Enemies or Learning Partners? The Interplay of Power and Learning in a Cross Boundary Work Group

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Abstract: This study investigated power relationships in a cross boundary health care work group. The study found that power within groups is more fluid and flexible than previous studies suggested. Factors that influence power levels and their impact on learning are discussed.

Introduction

Today as work organizations and the work they do becomes more complex and competitive the decisions and actions of individuals often occur within the context of a work team. Teams are the focal point of how organizations engage in such learning tasks as strategic planning, process improvement, or developing and improving new services (Parker, 1994, Brooks; 1992, 1994). Team-based problem solving has moved beyond organizational walls to accommodate the nature of today's business problems. Staff crosses boundaries when they work, on either short or long term basis, to solve problems by collective discussion and inquiry. Organizational conditions can provide support for working across functional, divisional, and hierarchical lines, such as cross boundary interaction (Watkins & Marsick, 1993). Given the nature of today's workplace wherein work often occurs across organizational lines, there is a need to understand how such groups engage in real-time learning in order to solve problems.

One of many workplace environments undergoing work reorganization is health care. This particular industry is in the process of redesign and upheaval due to the impact of managed care. The missing element in most health care delivery systems is a virtual lack of integration of these components (Witt, Kieffer, Ford, Hadelman, & Lloyd, 1993). The health care work environment is shifting from within institutional walls to working with the extended or integrated delivery system of care that spans across geographic regions and across organizational lines. This creates particular challenges from an Adult Education perspective for the preparation of staff and the possibility of utilizing this forum as a learning experience for personal, professional and organizational benefit. While working in the health care environment, I was curious as to the relationship of power between competitive organizations as it relates to the learning process of a cross boundary work group. This paper provides an overview of the findings related to power and learning in a seven-month study.

Background and Theoretical Framework

From particular studies in the literature regarding learning as a collective team activity there is focus on the adult learning process (Dechant, Marsick, & Kasl, 1993); notion of dialogue in collective team learning (Cicourel, 1990; Dixon, 1994); capture of reflective and communicative behavior (Purser, Pasmore &Tenkasi, 1992); distribution of formal power to individual team

members and the collective team-learning outcome of productive useful new knowledge (Brooks, 1994); and a study of factors affecting group learning with a distinction between learning and task in relation to group purpose (Marsick & Kasl, 1997). This study addressed research needs as described by Goodman, Ravlin, & Schminke (1990); and Brooks (1994) in the following way: (a) within the natural context of workgroup activity rather than artificial; (b) chose a cross boundary work group that was charged with improving the way in which care is delivered to a population of patients to maximize impact; and (c) examined a work group that developed new protocols.

Today the ways we make meaning of ideas, distribute privilege and power, are held accountable to validity testing through rational dialogue. Communicative or dialogic learning is explained as achieving coherence, a critique of relevant social norms, cultural codes and a critique of the assertion itself. As such, meaning is validated through critical discourse, and each item of relevant information becomes a building block of understanding (Mezirow, 1991). I looked to the reflective learning theory literature to provide a foundation for the study. By definition the focus of reflection is not a purely internal thinking process, but also involves action. What gives reflection its' character and significance is thought-in-action immersed within a context. The process of reflection and critical reflection helps us to adjust the distortions in our beliefs, and our errors in problem solving (Schön, 1987; Mezirow, 1991). Within a work group context, reflective learning becomes generative of new thinking as members challenge one another's thinking, reframe their perspectives, and build on integrated perspectives to construct new knowledge (Mezirow, 1991; Dechant, Marsick, & Kasl, 1993). Learning through critical reflection provides a transformation of personal frames of reference, and can be described as a "holistic" blend including personal development, work related knowledge, and skills (Marsick, 1991, p. 24).

Research Design

Since space restrictions prevent a detailed discussion of the research design, this is necessarily a brief summary (see Carkhuff, 1998 for a more thorough discussion). Following Denzin & Lincoln (1994), a qualitative, phenomenological method was selected as the appropriate methodology to made sense out of their work group experience. The central question addressed was: What meaning do participants give to learning when working within a cross boundary work group? Sub-questions were developed after the first round of interviews, during the observations, prior to second interviews. These sub-questions were (1) How do the participants perceive their assumptions about learning affect collective work group learning? (2) How does the group share knowledge and ideas? (3) How do differences in formal power distribution between individual work group participants affect the meaning of learning for participants?

The particular cross boundary work group called the Diabetes Awareness Team, or DAT, was selected based on the criteria of an effective group (Goodman & Associates, 1986). The eleven group members had a range of four to over twenty-five years of work experience, and varied clinical and administrative roles in five competing health organizations located in a metropolitan area in Pennsylvania. They were charged by their respective organizations to work towards developing a plan that would improve health care for at-risk diabetic patients within this metropolitan area. The various health care organizations sending representatives to this work

group had a long history of inter-agency rivalry and competition on who would provide services to the diabetic population. The expressed goal for the DAT was to improve the diagnosis, reduce the number of complications and contain increasing cost of treatment through education, collaboration and organizational cooperation. The members' organizational roles were as follows: Diabetic Nurse Educators, Home Health Nurse, Pharmacist, Rehabilitation Specialist, Health Promotions Administrator, Business Executive, Community Health Workers, and a Staff Development Specialist. The membership included nine Caucasian, one African American and one Latino, of which nine were female, and two were male.

The data collection was divided into two phases. Phase One included: a) pilot interview and subsequent refinement of the interview tool; b) an initial sixty-minute interview regarding social-biographical information, past work group experiences, and a problem solving critical incident; five work group observations with field notes; and document analysis of all agendas, reports, and meeting minutes (Flanagan, 1954; Ericsson & Simon, 1980). I attended all work group meetings over the six-month period, took field notes, and tape-recorded all interviews. I related this to the initial interview information to validate information gathered, and to plan for clarification and additional questions based on the observations during the ninety- minute Phase Two interview. All Phase One and Phase Two data were analyzed in light of the multiple data sources in a continuous process in that I sorted, coded, and interpreted on an ongoing basis throughout the seven month period (Patton, 1990). I verified authenticity of the data analysis through the triangulation and use of multiple sources (Lincoln and Guba, 1985), corroborated through member checks and peer review. Taken together these sources provided a holistic picture of the work group experience.

Findings

This paper focuses on the issue of how power relationships affected learning (see Carkhuff, 1998 for additional findings). One significant finding was that the individual members' power level within the work group was flexible and changeable. Despite the competition between the organizations, the unifying factor in the group was the overall concern for the care of the diabetic patient across the region. The power that members brought to the group by virtue of their individual expert knowledge and life experience shaped the learning experience for themselves and others; and had significant influence on the outcome of the group work. Thus despite their "placement" of themselves in various power statuses, the members of the group perceived power connected to one's as expertise in diabetic health care, whether as consumer or clinician, as centrally important. The members' role in the active work, and the value of their expertise for the production of new knowledge as seen by the group was intricately related. Power levels of members fluctuated as their role with active work changed. Another way that members with lower power raised their power was through "sponsorship" by a higher power member. For example, one team member was a diabetic patient. He was "invited" to assist in the problem solving as a member of the DAT by a member who as a diabetic educator, had a great deal of clinical expertise. The diabetic entered with a lower power as a non-clinical person but because of his sponsorship by the diabetic educator, he soon became an active work participant, and as such his power level increased. He described his participation as "an opportunity for learning..that's what this group is all about". He spoke of his role changing to "learner", and on occasion "educator".

The group leadership style ranged from a combination of supportivity and inclusivity to occasionally allowing lower power members only supportive roles. Of the members with initial low power, two were community workers who directly reported to the person who was the group's facilitator and one was a businessman, outside the health care industry. Since the group's problem solving revolved around solutions for diabetics, their initial status could be attributed to their absence of clinical expertise. Data gathered over many months indicated that the power level of an individual member was directly related to the perceived value of their contribution to the work group goal despite the facilitator's occasional disempowering leadership. For example, both community workers remained at a lower power level until the last DAT meeting. The group facilitator had consistently assigned them tasks during work group meetings instead of allowing the two to volunteer for assignments. The group facilitator also reported the status of their active work for them instead of asking them to report to the group. The two community workers became actively involved when assigned an active work role together, to make bilingual flyers to communicate the project event to the region. During the last DAT meeting, one worker presented the flyers (both English and Spanish versions) herself to the DAT because the group facilitator did not know they were completed. The other DAT members immediately embraced the work they (even though one community worker was absent), had accomplished as this became the vehicle of communication across the region for the project event. Several higher power (clinical expert) members focused their attention to her and revolved the decision making and problem solving around the issues of communication. The community worker for the first time took an active role in the problem solving, and the group facilitator was diminished to a medium power level for the entire meeting. The worker described this meeting as a pivotal point for her. She saw an "opportunity to teach others" regarding outreach to the urban citizens. Her experience in the DAT shifted from the learner to the educator role, her power from low to medium level. This rise in status within the group was a migration of role directly related to how the members perceived the active work role related to the problem solving at hand, as the two community workers were transformed in their active work roles, and assumed leadership as "educators" of the group related to issues of how to handle communication and planning relative to the minority diabetic population. This contribution to the mission of the group was direct and provided an enduring power shift, a transformational learning experience for the two community workers, and produced new knowledge for the group.

The issue of race and the accompanying cultural differences mattered in the work group experience for the two minority members. When they were faced with an issue or problem to solve in the DAT they saw it through the lens of race and culture, and how decisions would impact their diabetic "communities". They faced issues of symbolism related to the use of agendas and reports, access to care and education, and language barriers while the other members were concentrating on clinical protocols. Related to this issue was the importance of specific cultural norms related to assumptions about use of reports and agendas in work groups. Minority members attached the meaning of formality to the use of reports and agendas that signified superiority, a separateness between minority and non-minority work group members. Due to this barrier, individual learning for these members was fragile. They felt power was controlled by the Caucasian membership, and at the start felt like "tokens". What changed was that by pooling their resources in lieu of "quitting the group", they recognized the need to educate the Caucasian members. The African American member had previous experience as a "champion", and provided mentoring and support to the Latino member. The group facilitator

encouraged and supported both minority members in the work group, but was at times, disempowering by limiting their input. The minority members mentored each other and became transformed from passive members to "learners" and "educators" regarding communications across the region, and provided insights to the membership regarding the mission of the work group to serve the at-risk diabetic population. At the end of the six months they were changed both personally and professionally as they educated and supported the work group to refocus their priorities to fulfill the mission of service to the underserved diabetic population, and assumed an elevated power status in the work group.

Implications

Brooks' (1994) research described the distribution of formal power as a critical lever in the successful production of knowledge by teams. Her research addressed the notion that formal power assigned by organizations either supports or excludes employees from carrying out the reflective or active work of team learning. In clear contrast to Brooks, this study examined power relationships within the group itself and suggested that the power relationships are fluid and more complex than suggested by Brooks. Flexibility of individual power levels within the work group was not exclusively dependent on the power of the organizational origin nor on individual's power in that organization. There was a relationship between the definition of expert knowledge and work group priorities, the role of "educator" and "learner" and as such the power shifted as the priorities and roles shifted. In addition, movement to a higher power position occurred was through sponsorship by a high power member. This sponsorship facilitated individual members to "accrue" power from a low to medium status and thus "validated" their expertise. Race was an issue of power between the Caucasian, African American and Latino members. Minority work group members were at-risk for learning in a work group setting due to cultural and language differences, and their focus on protecting service to their "communities" while the majority members assumed active work roles. The use of mentoring was important to salvage their role as "learners" and "educators" in the work group and to strengthen their position of assuming active work roles and securing a higher power status. Although learning in cross boundary work groups is problematic, the flexible nature of power relations within a work group with diverse membership and competitive organizational histories can result in significant transformational learning that can change members' personal lives, their role as professionals, and their contributions as team members.

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