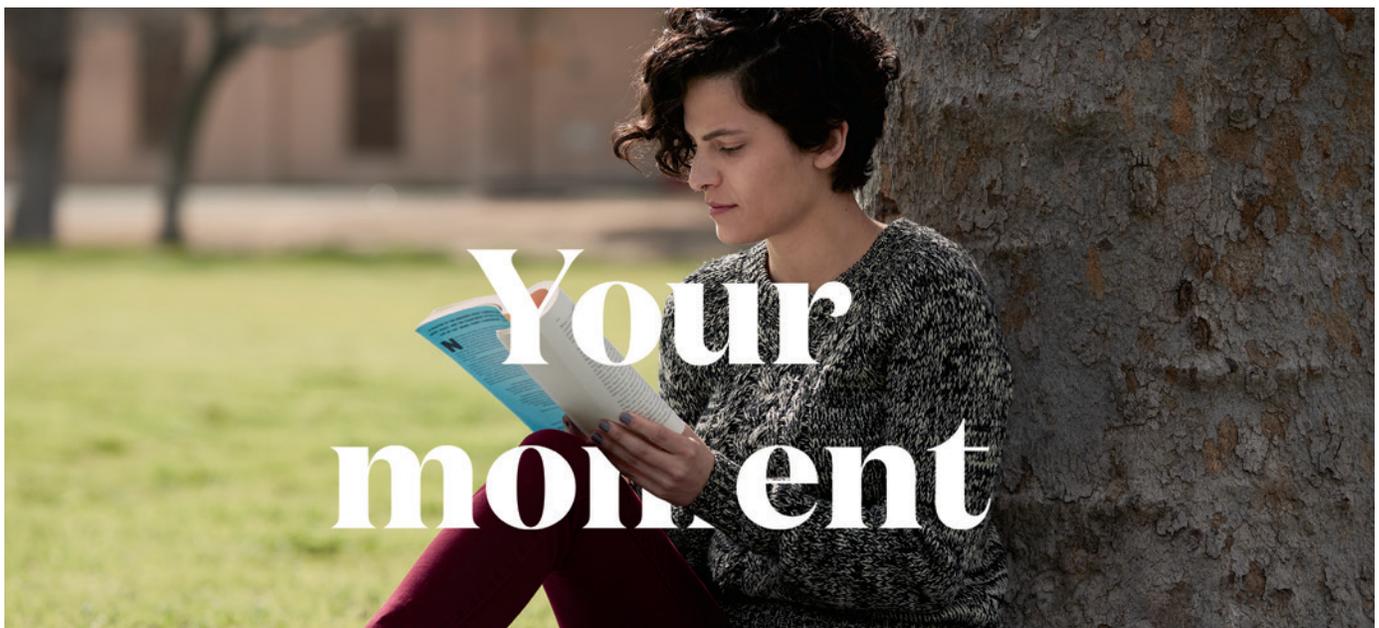
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