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A Case Study of The Adaptation of a Team Building Model Using Action Learning

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Submitted to the Program of Organizational Dynamics in the Graduate Division of the School of Arts and Sciences in Partial Fulfillment of the Requirements for the Degree of Master of Science in Organizational Dynamics at the University of Pennsylvania
Advisor: Charline S. Russo

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Abstract

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Comments

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ABSTRACT

This capstone examines the adaptation of an existing team building model proposed by Patrick Lencioni (2002) in *The Five Dysfunctions of a Team: A Leadership Fable*. I present a case study of the adaptation of that team building model within the context of a United States Public Health Service (PHS) disaster medical response team, the PHS-2 Rapid Deployment Force (PHS-2 RDF). It provides background on the history of PHS and origins of the part-time, volunteer, disaster medical response teams used by the Department of Health and Human Services. I demonstrate how the lack of a formalized officer and team training program provided the impetus and opportunity for a team to adapt a team building model in real time. The study examines the challenges faced by the team in the model adaptation process. The adaptation process resulted in a customized version of the team building model for ongoing use by the executive staff in carrying out their leadership responsibilities within the team. The team did this as a means to aid in the growth of a team culture. I show how the model can be used in the future.

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CHAPTER 1

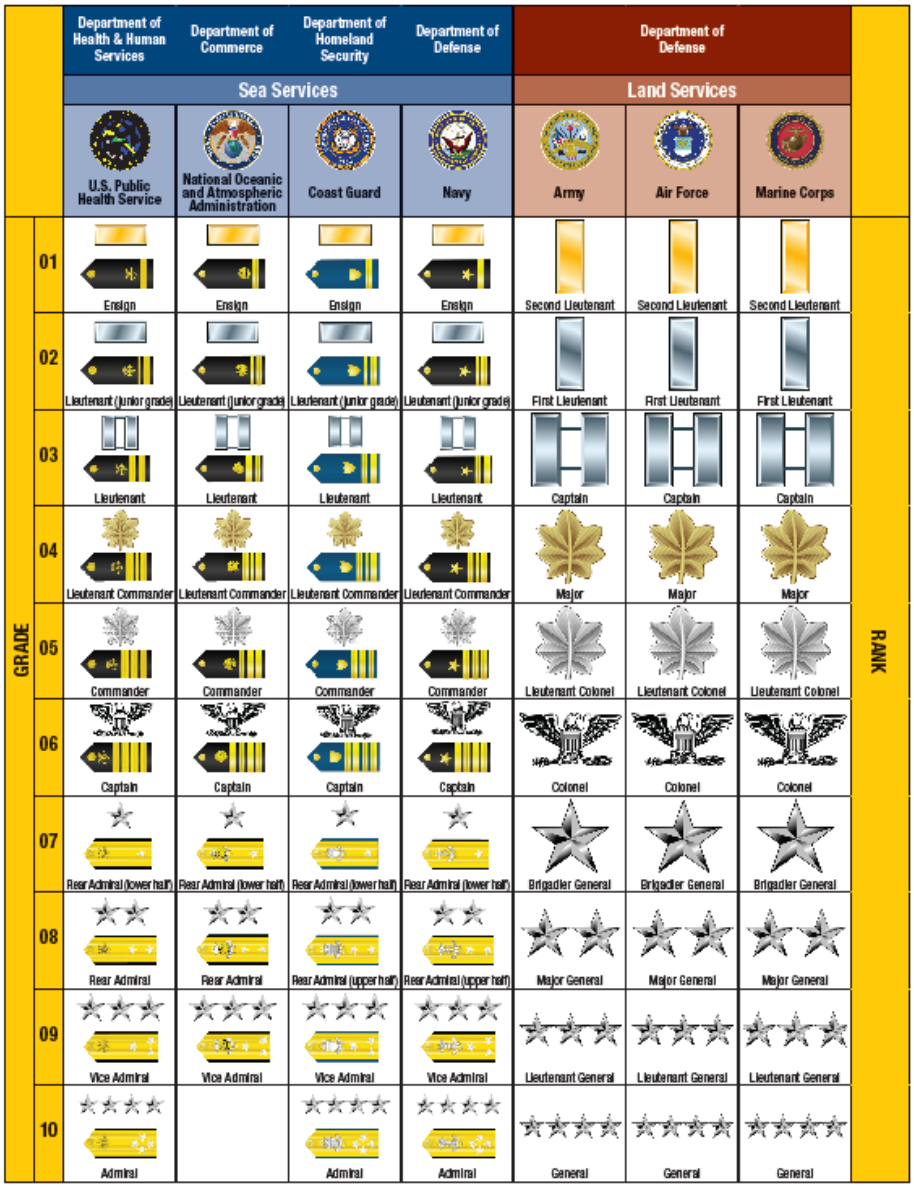
INTRODUCTION

The United States Public Health Service

The Commissioned Corps of the United States Public Health Service (Public Health Service or PHS) is a branch of the U.S. Uniformed Services that includes the Army, Navy, Air Force, Marines, Coast Guard and the Commissioned Corps of the National Oceanographic and Atmospheric Administration. Like the officer corps of its sister services, the PHS is comprised of active duty, presidentially-nominated and Senate-confirmed commissioned officers. PHS officers are exclusively medically-oriented health professionals such as physicians, dentists, nurses, pharmacists and other allied health professionals. Another distinguishing feature of the PHS is that has no enlisted personnel. In the broadest context, commissioned officers in the Uniformed Services are white collar workers and generally require a bachelor's degree for commissioning. Enlisted personnel are blue collar workers and generally require a high school diploma. PHS officers hold the same ranks as officers in the other sea services from ensign to admiral as shown in Table 1 below. They advance through those ranks in a similar competitive promotion process. The most widely recognized officer in the PHS is the United States Surgeon General. The most well known Surgeon General of recent times has been C. Everett Koop. As the highest ranking officer in PHS, the Surgeon General of the Public Health Service holds the rank of Vice Admiral.

Table 1 Ranks of various Uniformed Service Officers

Uniformed Service Rank Chart



Source: http://www.usphs.gov/pdf/Uniformed%20Service%20Rank%20Chart.pdf

The forerunner of the PHS was created in 1798 by President John Adams. Maritime commerce was critical to the new United States. President Adams signed into law an act that required the Treasury Department to provide "for the relief and maintenance of disabled seamen." Effective medical care of mariners helped to ensure the new nation's ability to conduct international commerce. "Disabled seamen" could not sail the ships on which trade depended. The act created a fund that was used to build hospitals in ports around the country. The hospitals were collectively known as the Marine Hospital Service. The Marine Hospitals provided medical care to all mariners including merchant seamen, the Navy and Coast Guard.

After the Civil War, public scandal erupted over mismanagement of the Marine Hospitals. This precipitated a reorganization that resulted in the appointment of a Supervising Surgeon (later Surgeon General) to oversee and administer the Marine Hospital Service hospitals. That Supervising Surgeon reformed the Service along military lines with uniforms, rank and entrance examinations for physicians. He created a mobile cadre of medical professionals who could be assigned anywhere needed within the Marine Hospital Service. In 1889 Congress passed legislation that formalized the reforms and created the Commissioned Corps of the Marine Hospital Service as one of the Uniformed Services of the United States. Over the next century, the Service's responsibilities in public health related activities expanded to the point that the name was changed to the Public Health Service. Further governmental reorganization in the 1950s moved the PHS from the Treasury Department to what is today the Department of Health and Human Services. The last Public Health Service Hospitals were closed in 1981 as a budget cutting measure. PHS today lives on as the collective name given to a group of

agencies within the Department of Health and Human Services. These include the Centers for Disease Control, National Institutes of Health, the Food and Drug Administration and others. The 6,500 officers of today's PHS are assigned to those PHS agencies. During normal day to day PHS agency operations, PHS officers work alongside and follow the same chain of command as their civil service counterparts. However as a Uniformed Service, regulations governing PHS officers' promotions, leave, and pay mirror those of the other Uniformed Services, distinct from those of the civil service. During emergencies PHS officers are directed by the Surgeon General to respond anywhere as needed to provide emergency relief to stricken populations. A more detailed history of the PHS is included as Appendix D.

PHS Disaster Response

In 1984, PHS fielded its first team of volunteer officers to respond to disasters such as hurricanes, earthquakes, floods, terrorist events, and disease outbreaks. The PHS Disaster Medical Assistance Team was a prototype, part-time, team of 35 medical and allied health professionals. The team's mission was to provide pre-hospital medical services in an austere field environment similar to a front-line military field hospital. Members of the PHS Disaster Medical Assistance Team had "day jobs" in PHS agencies within the Department of Health and Human Services. As volunteers, team members were required to obtain supervisory approval from their day job chain of command to deploy with the PHS Disaster Medical Assistance Team. Depending on the workload of the agency and the degree of cooperation from upper management, the agencies sometimes granted approval and sometimes not. The team's success in relieving suffering and providing medical care provided the proof of concept that resulted in the

formation of other Disaster Medical Assistance Teams. These other teams were comprised of civilian volunteers whose day jobs were not with the Department of Health and Human Services. These teams still function and serve in disasters today. In its 20 year history the PHS Disaster Medical Assistance Team deployed to provide field medical services after hurricanes, during mass gatherings in Washington, D.C. such as Presidential Inaugurations, and notably to Ground Zero after 9/11.

A post 9/11 reorganization of the Department of Health and Human Service transferred control of the Disaster Medical Assistance Teams, including the PHS Disaster Medical Assistance Team to the newly created Department of Homeland Security. This did not affect the civilian Disaster Medical Assistance Teams in their ability to deploy to disasters since their members were not employed by the Department of Health and Human Services. However, it rendered the PHS Disaster Medical Assistance Team undeployable because the Department of Homeland Security could not deploy a team whose members belonged to another federal department, the Department of Health and Human Services. This bureaucratic snafu prevented the PHS Disaster Medical Assistance Team from responding as a team to Hurricane Katrina. Still, more than 2,100 PHS officers were individually deployed to the Gulf States to set up Federal Medical Stations, staff mobile emergent care clinics and to replace local health departments whose employees evacuated because of the catastrophic hurricane (U.S. Department of Health and Human Services, 2007, p.4). A Federal Medical Station is a special medical shelter for people who are too ill to care for themselves but not ill enough to go to a hospital. Since the PHS Disaster Medical Assistance Team was undeployable and no other PHS disaster response teams existed, individual PHS officers were deployed based on their

skills. Officers who deployed in response to Hurricane Katrina met as a group for the first time when they arrived at their deployment location. PHS officers performed their shelter healthcare and other duties well despite the cobbled together nature of the groups but the approach was sub-optimal. Officers generally had no idea what their actual role was until they arrived at the disaster site. They could be assigned as a staff doctor or nurse or could be put in charge of shelter with 1000 evacuees and a staff of a hundred PHS officers. Many times the role for which they deployed changed because the officer who was supposed to be fulfilling that role never arrived or was redirected. This was due to the lack of response infrastructure and familiarity with moving many officers quickly to the site of a disaster. Additionally, due to sheer manpower constraints, officers were frequently assigned roles for which they had no experience. For example, a therapist officer might be assigned as a planning officer or a pharmacist officer might be put in the role of a logistician.

In 2006, the Department of Health and Human Services conducted an evaluation of its response to Hurricane Katrina as part of the White House report, The Federal Response to Hurricane Katrina: Lessons Learned. Recommendation 57.c. of that report's Appendix A advised that Health and Human Services "…should organize, train, equip, and roster medical and public health professionals in pre-configured and deployable teams (Townsend, p. 105). The Department of Health and Human Services directed PHS, through the Surgeon General to carry out this task using volunteer PHS commissioned officers in much the same way volunteer officers were used to staff the now defunct PHS Disaster Medical Assistance Team.

In 2006, PHS created five Rapid Deployment Force (RDF) teams comprised of 105 officers each including every type of PHS officer: doctors, nurses, pharmacists, dentists, veterinarians, therapists, dietitians, engineers, environmental health officers and health services officers. The intended mission of RDF teams was manifold, but included setting up and running Federal Medical Stations, administering mass vaccination/mass prophylaxis programs (such as occurred during the anthrax attacks of 2001), providing medical staff for inundated hospitals, and others. PHS also created 36 other teams that respond to various types of medical public health missions. All PHS response teams are comprised solely of PHS officers for whom team membership is a collateral, volunteer duty. I am the Commanding Officer of the PHS-2 RDF.

Introduction

The USPHS created a total of 41 medical and public health response teams between 2006 and 2010. These teams are part-time; their closest analogs are Armed Forces Reserve units. For the Armed Forces (Army, Navy, Air Force, Marines, Coast Guard), forming a new unit is a straightforward process whether the new units are brigades, ships, or squadrons. Using an existing template, the new unit is staffed with service members whose career to that point has prepared them for their role in the new unit or a similar unit already in existence. They have attended their service's technical training, leadership and career development courses. They have had assignments that prepared them for their new roles in the new unit. The individual members of the new brigade, ship or squadron have trained with a similar unit in the past. They possess an understanding of how the unit is to do its mission in the field, sea or air. For PHS, no such templates existed. PHS did not have and still does not have formalized technical

training, team training or rank-specific career or leader development training. At the time of their by-fiat creation, no response units existed where PHS officers would have been groomed with various assignments to prepare them for service or leadership of the newly created teams. Some team members of the former PHS Disaster Medical Assistance Team volunteered for service in the RDFs. This provided some of the RDFs with experienced field responders but the 35-person PHS Disaster Medical Assistance Team was a shallow well with which to water five 105-officer RDFs and 36 other teams. The PHS Disaster Medical Assistance Team similarly suffered from the same lack of a structured training program, grooming assignments and planned succession for its officers. In addition, severe budget and staffing constraints prevent the development of PHS disaster response doctrine. Once developed, response doctrine defines the types of missions to which teams can respond. Those missions dictate the type and extent of role specific training, team-wide operational training, career/leader development and team building training. This capstone will focus on this last element, team building. Using a case study of how PHS-2 RDF adapted a team building model, it will recommend a reproducible and sustainable model for PHS response team commanders to begin building their teams into highly functioning teams at little or no cost.

Chapter 2 is a literature review of teams, learning modalities that were used in the development of the team building model, and team building models. Chapter 3 provides an organizational description of an RDF, an organizational analysis common to response teams, challenges with building teams and solutions that have been used to date. Chapter 4 is a description of the process used to develop a tailored team building model, blending the various learning modalities. Chapter 5 is a presentation of the team building model.

Chapter 6 recommends a plan for implementing the team building model across the PHS disaster response teams. Conclusions and recommendations are included in Chapter 7.

CHAPTER 2

LITERATURE REVIEW

Teams

Many times throughout industry, academia, government and nongovernmental organizations, the term team is loosely applied to a grouping of people that have something in common or a group whose management wishes them to be a team. Parker (1990) indicates that this latter group, masquerading as a team, is actually an "administrative convenience" (p. 32). The factors in common can be their mission, their organizational affiliation (everyone's part of the team) or a particular project. It is important to understand that neither will alone nor grouping creates a team. It is likewise important to understand what a team is. Maria Guerin's research (1997) indicates the commonalities in team definitions are the presence of a unifying task and necessary interdependence among the members in accomplishing the task. The unifying task is straightforward enough (Why are we here?), which varies according to the reasons the team was created. In the case of long standing teams, the unifying task can be the specific project or mission the team happens to be working on. The interdependence component of teams seems to be the clearest indicator of a group that is a team. Without interdependence of team members, what remains could be a group of individual contributors. A sales force in which each member is independently responsible for a number or volume of sales is a group but is not a team. Similarly, runners in a race have a common goal (winning) but they do not act as a team. Parker also indicates that

> A group of people is not a team. A team is a group of people with a high degree of interdependence geared toward the achievement of a goal or completion of a task. In other words, they agree on a goal and agree that the only way to achieve the goal is to work together (p. 16).

Katzenbach and Smith (1993) clarify the distinction between a group of people and a team in their definition:

> A team is a small number of people with complementary skills who are committed to a common purpose, performance goals, and an approach for which they hold themselves mutually accountable (p. 45).

This last definition most closely describes the PHS-2 RDF executive staff on which this capstone is based. Katzenbach and Smith point out that a team generally should have 12 or fewer members (xvii) though they later point out that this is more of a pragmatic number related to adequate meeting space, time to allow each member to participate, and amount of unifying work for each team member (p. 45). The members of the PHS-2 RDF executive staff also have complementary skills from a number of viewpoints. In their roles as leaders of medical operations, planning, logistics, administration, safety and public affairs they are dependent on each other for accomplishing the mission in the field. They also represent a rich variety of medical professions: including physicians, nurses, pharmacists, dentists, EMTs, allied health professionals, social workers, research scientists, engineers, epidemiologists and hospital administrators. That variety provided a spectrum of viewpoints and input while the team adapted an existing team building model. The executive staff was also committed to the development of the team building model, understanding that maintaining a high performance team was an important goal for the future of the team. I believe PHS response team commanders should define for themselves which unit members should be part of their executive staff. Since the various types of PHS teams can vary from five members for a Capital Area Provider Team to 105 for an RDF, the ultimate appropriate number for the executive staff depends on the team commander's judgment. I suggest that team commanders implement an incremental

approach, beginning with their direct reports (ideally 5-7) and build from there. This is similar to the Burlington Northern case from Katzenbach and Smith where a small executive team at the top manages an extended team (p.46). Regardless of the actual number, I suggest that a team commander work through the training model with his executive staff which then has the opportunity to pass on the concept and model it to their direct reports. In this way, the team commander can not only build the team, but in the process, model the process so that each of his subordinates can infuse their subordinates with the team building principles. In this way it becomes the part of the team's culture. This dual process of building the model and modeling the model blends elements of transformative learning and action learning.

Transformative Learning

Mezirow (1978) first introduced the concept of perspective transformation. This theorem postulates that at some point, a person experiences unsatisfactory results in some aspect of his life: an important personal goal is not met, a relationship ends badly, a work project fails. The level of dissatisfaction is of such a degree that the person wants to seek ways to avoid the recurrence of the event in the future. This causes the person to begin to reflect on the incident in an effort to attribute causality. This can lead to the person coming to the realization that the unique combination of his experiences, education and beliefs that created his viewpoint (Mezirow's "meaning perspective") ultimately led to the failure. Further, that in order change the outcome, he may have to change one or all of his experiences, education, or beliefs. Perspective transformation occurs when the person discovers, is taught, or creates a new viewpoint and embraces it to arrive at a desirable outcome. Perspective transformation is the process of moving from an unsatisfactory

meaning perspective to a new and more satisfactory meaning perspective. The period between leaving an old meaning perspective and gaining the new one is the period in which transformative learning occurs. Mezirow identifies this when he says

> Transformative learning refers to the process by which we transform our taken-for-granted frames of reference (meaning perspectives, habits of mind, mind-sets) to make them more inclusive, discriminating, open, emotionally capable of change, and reflective so that they may generate beliefs and opinions that will prove more true or justified to guide action. (2000, pp. 7-8)

In essence, in his conceptualization of perspective transformation, Mezirow scholarizes the life altering epiphany that occurs when one acts on the realization of the truth of the old saw about the definition of crazy being when one does the same thing over and over again expecting a different result:

> a conscious recognition of the difference between one's old viewpoint and the new one and a decision to appropriate the newer perspective as being of more value." (1978, p. 105).

Rossiter's (2007) comparison of Mezirow, Freire, Tennant and Jarvis yields similar elements common to their various conceptualizations of transformative learning: recognition of a need for change in one's life, perspectives, or circumstances; critical reflection on individual or societal assumptions; communication and connection with others who have a similar life experience; exploration of what course of action is possible and desirable; and enacting the new learning as an individual or through social action. (p. 88)

Transformative learning also describes the process the PHS-2 RDF executive staff went through in participating and enacting the team development effort. While transformative learning requires recognition of the need for change, in the team's case it was a gradual realization that it needed to have a deliberate foundation on which to build

a continuously high functioning team. The entire project was aimed at avoiding the unsatisfactory situation of being a team in crisis, having recognized too late the need for a solid foundation. This insight from ADM Hyman Rickover's admonition on learning from mistakes is particularly salient: "You must develop the ability to learn from the mistakes of others. You will not live long enough to make them all yourself." Since no team development support structure, philosophy or training exists within PHS, the PHS-2 RDF executive staff was free to develop its own.

Using Rossiter's common elements, the team went from recognition to exploration of possible courses of actions in adapting team building principles to the current and ongoing stage of enacting the new learning acquired as a result of the team development process. The process the PHS-2 RDF executive staff used was a form of action learning.

Action Learning

Action learning as a concept was formalized by Reginald Revans in the 1940s (Rimanoczy p. 233). This was further developed as Revans' Learning Equation: L = P + Q where L is learning, P is programmed instruction and Q is questioning inquiry (Dilworth, xiv). Revans held that action learning could be very broadly applied to situations where there existed

> A **REAL** PROBLEM, empowerment of the learners; making questioning inquiry the start point and central to the process; operating in teams (which he called "sets") of five or six, all team members to be equal, no designated team leader; an emphasis on balancing action with reflection; ideally placing learners outside their expertise and comfort zones in order to trigger "fresh questions:' a preference for teams where all team members share a common problem; a minimum of external facilitation by experts; and simply trusting the process (Dilworth, xvi).

Potential action learning applications include business, non-profits, all levels of education and academia, government and the military. The overarching concept of action learning is learning by doing, doing by learning (Weisbord, p. 203) with the addition of reflection on the learning. This was characterized by Argyris as double loop learning. Single loop learning involves solving a problem whereas double loop learning solves the problem and learns about the problem solving-process itself (Burke and Noumair, p.145). This is also supported by Huge and Bing who point out that teams that use action learning will fail unless part of the action learning is individual development of the team members (Huge and Bing, p. 134). In addition Dilworth points out that the value of action learning is not confined to the instances where the technical components identified by Revans all need to be in place in order for action learning to take place: "label is much less important than results" (Dilworth, p. 56) and only a few need to be present. The elements that were in place for the PHS-2 RDF executive staff included a real problem, empowerment of learners, a relatively small team, reflection and placement outside of our area of expertise.

The team's problem, as I saw it was that it didn't have any problems. This is in line with Mezirow's (1978) quote of Laing:

> He does not think there is anything the matter with him
> because
> one of the things that is
> the matter with him
> is that he does not think that there is anything
> the matter with him
> therefore
> we have to help him realize that,
> the fact that he does not think there is anything
> the matter with him
> is one of the things that is
> the matter with him

The PHS-2 RDF had performed their assigned missions well. The various phases of deployment including initial call up, travel, setting up operations, concluding operations and redeployment home had gone off with few surprises. However this had not been the result of a deliberate and methodical plan for problem solving or team building. The team had been fortunate to have the right people in the right places. The Laing quote above describes my own perspective transformation. I saw that our problem was to develop a deliberate and methodical plan for team building. The learners, the PHS-2 executive staff, were empowered to learn as there was no previous plan to develop the team. Since no one on the PHS-2 RDF executive staff had been through a team building process there was no expertise on the team in doing team building. This is consistent with Revan's action learning model. Throughout the team building model development process, which continues as part of team life, time was built in for reflection and thought sharing on the process.

Watkins and Marsick (1993) also identify three action learning technologies that can enhance team learning: action research, Action Learning Reflection™ and action science (p. 118). Action research is a single loop process in which an intervention is followed by data collection on the effectiveness of the intervention. The data gathered from the intervention are reflected on and new interventions are designed to solve the problem and the process repeats. In Action Learning Reflection™, the emphasis is on reflection of the action taken by teams to solve real problems in real time, generally in a work context. This methodology also stresses the use of non experts in the inquiry reflection. This allows the fresh thinking that can provide solutions overlooked by the stovepiped thinking of subject matter experts. Action science is used to bring about

individual awareness of the effects that unvoiced assumptions can have within organizations and how the organizational culture can affect unvoiced assumptions (p. 121- 131).

The situation the team encountered where there was no team building guidance from the parent organization (PHS) is identified by Watkins and Marsick as an important part of the organizational environment in which enhanced team learning can take place: "Teams may not have much control over organizational conditions (PHS has no team building training), but they can improve their own team practice. Some problems can be solved by team training…" (p. 115) Watkins and Marsick point out that key aspects of action learning include using "experiments" to solve problems, providing new tools for team members and changing aspects of the entire system. The process the PHS-2 executive staff went through reflected these components.

Blended Prospective Transformative and Action Learning

The process the PHS-2 executive staff went through was not purely transformative learning, nor was it purely action learning, but rather a blending of elements of both. Transformative learning begins with a crisis and action learning similarly begins with a real problem. The PHS-2 executive staff "problem" was that it didn't (yet) have a problem, and in Laing's parlance, that was the problem. Recognizing this is why I have labeled the process as blended prospective transformative and action learning. Since no previous model of team building existed within PHS, I was free to prospectively appropriate, on the suggestion of Dr. Charline Russo, a model which resonated with my situation as Team Commander and one which would represent the new meaning perspective once fully implemented. Getting the PHS-2 executive staff,

including me, from where it was, devoid of a model, to the place where team building was part of our the team's culture involved action learning: learning by doing, doing by learning combined with reflection; this parallels the implementation phase of transformative learning.

Team Building

The various stages of team development were described in 1965 by Tuckman in his now famous forming-storming-norming-performing model. Tuckman points out that his labels originally came from four elemental groupings of orientation / testing / dependence; conflict; group cohesion; and functional role-relatedness. One of these, conflict, is seen in many team building models. However, as widespread as Tuckman's model is (2997 citations as of 24 June 2011), its purpose was to extrapolate general concepts of group development, not provide a model for building a team. The definitions of team building may provide clarity.

Wideman (2011) provides three definitions of team building:

> 1) The process of influencing a group of diverse individuals, each with their own goals, needs, and perspectives, to work together effectively for the good of the project such that their team will accomplish more than the sum of their individual efforts could otherwise achieve.
> 2) The ability to gather the right people to join a project team and get them working together for the benefit of a project.
> 3) The vital soft skills for project managers who need to understand team dynamics and the individual characteristics that make up a high performance team. According to Tuckman and Jensen the stages are forming, storming, norming, performing and adjourning.

These definitions are valuable in describing and understanding the dynamics of a team being built from the perspective of an observer, however, they lack the specificity necessary for an in-process leader to build the team. For this I turned to a model of behaviors and practices that would form the foundation of a lasting, highly functioning

team. I found this model of behaviors and practices in Patrick Lencioni's *Five Dysfunctions of a Team: A Leadership Fable* (2002).

Lencioni uses the literary device of a novel about a Silicon Valley startup company to introduce the principles of team building. In the novel, a new CEO illuminates a talented but dysfunctional team to the reasons and cures for its dysfunctions. Lencioni identifies these dysfunctions as: absence of trust, fear of conflict, lack of commitment, avoidance of accountability and inattention to results.

In Lencioni's model, the trust referred to in lack of trust refers not only to "predictable behavior" – we trust an employee is going to complete a project on time because they have repeatedly demonstrated a propensity to do so – but also a more elemental kind of trust. This is the kind of trust that exists when one is comfortable enough with fellow team members to allow himself to be vulnerable. It permits an individual team member to admit weaknesses in an environment where other team members will use that information to collectively find solutions and not as ammunition against the employee in a competitive system. Fear of conflict is the situation that exists when because of a lack of trust, team members are not willing to engage in debate over ideological ideas. Without trust, people disengage for fear that expressing a differing viewpoint will expose vulnerabilities which will put them at a competitive disadvantage or encourage simple ridicule. Lack of commitment exists primarily because team members have not bought in to the team's goals or objectives. This is caused primarily not because they do not agree with the goals or objectives of the team, but because they perceive that their voice has not been heard in the goal or objective development process. This occurs because they avoid the conflict of having their voice heard which in turn is

due to a lack of trust. Avoidance of accountability exists as ambiguity on the team in terms of meeting specific outcomes or occurs when leaders do not enforce adherence to objectives or timelines. It also refers to the situation where team members do not hold each other accountable for meeting objectives or timelines. Inattention to results occurs when team members place personal objectives or ego above team objectives.

To focus on the positive nature of team building and to reinforce positivity with the PHS-2 RDF executive staff, I recast Lencioni's dysfunctions as strengths: trust, use of conflict, building commitment, accountability and attention to results. I note here that the version of *The Five Dysfunctions of a Team* I began with was an audio version. I cannot account for fact that I did not hear Lencioni's positive recasting in the audio version. He provides the positive approach in the print version (p. 189-190).

Lencioni's five dysfunctions of a team seem to parallel Parker's eleven signs of an ineffective team (p. 57). Lencioni's lack of trust describes the root cause of Parker's stuffy, formal meetings that have talk and participation but lack accomplishment and real communication. It also explains the circumstance where there are private post meeting conversations over issues that should have been brought up during the meeting but weren't due to a lack of trust. Parker also posits that a leader that makes decisions without meaningful input from other team members is a sign of an ineffective team. This is attributed to a lack of trust also but not between team members but rather a lack of trust of team members by the leader. Parker describes an inability to easily describe a team's mission and confusion or disagreement on the team about roles or work assignments. This appears to be directly attributable to a lack of focus on what the team is actually

accomplishing or was meant to accomplish. In Lencioni's words this is a lack of attention to results.

CHAPTER 3

PROBLEM BACKGROUND: ORGANIZATION, ANALYSIS, AND SOLUTIONS

When the PHS-2 Rapid Deployment Force formed in June of 2006 I was appointed as a deputy commander. I was actively engaged in the team's formation, recruitment and selection of personnel for team leadership positions. Before my appointment as Team Commander in 2008, the team received a total of one week of training which occurred the previous year. That one week of training was a field training exercise comprised mostly of classroom training with one brief 12 hour emergency response exercise with moulaged (stage make-up "injuries") "patients" and "casualties." PHS-2 RDF performed well during the exercise by sorting through the exercise chaos and providing necessary medical care to the "patients." From the viewpoint of an external observer, PHS-2 RDF was a successful team: it did its job, took care of its people, and enjoyed high morale and esprit de corps. It voluntarily met on a monthly basis even though there was no requirement to meet at all. During the meetings team members provided short trainings created by various team members such as an overview of triage. The team also established a few traditions. When I assumed command, the team's response to real world missions was very limited. It had been called on for one brief weekend medical support mission to provide care to the masses of attendees at the funeral of President Gerald Ford in Washington, D.C. The team was something new and fresh in PHS and officers were excited to be part of it. One of the traditions the team established was a call and response. When someone was speaking in front of the team and said "PHS-2" the entire team would echo back in unison "Second to None!" It served as a common touchstone for the team and helped to build esprit de corps in those first years. It

gave the team something uniquely its own and helped identify to the team that it was part of a greater good.

In August of 2008, shortly after I had assumed command, the team was called on for its first major deployment. In anticipation of the landfall of Hurricane Gustav, the team was prepositioned in Alexandria, LA to set up a Federal Medical Station for medically compromised people. These people were evacuated in advance of the storm. The value of evacuating potentially impacted populations well in advance of hurricane landfall was a Hurricane Katrina lesson learned. This deployment was the first time any of the newly formed PHS response teams had been deployed on a large scale. There were many hiccups in the system that caused extreme stress on the team such as lack of sleeping quarters, lack of sleep, lack of privacy, and poor to nonexistent logistical support from higher headquarters within the Department of Health and Human Services. This lack of support included lack of food for patients and the team, lack of necessary medical supplies and equipment, poor coordination of team transportation and abysmal communications with higher headquarters among many others. After the hurricane had passed, and within the span of a week the PHS-2 RDF was able to discharge all 200 of its patient-evacuees back to their homes, families or communities. In most cases the patients left in better condition than when they arrived at the shelter and with greater access to public services. In all, it was a trying but successful deployment that provided proof of concept for the disaster response teams.

In the monthly meetings that followed the Hurricane Gustav deployment, PHS-2 RDF's high morale was sustained through awards ceremonies for individuals' performance during the deployment, mental health debriefings of the team's experience,

and after action reviews. It was at this point that I slowly began an internal inquiry as to why this team was like this. Why was there still a thunderous "Second to None!" after what the team had been through? Why *was* this team Second to None? It had been poorly treated and supported when it was most needed by those who sent it to help a vulnerable population, yet it appeared to demonstrate a high degree of resiliency. It wasn't the extensive training it received in how to set up, configure and run a Federal Medical Station; it hadn't gotten any that was of any significance. Nor had it been trained to deal with the psychological trauma it had just been through at the hands of those who had sent it off to do good things. It was as if the too-young chick pushed out of the nest learned to fly before hitting the ground and did acrobatics on the way back up to the nest. Certainly some of the resilience and professionalism could be ascribed to the fact that when the team was formed, the leadership had great flexibility in recruiting team members and recruited the "best" officers available. The fact that there was a unifying mission also aided in resilience. A team doing difficult things together builds esprit de corps, a primary contributor to developing greater resilience. Every time I heard the "Second to None!" ring out, I also knew that, among other factors, the team was the beneficiary of picking good people to start with. I also knew that as highly educated medical officers of one description or another, these professionals had greater awareness of the necessity of good emotional health. They were likely to engage in the kind of introspection that results in a good state of mental health. However, I came to the conclusion that sustaining our claim of "Second to None!" needed to be the result of a deliberate process that didn't rely solely on picking the right people. It was also entirely possible that there wasn't an endless supply of right people. At some point the team

might have to get by with whomever volunteered. As officers' three-year tours on PHS-2 RDF ended and they were replaced by other officers, there would need to be a person-transcendent culture in place that would sustain a high performing team. There would have to be a plan. But what was it that would instill that culture and keep us "Second to None!"? What kind of training would build the team most effectively?

In looking for an answer, I found that Maxwell (2006) makes a distinction between developing individuals and equipping individuals, which I propose is applicable to teams (p. 220). In his convention, equipping involves teaching someone (or a team) to do a particular task and results in the person being able to make a sale, start an IV, or replace the brakes on a car. The RDF application of this paradigm is teaching people to set up, configure and operate a Federal Medical Station. Maxwell's other convention of developing individuals (teams) results in improvement of the person (team). This type of training develops officers into better officers and by extension the team a better team. Deciding which type of training to engage in, equipping or developing, needed to take into consideration the desired outcome (sustained Second to None-edness) and the practicality of that type of training. The potential value of both of these types of training in achieving that goal is analyzed next.

Equipping the Team vs. Developing the Team

In determining if equipping the team would provide a foundation for sustained high performance of the team, consideration was given to what equipping the team would result in. This training would be technical in nature and would be related to the team's various missions. A review of the intended potential missions of an RDF indicated that the team would provide:

1. Mass care (primary care, mental health, and public health services for sheltered populations);
2. Point of distribution operations (mass prophylaxis and vaccination);
3. Medical surge (supplementing medical staff of an affected hospital);
4. Isolation and quarantine of populations with communicable diseases;
5. Pre-hospital triage and treatment;
6. Community outreach and assessment;
7. Humanitarian assistance;
8. On-site incident management;
9. Medical supplies management and distribution;
10. Public health needs assessment and epidemiological investigations;
11. Worker health and safety, and;
12. Animal health emergency support.

One problem with providing training covering this myriad of possible deployment scenarios is that the team does own any equipment. An RDF is essentially the officers and their skills. Any equipment the team uses during a deployment is provided "just-in-time" including the shelter building itself, cots, beds, any and all medical supplies, computers, printers, communications gear, vehicles, and so on. The team doesn't have its own "stuff." Further, as the team response paradigm was still in flux and continued to evolve within PHS, potential deployment missions could change. It was possible that the team would need to be prepared for missions other than those above. The upper echelons of PHS understood the mission-related technical training that teams needed. They would provide whatever training their limited budgets could support. Apart from relying on

PHS to provide training, another option would be for the team to take on the task of coming up with its own mission-related technical training and self-delivering it. Considering the enormous investment in time such an effort would require for a part time volunteer team, it seemed an unwise venture to self-generate technical training. The vast scope of potential missions, lack of equipment, and lack of time for team members to plan and execute training plans demonstrated that equipping the team, regardless of its potential positive impact on sustaining a high performance team was not practical. Nor was there any indication that such training provided a basis for a sustained high performance team. Further, my experience in PHS was that if training that equipped people for various missions was minimal, training in the soft skills such as team development was nonexistent. This indicated that what the team needed most, and the training least likely to be delivered by PHS was training that built the team. In Maxwell's language, the team needed to be developed, not equipped. The effort to develop a team building model in real time is the subject of this capstone. I decided that the most effective way to put in place a team building culture was to start with the leaders of the team. By taking the PHS-2 RDF executive staff through a learning process in team building, they would project and reflect that learning onto their direct reports. This would begin to infuse the team with a team building culture.

In order to understand the challenges and limitations associated with developing this team building model, it is useful to characterize the organization that is being developed, in this case the PHS-2 RDF executive staff. One method of characterizing an organization and identifying challenges is use of a BART (boundary, authority, role, task) analysis developed by Green and Molenkamp (2006). BART

provides a systematic and comprehensive method of organizational analysis. This analysis will provide additional evidence that the development of soft skills, specifically development of a team building model was not just necessary but the only training that could be done due to organizational constraints on the team. I use the BART method to analyze the PHS-2 RDF executive staff as an organization.

Team Organization

PHS response teams, as part the federal government emergency response structure follow standard emergency response team organizational structures in establishing team organizational structure. The PHS-2 RDF executive staff is organized thusly:

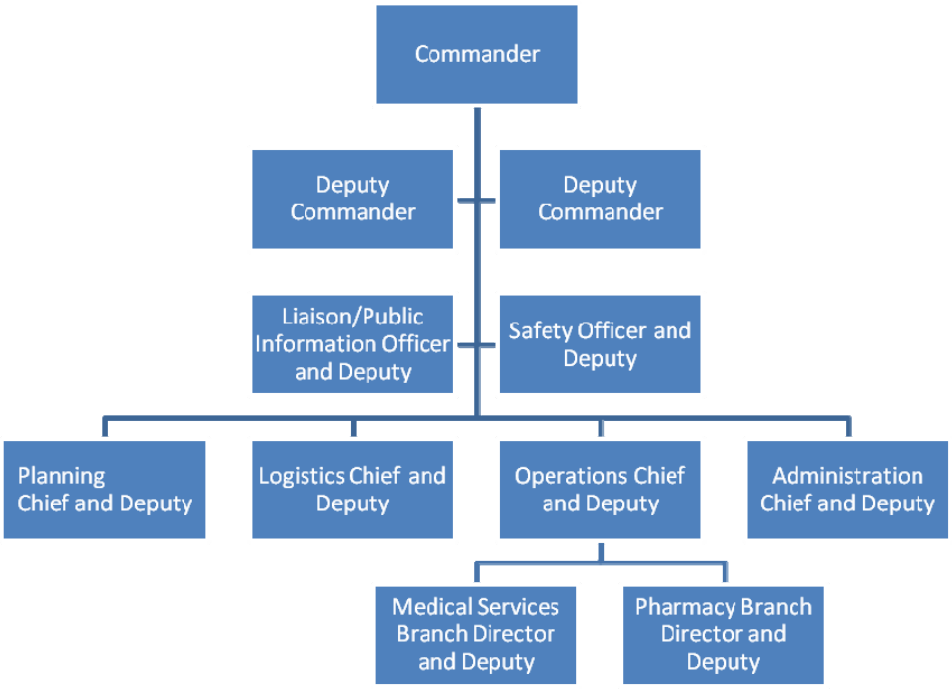


Figure 1 Executive Staff of the PHS-2 Rapid Deployment Force

The PHS-2 RDF executive staff consists of a Team Commander, two Deputy Commanders, a Safety Officer, a Liaison/Public Information Officer, and the leaders (Chiefs) of the Planning, Logistics, Operations and Administration Sections. Each of these Section Chiefs has a deputy whom I include as part of the executive staff. The Medical Services Branch Director and Pharmacy Branch Director are also included as part of the executive staff. The entire team is comprised of 105 officers. Section size relative to overall team strength is as follows: Operations – 51%, Logistics – 16%, Planning – 8%, Administration – 9%, Safety – 10%, and Public Affairs – 3%.
The deputy commanders are selected based on their capacity to assume command of the team in the event the team commander is incapacitated or otherwise unavailable. For this reason, the team has an authority structure comprised of the commander and deputies to form a triumvirate. In this construct, the deputy commanders are empowered to make decisions on behalf of the commander in his absence, and if possible in consultation with each other, up to the limit their own judgment-based comfort level. The team commander makes most decisions in conjunction with the deputy commanders and retains final accountability.

The Safety Officer leads a staff of safety professionals who are responsible for the overall safety of the deployed team. The Public Information/Liaison Officer is responsible for messaging and providing a media and press point of contact along with liaison with state and local government officials. The Operations Section Chief runs the most of the team with about 50% of the team reporting to him/her. The Operations Section includes doctors, nurses, pharmacists, midlevel providers, laboratorians and mental health professionals. The Logistics Section Chief provides support for supply

acquisition, communications and information technology. The Administration Section Chief maintains personnel records for the team and for patients. The Planning Section Chief plans team operations and provides reports of team status and activities to the team commander and higher level organizations.

Organizational Analysis and Challenges

A common challenge associated with developing or building a PHS response team is that every officer on the RDF (and all other PHS response teams) has a full time, active duty position with an agency within the Department of Health and Human Services. Service on a response team is a completely voluntary collateral duty. About half of the team has a day job that is unrelated to their function within the team with the other half are clinicians who either work as a practitioner during the day or find other ways of maintaining their clinical skills.

A BART analysis examines an organization's boundaries, authority, role and task. These elements describe the playing field on which an organization operates. It is a useful method to systematically identify organizational challenges. The first step of this analysis is to identify the team's primary task. Doing so provides "…an invaluable starting-point for thinking about what is going on in a group or organization." (Roberts, p. 30) While the mission of the PHS-2 RDF is medical public health disaster response, in context, the task of the team – the PHS-2 RDF executive staff – is to co-develop a team building model that will be used by current and future team members to build the team. The first element of the analysis is boundary.

Organizational Analysis – Boundary

Boundary circumscribes the "container" (Green and Molenkamp, p. 2) within which the task of the group is performed. It is comprised of time, task, territory, and resources.

Time was a challenge in developing a team building model in that the team is part time. Since officers' day time jobs in PHS are with Department of Health and Human Services agencies, those agencies expect that officers working for them will be engaged in the direct work of the agency during normal working hours and not on PHS response team activities. Agencies within the Department of Health and Human Services generally do not view support of PHS response team activities as part of the agency's primary mission. This means that officers must attend to team duties on their off duty time or blend them with their assigned agency tasks in such a way as to be able to complete both. Time is also a boundary in terms of getting time off to attend meetings. A recent survey of PHS-2 RDF executive staff officers showed that ~65% had issues with time in getting to meetings because of work, family or travel to the meeting location.

The task of the executive staff is straightforward in this case – to develop a team building process that will begin to develop a culture of team building within the team. The agency sense that the PHS response team activities are not part of the agency mission is also direct territory boundary. The PHS-2 executive staff met the time/territory challenge during this process by a combination of meeting during off-duty hours and work blending.

Resources are a boundary challenge in that the team has no budget. Without funding, there is difficulty in meeting even the most basic needs of team building, including something as fundamental as meeting space. The team has found creative ways

to overcome this boundary. Because the team is based in the Washington, D.C. metro area, the team has thus far been able to resolve this challenge by meeting in a lecture hall at the Uniformed Services University of Health Sciences (located in Bethesda, MD, a few miles outside D.C.). The university doesn't charge a fee since one of the officers on the team is on faculty there. When this space hasn't been available, team members opened their own homes to hosting team meetings. No budget also means that there is no money for purchase of team development training materials and as a result, team members purchase their own training materials. Another resource issue is that as previously noted, unlike the other Uniformed Services, other than a two week initial Officer Basic Course, PHS has no service-specific officer professional or leadership development courses that prepare officers at various stages of their careers. There is specifically no training on how to lead or manage a near-virtual, part-time, volunteer team. This is a double edged sword. On one hand, there is no playbook to follow or standardized professional development courses for officers to attend. Nor is there any formalized planned succession or schedule of assignments that groom officers for higher levels of responsibility. There are similarly no specific team development courses. On the other hand, the PHS-2 executive staff was not was not bound by rigid training doctrine that may or may not have been what was needed.

Organizational Analysis – Authority, Role and Task

Green and Molenkamp point to the Heifetz definition of authority as "conferred power to perform a service" (p. 5). The service in this case is the act of developing a team building model. While the PHS-2 executive staff was never specifically authorized to develop a team building model, it is difficult to imagine a scenario where they would

have been forced to stop. The executive staff acted in the absence of orders to the contrary to assume the authority to develop the model. The role and task of the team in this context are also straightforward – to be engaged and participate in the process of team development.

The challenges the PHS-2 executive staff faced and continue to face as a team include both technical training for the team and soft skills training. PHS provides technical training as much as possible; self-reliance on the team to conduct its own technical training is infeasible because of lack of resources. However, because of the lack of any standardized leadership or team development training within PHS, and the necessity to lay the foundation for a Second to None team for years to come, team development training was not just more necessary than technical training, but the only training that could be done due to constraints of time, territory and resources.

CHAPTER 4

DEVELOPING THE MODEL

In the six years of its existence, the PHS-2 RDF has enjoyed high morale, worked together well when not deployed. It demonstrated competence and resilience during deployments. Nonetheless, I began to question why this was the case. Some of this was undoubtedly due to picking the right officers for leadership positions when the team was first formed as previously noted. In Collins' words, the team had "the right people on the bus (Bernhut, 2003)." When the team was formed, the PHS-2 RDF team commander, both deputies (of which I was one), and three of the six section chiefs had served together on the PHS Disaster Medical Assistance Team. Most of the PHS-2 RDF executive staff had deployed together as members of the PHS Disaster Medical Assistance Team to Ground Zero after 9/11. We had a history of many hurricane responses and other deployments together. I couldn't fend off the thought that the PHS-2 RDF couldn't survive off the largesse of that successful team forever. I knew and intuitively understood that without a deliberate and proactive plan for being Second to None that the PHS-2 RDF wouldn't stay that way. And since Second to None was all about the team, what the team needed was a way to deliberately and proactively build the team. As one who subscribes to transformative leadership, I decided that what I needed to do was build the executive staff who could in turn apply those same principles in building their individual sections. Lencioni's model provided a place to start. Developing the model began at the next opportunity which was a week long field training exercise.

Field Training Exercise

Before the exercise began, I met with the executive staff and told them what I'd been thinking: "Second to None! is more than a Pavlovian response to me. I believe we are the best Rapid Deployment Force team in the Public Health Service and by a very wide margin. The credit for that goes to you, the excellent leaders of PHS-2. What I want to guard against, and I don't think we're within a hundred miles of it happening, is complacency. Assuring that we stay Second to None will happen not by accident, but by having a plan for building the team. For the next year we are going to be deliberate and proactive in implementing principles that will build our team."

I provided handouts that explained the five principles of team building and we talked about them. I asked them to privately rate their sections on a scale from 1-10 with 10 being highly functional in the areas of trust, conflict, commitment, accountability and attention to results. I asked them to pick one or two of the principles and focus on working on them with their sections over the next week of the exercise. Then at the end of the week, I'd ask for their feedback to determine if from their perspective they were able to improve their beginning of the week rating.

My role as team leader during the exercise with regard to team building was to model those behaviors I was asking my subordinate leaders to model. In order to understand one method I used to do this, some information on how the team functions in the field is necessary.

Every morning before the day's work/activities start, the entire team assembles in a structured and formal gathering called a "formation." This is something of a morning meeting or stand-up meeting used in some organizations. It is important to note that PHS

does not teach this and my concept of the necessity of it is borrowed from my prior service in the Navy and Army. A formation is a highly orchestrated event with officers standing in particular places depending on their role and leadership position. Each member of the team is assigned to one of four squads headed by a squad leader. The squads stand in rows one behind another with the squad leader of each at the right end as the squad faces forward. The squad leaders then take attendance and account for the whereabouts of the officers in their squad. Once all the squad leaders have done this, they are ordered to report to the team leader who has taken a position in the front of the formation where the entire unit can see him. After the squad leaders have reported squad accountability, the team leader takes a few minutes to address the troops, giving information on the day's events, important reminders, and a bit of inspiration or positive reinforcement. The team leader then instructs the team to carry out the day's activities.

In other types of organizations, there is an expectation by the members that the leader is the font of all knowledge with respect to that organization and even more so in a military unit. The team would therefore expect that as the team commander, I would have the orchestration and conduct of a formation down to a science.

At the end of the day's work/activities I held a meeting with the PHS-2 RDF executive staff. This was a much less formal meeting where we went over the day's events, and provided feedback for improvement. This is also the time when the executive staff brings issues to the team commander's attention and discusses possible solutions.

I used formations, the executive staff meeting and other situations to begin to model some of the principles for the PHS-2 RDF. For example, one element under the trust rubric is to solicit questions in your area of expertise or responsibility. After the

executive staff came up with a plan of action for a particular part of the exercise, I made a point to ask questions such as "What have we overlooked? What haven't we thought of? What are we missing?" This served the dual purpose of modeling the skill and using the outcome of the modeling to acquire information I may not have actually had; I really did want to know if we were missing anything. Another way I modeled soliciting questions into (what should have been) my area of expertise was the conduct of the formation. As the team commander, officers expected me to know all there was to know about the morning formation, how to conduct it and how to end it. I had a general idea of what to do but to reinforce the solicitation of input into my area of expertise, I delegated the task of coming up with a specific formation procedure to a junior officer. He was a militarily squared away officer who had previously served in the military and one whom I thought could do a good job. That may have been the case if I had given him specific expectations. As it turned out, I hadn't been specific and the formation the first morning was mildly disorganized. Having a disorganized formation would cast a long shadow on the confidence the team had in me and the rest of the team leadership. I needed to correct that situation immediately. That night another prior military officer on the team pointed out to me privately that the formation was disorganized. I acknowledged that and asked him if he would be willing to provide instruction to the team the next morning to make it less so. I solicited his input into my (or what should have been my) area of expertise. This time I was specific and asked him to provide that instruction in front of the team at the next morning's formation on how to properly conduct a formation. He agreed to do so. The next morning at formation, I apologized in front of the team for the previous morning's disorganized formation, telling them that it was completely my fault for not

being more specific to the junior officer (by name) I had put in charge of it and I directly apologized to him. This was also a public modeling of offering apologies without hesitation, another of the trust elements. I also thanked the other officer who provided instruction in conducting the formation training that morning. The formation that morning went off smoothly.

In the conflict rubric, one element is to put crucial topics up for discussion. Toward the end of the field training exercise there was to be a mock disaster drill for which we would set up a Federal Medical Station; this was the culmination and most important part of the training. Properly setting up a medical shelter in a "building of opportunity" that accounts for patient triage, intake, flow, communicable disease control, patient accountability and ongoing care is a complicated process. It is one in which a minor flaw can have major consequences. I am accountable for this process being effective but it is not something with which I have an abundance of skill or experience. After the executive staff came up with a plan of how the team was going to set up the shelter, I again invoked the "What are we overlooking?" questions to the executive staff at the meeting the afternoon before the drill was to begin.

Another component I specifically modeled was that of getting commitment from the team. Two important elements of gaining commitment are clarity and aligning the team around common objectives. The first night we arrived at the training location, I had the team gather in the barracks where I provided both clarity and objectives by providing my expectations for the team. Appendix A is a near-verbatim brief that I gave to the team on the first night of the field training exercise. I also modeled the ability to learn from

mistakes by having a public re-do of the formation process in front of the team on the second morning.

The feedback I received from the executive staff after the week long exercise regarding their implementation of a few of the team building principles was, in hindsight what I might have expected. I had given a fairly brief description of the team building principles. They did use the principles throughout the week long training exercise but there was not a great deal of quantifiable difference and that is what they told me. An affirming outcome of the training for me was a post-training anonymous survey in which 100+ team members collectively ranked "The amount of confidence in those in command" as 4.1 out of 5.

Need for a Team-Owned Model

After we returned from the exercise I decided to more fully cover the team-building model with the executive staff during our monthly meetings. This would provide the opportunity for the executive staff to fully engage in the team building model. It would also provide a real time demonstration of the commitment component of team building. The plan was to facilitate the executive staff in adapting the team building principles to the environment in which our organization operated, thus enabling buy-in and in doing so, commitment to the principles. These monthly meetings typically lasted two hours with an hour for the executive staff to focus on the team building model adaptation component and the balance for other team operational and administrative issues.

Further, in order to maximize the commitment of the CGS to building the team, and to demonstrate the value of the principles while doing real work, principally the "no

buy-in without weigh in" principle, the executive staff would adapt the Lencioni principles to our particular circumstance.

Monthly Meetings

In the first meeting, I gave a more in-depth presentation of the broad overview I had given at the field training exercise. In order for us to understand the playing field on which we were operating I asked the executive staff what sort of realities or understandings they had about the conditions or circumstances in which the team operated. I provided a few examples of what I meant by "understanding."

- We are a part time team – our individual performance as team members was independent of (not captured as part of) our individual day job performance reviews. And we have no formal performance review system within the team. This wasn't our full time job.
- We have no budget – I intentionally used the word "understandings" instead of boundaries so as to break the propensity for only seeing boundaries as negatives. There was a bit of silence until one officer asked "You mean *boundaries or limitations*?" to which I answered "Yes." The list of limitations the executive staff developed was an affirmation of the synergy of smart people bringing together different perspectives. I began posting their responses on flip charts.
- Resources: I asked if this wasn't the same thing as money. The officer pointed out that it wasn't. We didn't have our own computers, communications equipment, and even the meeting space we were meeting in, an unused lecture hall at the Uniformed Services University of Health Sciences was only available because a team member was on faculty. That enabled the team to reserve meeting space.

- We can't make people do anything: We are a military unit and while we have a rank and rank structure, we are not under the Uniform Code of Military Justice, so there's no mechanism in place for forcing people do things they don't want to do. We're a volunteer force and if at any point, people get fed up, they can just quit with no repercussions. Even if we were deployed someplace, the only thing I as team commander could do is put someone on a plane home, which is likely what they would want anyhow. Disciplinary actions while a remote possibility, in practice do not occur enough to be any deterrent to unacceptable behavior or even disobedience. I asked the officer making this observation if he could narrow that down as a singular reality. After some unproductive discussion, I simply wrote "Can't make people do stuff" which was followed by some laughter and head-nodding agreement.
- We all have regular full time jobs: the team has nobody that is a full time employee. Being on the team is not part of anyone's day job description. Every team member in their day job works for one of the Department of Health and Human Services' subordinate agencies such as the National Institutes of Health, the Food and Drug Administration or the Centers for Disease Control. Each of those agencies rightly expects their officers to be fulfilling their agency role when they are at work. While the disaster medical response mission is a responsibility of the Department of Health and Human Services, it is generally not a concern of the individual agencies. Since the amount of time each officer has to work is finite, an officer must balance their day job with their team responsibilities, doing them at night or carving out time in their day job so they can fit in team work.

- What we do on the team generally has nothing to do with what we do in our day jobs: about half the team is made up of clinicians, a portion of whom don't practice on a daily basis. They engage in creative ways to maintain their skills through work scheduling. The other half of the team whose role is nonclinical – the planners, administration and logistics officers generally have day jobs that don't bear any resemblance to what they do on the team. The agencies from which we draw team members do not have planning, administration and logistics sections.
- Lack of specific role training: there is no budget for training officers in the specific roles they fill on the team. While there is some overall team training such as the field training exercise, it generally is not specific to the person. For instance, one role of the logistics section is to acquire food for the team while deployed. There is no training in how to determine who the vendors are in a particular area, how to set up contract services with a vendor once found, how to let the contract, how to get the food to the shelter, how to hold, serve and store the food and how to dispose of the waste from meals. The Logistics Section would simply be tasked with getting food for the shelter guests and the team. While we have successfully relied on the ingenuity and native intelligence of the Logistics Section to accomplish this, the team members may at some point encounter situations where these attributes will not be enough.
- Geographic dispersion of team members: While most of the team is stationed within the greater Washington, D.C. metropolitan area, about 30% is stationed more than 100 miles distant making attendance at face to face team meetings difficult in not outright impossible.
- Not having final say in policy decisions that directly affect the team.

- Having to integrate people into our team who don't know our culture. When the team is deployed, shortfalls in officer staffing are made up with officers from across PHS who are not part of any team and who happen to be available. The team is also augmented by civilians from the Department of Health and Human Services' Medical Reserve Corps.

Once we had our complete list of realities we began working on the meat of adapting our own trust touchstones.

Trust

I told people to count off by fours and to remember their number. I picked places around the room for them to go (more effective than just telling them to get together) and explained how we were going to arrive at our bullet point-touchstones for the five areas of team functionality.

Once they were in their groups I explained the process. They would have five minutes to come up as many bullet points as possible for the first functionality, trust. I told them that someone was to be appointed as scribe and that I would act as timekeeper.

Before telling them to "go" I thought it necessary to say a few words about what we were doing. At this point they had read, listened or otherwise been exposed to the material in the text. I told them I wanted them to arrive at what they specifically thought were the right elements of trust building for our team. It was not meant to be a quiz to see if they could regurgitate what Lencioni thought trust meant. If they agreed with Lencioni, that was fine, but this was about them, not Lencioni.

I gave the signal to start. At the four minute point, I told them to rank their top three bullets. At five minutes I stopped them and directed their attention to the flip chart I had at the front of the room.

Starting with the 1 group, I had them read off their top three bullets as I wrote them down. Then we went to the 2 group and so on until I had collected them from all groups. In the process there was a little discussion about each of the eleven items that were listed. Looking over the list it was obvious that there was some clear duplication and a few close overlaps, which resulted in a little more discussion. They came up with eleven items:

- Show up for events
- Open communications
- Keep agreements
- **Spend time together (x3)**
- Sign-out/ shift change → After Action Report (AAR)
- Be honest about abilities
- Be non-judgmental
- **Be willing/ able to do what you expect your team to do (x3)**
- Listen
- **Have open and adequate communication (x4)**
- Be accountable, to yourself, your mission, and your team

I then told them they would have a minute to consider which one of the twelve would be their top pick to keep if they could only keep one. After I told them that they could only vote once, they voted for their top pick. Interestingly enough, only 4 of the bullets got any votes; one of those only got one vote.

- **Spend time together (3 votes)**
- **Be willing/ able to do what you expect your team to do (3 votes)**
- **Have open and adequate communication (4 votes)**
- **Be accountable, to yourself, your mission, and your team (1 vote)**

In future meetings, this list of trust touchstones would be slightly altered. For instance, having open and adequate communications more appropriately fell within the

conflict rubric. Likewise, being accountable to yourself, your mission and your team belonged in the accountability rubric.

I asked the staff about the concept of spending time together. I asked if "spend" had the connotation of a finite quantity that, once used was gone. I asked if "investing" time together carried the same connotation as spending time together. When you invest, there is an expectation of return as opposed to the endpoint of having "spent." They agreed and we changed the wording to "invest time together." Our two precepts for trust in our adapted model then are invest time together and be willing and able to do what you expect your team to do.

We more clearly defined "investing time together" as being physically present for our monthly meetings, engaging each other socially and electronically via email, Facebook and other social networking sites; conducting our annual physical fitness test together and by attending training together. Similarly, we defined being willing/able to do what you expect your team to do as doing extra work, working hard at whatever we happen to be doing. It meant maintaining a sense of mindfulness where we choose to deliberately act in situations instead of reacting to them.

In addition to the trust building principles of accept input into your area of expertise and offer/accept apologies without hesitation, we had two things we were going to do to build trust in the current team. We would incorporate them into our culture so that we could function more effectively as a team. These would help in establishing an enduring culture of trust for years to come.

Conflict

I explained to the executive staff that in my view Lencioni well described the concept of using conflict as a mechanism to hear all viewpoints. What I didn't think that was well developed was the concept of dealing with conflict and that we needed to address that as part of our model.

However, for conflict and the remaining elements (commitment, accountability and attention to results) I determined that I needed to do this more instructively than I had originally intended for the following reason. When going over the accountability rubric, I mentioned that one method of assuring accountability was the use of well established management techniques, one of which was using SMART goals. I sensed that this did not resonate with them and asked how many were familiar with SMART goals. Although a few raised their hands it occurred to me that shifting from a collaborative process to an instructive one was advisable.

Another factor contributing to my sense that the staff might not have a broad exposure to management practices was a situation that arose during the field training exercise. In a mock exercise, an outbreak of H1N1 actors posing as irate townsfolk (actually fellow teammates) stormed the shelter because it had been rumored that we had a supply of scarce vaccine which was otherwise being rationed. A chain of events transformed scenario anger into real anger and an actual mob scene erupted. Eventually cooler heads prevailed but it pointed out to those involved that we needed some type of conflict training. I chose to provide a conflict model developed for DYNM 653, Coaching Others to Manage Conflict, as part of our team building model. I include this component as Appendix B.

In adapting the trust component of the model, the executive staff identified open communications (up, down, sideways) to be important but we moved it here as felt it was more of a conflict prevention tool.

Commitment

Given the transition to a more directed or instructive model, the elements of commitment in team building follow the book model: clarity, gaining buy-in using weigh in, doing a meeting wrap in the last 5-10 minutes of each meeting and doing a 24 hour check in after each meeting.

Accountability

These elements I kept very simple and again, they closely followed the book model. For us, the accountability principles are silence equals approval and use of SMART goals. For the silence equals approval component, team members need to overcome the general ill ease people have with confronting others about their behavior. I also presented a block of instruction on developing SMART goals and what they looked like.

Attention to Results

This element I admitted to the team was one with which I had the most difficulty. Our most likely mission was to set up and run a Federal Medical Station but the details of doing so would change every time. Certainly when the team is deployed, we need to attend to the details of medical care but I was not certain how we could entrain this into our team's culture between deployments. Additionally, as previously discussed wide reaching technical training is not feasible. Like the Martin character in the Lencioni book, I decided that a scoreboard was what we needed so that in any undertaking, we

could have an idea of whether or not we were paying attention to results. And then it occurred to me. Our call and response was a perfect scoreboard. Second to None was a scoreboard against which we could always measure our performance. Was the meeting second to none? Why not? Was the process of getting our on call month roster together Second to None? Were our call-down phone tree drills Second to None? What had started out as a means to build esprit de corps had become an unintentionally prophetic means of gauging our performance.

CHAPTER 5

A SIMPLIFIED TEAM BUILDING MODEL

The purpose of this capstone is to present a case study of how a team in action developed an action model. It provides a reproducible and sustainable model for PHS response team commanders to begin developing their teams into high performance teams at little or no cost.

Assumptions

The BART analysis results with respect to teams applies across all PHS response teams. Lack of resources brings about a lack of ability to train teams in their technical roles. However, the primary need is not for technical training, but for soft skills training such as leadership and team development training.

The first assumption I make in this model is that team leaders have a desire to help develop their teams. The role the team leader plays in developing a team is substantial and desire is essential. It requires will, determination, discipline, likely sacrifice of personal time, commitment and most importantly, a caring spirit for the team they are trying to develop.

The second assumption is that team members are willing to invest a small amount of their personal finances to purchase training materials. This is a very modest investment as a book, workbook, and leader's guide can be purchased inexpensively through various on-line outlets for less than $100.

The third assumption is that teams have some ability to meet together on a regular basis with sufficient frequency to introduce and discuss the principles. This may involve some creativity and sacrifice of personal time. Ideally this meeting would be face to face.

While other methods (teleconferences, web-based meetings) provide convenience, the object of team building is to build the team, not to provide convenience. There is simply no substitution for meeting in person. I acknowledge that the membership of some teams may be geographically dispersed and this may present a challenge the PHS-2 RDF executive staff didn't face. However, many of the other teams are centered round a specific city (e.g. Dallas, Atlanta) and may simply require teams to adopt a new paradigm of driving much longer than a normal commute or otherwise making arrangements for being physically present for team meetings. The PHS-2 RDF is based in Washington, DC and I reside in southern Pennsylvania so my drive to team meetings is always at least 100 miles in each direction. As pointed out, some small amount of personal sacrifice may be necessary.

The fourth assumption is that team leaders will have the will to continue to reinforce and re-reinforce these principles over time. As Lencioni points out, "teambuilding ultimately comes down to practicing a small set of principles over a long period of time (2002, p. 220)."

The simplified team building model as adapted and developed by the PHS-2 RDF executive staff is below. The Leader's role is taken directly from Lencioni.

Building Trust
- Invest time together (virtual teaming, telecons, social settings – in person, Facebook, etc.)
- Do what you expect your team to do (do real work, work hard at whatever you do)
- Solicit questions/input into your AOR [Area of Responsibility] (*What do you think we should do? I need help. I'm not sure. You're better than I am at… What are we missing? What haven't we thought of?)*
- Offer/Accept apologies without hesitation ("*I was wrong. It was my fault." "I made a mistake." "I'm sorry." OR "It's okay." "I feel resolved. Let's move on."*)

Leader role: Must demonstrate vulnerability in front of your team and create environment that doesn't punish vulnerability. Must seek counsel.

As was the goal of this team building project, these questions have become part of how the PHS-2 RDF executive staff conducts routine business. Although as team commander I am perfectly willing to make decisions when necessary without any input (e.g. in an emergency), these situations are exceedingly rare. Experience has taught me time and again the value of having many people provide input. We all see things differently and that difference can and does provide perspective that one person can't have. In terms of apologies, I have found this is a practice that becomes easier with use. It may be my nurturing but this has not been a real challenge for me per se (give the vast number of opportunities I have to do it) but I have noticed others struggling with it. Many times apologizing can be seen as a sign of weakness. I point out to my people that in my view it is actually a sign of strength and confidence. Of course as one of the officers on the PHS-2 RDF pointed out to me, it can't just be saying you're sorry. You have to learn from the error and not repeat it.

Conflict

- Open Communications (up, down, sideways; err on the side of too much, remember what it felt like to not be "in the know")
- No reservations about disagreeing with one another/each opinion unapologetically aired (Give permission to disagree – model it – what is best for the team? If no one appears to disagree, ask someone who does not appear to agree with you what they think.)

Leader role: Must acknowledge conflict is productive; encourage debate (discourage not debating to avoid hurt feelings); model good conflict behavior

I see maintaining open lines of communication as preventive conflict management. I have found that the more in touch with my people I remain the lower the probability of having to engage in conflict management. In the case of these model points, I know that I have come to understand that I need to maintain a state of mindfulness and recognize conflict when it starts. Acting rather than reacting is a key point in making conflict that does develop productive and not destructive.

Commitment
●Clarity (Being clear forces us to answer questions before we give others directions – how, what, who, where, why)
●Buy-in (People will buy-in only after they've had the opportunity to weigh in. May be necessary to enforce weigh-in.)
●Each meeting – what have we decided (Clarifies what has been agreed on; assures everyone is on the same page.)
●24 hour check in (Reinforces any messages to team from meeting to make sure everyone on the team is on the same page (meeting minutes are a good way to do this.)
Leader role: Leader must be comfortable making wrong decisions and not worship consensus/certainty. Be willing to commit when you have 80% of the information. Enforce weigh-in, meeting wrap-ups and 24 hour check in.

These practices have also become routine in the functioning of the team. The words "just to be clear…", "I want to make sure I understand…", and "for clarity…" have become commonplace in our dealings. The meeting wrap up and 24 hour check in have also become valuable tools in making sure everyone is on the same page. They have brought up issues where we thought there was agreement when in reality there was still uncertainty.

Ensuring Accountability
Silence = approval (Must overcome the unwillingness to tolerate the interpersonal discomfort that accompanies calling a person on his behavior and general tendency to avoid difficult conversations). Gandhi said "Silence becomes cowardice when the occasion demands speaking out the whole truth and acting accordingly (http://www.goodreads.com/quotes/show/51203)."
●Use classic management tools – SMART goals (Specific; Measureable; Attainable; Relevant: Time dependent)
Leader role: Say what needs to be said and use SMART goals

This principle has also become part of the team's way of doing business. Like its close relative conflict, the process of living silence = approval becomes easier with practice. Tasks or duties on the team use the SMART principles.

Attention to Results
●Unrelenting focus on specific objectives and clearly defined outcomes
●Ask yourself if what you're doing is Second to None!
Leader role: Keep your group focused on specific objectives

This rubric has shown itself in that the team developed goals for the year by developing specific objectives. Appendix C is the one page summary in use by the executive staff.

CHAPTER 6

IMPLEMENTATION OF THE MODEL ACROSS PHS RESPONSE TEAMS

Ideally, team building would be part of a continuum of officer professional development across an officer's career from initial entry into PHS through mid-level, senior and executive level officer courses. In this sense it would not be exclusive to PHS response teams, but would apply broadly across PHS. However, as noted PHS has no professional development training beyond the initial Officer Basic Course, the primary goal of which is orientation to being an officer in a Uniformed Service.

The positive side of this situation is that all PHS response teams are organizationally under the Office of Force Readiness and Deployment. This is positive because it is the single organizational point in PHS where team building training needs to be authorized and facilitated. This means that PHS is solely responsible for providing the training and the process cannot be stymied while waiting for approval from agencies attending to their own internal priorities. The Office of Force Readiness and Deployment establishes and implements policy for all response teams. In contrast, any movement of personnel for a deployment or training or even volunteering for a team involves multiple agencies or subordinate organizations within the Department of Health and Human Services, all of which can and do exercise veto powers over permitting an officer deploy or volunteer for a response team.

It has been shown that the training which is most needed because it is not provided elsewhere in PHS is training in team development. Further, this training is not dependent on a massive training support structure like exists in the other Services, merely

the desire and willingness on the part of team commanders to develop their individual teams.

After Office of Force Readiness and Deployment review and approval of this team building model, it could supply team leaders with the model and have them follow a similar process as outlined to begin developing their teams. An important facet of this training is that it is reinforced with the team being developed and modeled by the team commander over and over. Lencioni's premise that teambuilding ultimately comes down to applying a few simple principles over an extended period of time needs to be observed.

The Office of Force Readiness and Deployment could also develop a training module for training of the executive staffs of the various PHS response teams during their annual field training exercises and periodic short meetings with team leaders and their executive staffs. As with any governmental body, the Office of Force Readiness and Deployment is subject to the ebb and flow of funding, though it has most recently experienced the ebb portion. I have shown that all that is necessary is a caring team leader who has a vision of a well functioning team and the will to bring that vision to fruition.

Why This Model?

Lencioni's model is simple and addresses elemental issues in any organization, including trust, conflict and commitment. Undergirding the team building elements are fundamental leadership skills and traits such as clarity, using SMART goals, conflict use and resolution, the silence equals approval element of accountability and so on. Developing these strengths as team habits helps develop the team and it does so partially by making the individual officer a better leader.

Further, team commanders applying team building and the underlying leadership skills in an action learning environment enables team members to develop their team building skills in real time in a real environment apart from their day job. This leadership laboratory provides benefit to the officer's agency in that the officer is getting the opportunity to develop skills that can then be applied in the officer's day job in the agency for which he or she works. The federal government has personal development training programs and courses, but nearly all are short term. These training programs generally encompass a temporary leadership position in an agency where a vacancy exists, something along the lines of a leadership internship. While there is value in these leadership internships, no opportunity exists for the intern to see the long-term effects of his use of newly acquired management or leadership skills. Those whom he or she is temporarily leading know that in a short time, the intern will be move on to the next phase of training. Positive changes the intern has instituted will likely be retained, but others will be discarded. Using the team building model in the response team environment not only provides the opportunity to learn team building and leadership skills over an extended period of time, but to also see the results of applying those skills, to discuss them with peers and to refine and perfect them, and then transfer them back to their day job. I know of no other place in the federal government where this opportunity exists. Certainly in an era where federal budgets are highly scrutinized, there is no place where training this sound can be had at no cost to the agency.

Additionally, highly functional teams develop camaraderie and the personal bonds that are necessary for resilience in high stress environments such as disaster deployments. In these situations, officers are exposed to both physical and mental stress that they do

not likely face on a daily basis. Knowing that you are part of a highly functioning team supports one's own morale and resilience.

CHAPTER 7

CONCLUSIONS

Why is it important for the US Public Health Service to implement a team building model for medical public health disaster response teams? The best answer is that the stakes are too high not to. When a hurricane's projected path has trapped a response team in a shelter with 250 medically fragile patients, that is the wrong time to discover that your team is a group of individuals.

I want to deploy with a team that is already a team. My experience from this case study has shown me that Lencioni is right: teambuilding ultimately comes down to practicing a small set of principles over a long period of time (Lencioni, p. 220). Will and endurance are not the flashiest or latest management fads, but they do work. This appeals to me on a personal level. I know the team building principles are true because I see them at work on a near-daily basis within the PHS-2 RDF. Armed with that knowledge and knowing I am doing the right thing, I am able to endure nearly anything to build the team. I know that one day the lives of my team mates and those we serve may depend on it. I know that team building will sustain the team through the perpetual bureaucratic wilderness. When I was considering what kind of training would build the team, I asked myself what kind of training I would ask for if I knew I could get all the funding I could ever want. I could ask for training exercises that would help build the team's technical skills. The familiarity developed through such exercises would be valuable and build the team's confidence in its abilities. However this kind of technical training alone ignores the soft skills of leadership and team building. Without deliberate

team building skills, a team could be competent technically, yet rendered dysfunctional because of interpersonal and organizational issues.

At the same time, team building can't happen in a vacuum, without a mission. A team can't be a team because someone wills it or because it wants to be a team. This is why the real time, action learning component of building the team model is critical: You learn the skill of building the team while doing the team's mission. But in the end, the team does not have all funding it could ever want. Knowing that if I want the team to be a highly functioning team now and in the future, I will have to do it without departmental support puts an exclamation point in my mind on the decision to implement a team building model. It's the right thing to do regardless of who does or does not support it. The PHS-2 RDF's adaptation of Lencioni's team building principles represents an excellent starting point for all PHS teams to build themselves into highly effective teams. Highly functioning teams are better able to respond effectively (doing the right thing) and efficiently (doing things right) to protect the health and safety of our nation's vulnerable populations. They won't have to worry when they go out the door whether they are part of a real team.

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APPENDIX A

TEXT OF INITIAL FIELD TRAINING EXERCISE BRIEFING

If I were to ask how many officers here are Tier 3, how many of you would raise your hands?

From this point on, if I were to ask that question, nobody would be able to raise their hands.

If you left your house this morning as a Tier 3 augmentee, once you got to AP Hill, you have escaped the surly bonds of Tierdom and transcended to being a member of the PHS2….Rapid Deployment Force.

You are not part of us…you are us.

The only officers I see in this room are PHS-2…..Rapid Deployment Force officers.

Welcome to the PHS2….Rapid Deployment Force. If you are one of those folks who are doing the internal eye roll at the Pavlovian response every time I say PHS2, welcome to the team that will demonstrate to you what its like to be part of a high functioning team that serves a cause greater than itself.

I am CAPT Calvin Edwards. I am Team Commander. In everyday life, I am a Supervisory Investigator with the FDA.

I have been married for 24 years to the same wonderful woman (for those of you doing the math, yes, we went to our high school prom together). We have 4 beautiful children: a 17 y/o daughter, a daughter who turns 16 today, a 12 year old daughter and a 10 year old son. My hair is brown, my eyes are green, I like long walks on the beach and warm puppies.

I hope that one day if my children are in the uniformed services that their commander takes their safety as seriously as I take yours. On this team, safety and accountability go hand in hand. I am beholden to your husband, wife, children, brothers, sisters, mum and dad for your safety. On this team, safety and accountability go hand in hand.

That is why you are in one of 4 squads – for accountability. We'll have formation twice a day – morning and evening. And when we have formation, you need to be there; it's not optional. We'll go over squads at the end of my rambling here.

APPENDIX A - CONTINUED

Safety and accountability is also why we have buddies. I should be able to come up to you at any time and ask you where your buddy is and you need to be able to tell me.

Anyone nervous? Maybe a little anxious? That's natural and expected.

How many of you have deployed before?

Look around – what a wonderful opportunity to pass on what we have learned to our fellow team members…And you veteran deployers remember what it was like the first time you deployed and had tons of questions and no one to ask.

Expectations

Emotionally mature, adult professional officers who want to do a good job.

Emotionally mature – don't take things personally; goes hand in hand with "who want to do a good job"

Corrective guidance/instruction is for the good of the team; because of that we don't need to be defensive; not about us individually, it's about the team.

If I mess something up, I expect to be told about it. On this team, there is generally no shortage of people who will tell me I've messed up.

Great time to make mistakes

Adult –meet commitments; follow the rules; we pick up after ourselves; no alcohol

Professional – best of ability within the bounds of your skill

Officers

- We are guests here – we are ambassadors for the USPHS
- enlisted folks here; don't call them sir or ma'am
- Little to no interaction with officers above O3
- Field or combat environment…they won't be saluting you
- We will observe all customs
- Colors
- MH LT Jonathan White will be available for 30 min on a daily basis if you need to debrief.

APPENDIX B

A CONFLICT RESOLUTION MODEL

I. Recognize it!
   A. Realize it's happening – be "in the moment"; act, don't REact.
   B. Recall these skills – you're trained!

II. Use reflective listening
   A. "Wow, you really sound angry frustrated annoyed frazzled etc"
   B. This generally leads to more venting; restate A. so you don't add to the feeling, e.g. say something like "So what I'm hearing is that you're frustrated"
   C. Continue to diffusion

III. Ask "Is there more?"
   A. Good to let a nice pregnant pause hang in the air before asking "Is there more?" Note: don't use "Is that it?" or "Is that all?" in a snarky sort of tone that infers something along the lines of "Are you done yet?"
   B. If no, go to IV. If yes, recycle reflective listening and "Is there more?" until they confirm there isn't anything else.

IV. Be assertive
   A. Assertive = respect THEIR rights and YOURS; assertive ≠ it's my way or the highway, bonehead.
   B. Accurately restate their points. Accurately restate yours.
   C. Look for points of commonality and attempt compromise

V. Note that it's okay
   A. To have open and lively debate
   B. You can diffuse a heated debate (or fight) by stepping in and saying "Hey it's okay to do this…get it out"

Notes:

1. Not every situation is suited for conflict resolution, particularly if there is disagreement in a short fused, high consequence situation where life or limb is on the line.
2. Comfort in using the model or a similar one will increase with use.
3. The model presumes you have a vested interest in maintaining a relationship with other person and care about them.

APPENDIX C

Modified and adapted by PHS-2 Rapid Deployment Force Command Staff, August 2009 – February 2010 from Patrick Lencioni's *Overcoming the Five Dysfunctions of a Team*.

Effective Team Building

"…teambuilding ultimately comes down to practicing a small set of principles over a long period of time."

Five Components of Effective Team Building

1) Trust – in our context does not mean predictable behavior. It means a universally underlying presumption that decisions are made on the basis of what is best for the team, not the individual.

2) Conflict – no reservations about disagreeing with each other

3) Commitment – no buy in without weigh in; clarity

4) Accountability – silence = approval

5) Attention to Results – are your actions Second to None?

Understandings

- We have a budget of $0 (limited resources and $)
- We're all "volunteer"- we can't make people "do stuff"
- We don't really have the "final" say… ORFD/ ASPR do
- We face "part- time, volunteer status" even with our full-time jobs
- We lack training specific to deployments
- Our RDF functions are different than our 'regular' jobs/ roles/ functions
- We must integrate 'other' people (other RDF, Tier III, MRC, etc…)
- Team definition – the group under your command

APPENDIX C – CONTINUED

Building Trust

●Invest time together (virtual teaming, telecons, social settings – in person, FB etc.)
●Do what you expect your team to do (do real work, work hard at whatever you do)
●Solicit questions/input into your AOR (*What do you think we should do? I need help. I'm not sure. You're better than I am at… What are we missing? What haven't we thought of?)*
●Offer/Accept apologies without hesitation ("*I was wrong. It was my fault." "I made a mistake." "I'm sorry." OR "It's okay." "I feel resolved. Let's move on."*
Leader role: Must demonstrate vulnerability in front of your team and create environment that doesn't punish vulnerability. Must seek counsel.

Conflict

●Open Communications (up, down, sideways; err on the side of too much, remember what it felt like to not be "in the know")
●No reservations about disagreeing with one another/each opinion unapologetically aired (Give permission to disagree – model it – what is best for the team? If no one appears to disagree, ask someone who does not appear to agree with you what they think.)
Leader role: Must acknowledge conflict is productive; encourage debate (discourage not debating to avoid hurt feelings); model good conflict behavior

Commitment

●Clarity (Being clear forces us to answer questions before we give others directions – how, what, who, where, why)
●Buy-in (People will buy-in only after they've had the opportunity to weigh in. May be necessary to enforce weigh-in.)
●Each meeting – what have we decided (Clarifies what has been agreed on; assures everyone is on the same page.)
●24 hour check in (Reinforces any messages to team from meeting to make sure everyone on the team is on the same page (meeting minutes are a good way to do this.)
Leader role: Leader must be comfortable making wrong decisions and not worship consensus/certainty. Be willing to commit when you have 80% of the information.

Ensuring Accountability

●Silence = approval (Must overcome the unwillingness to tolerate the interpersonal discomfort that accompanies calling a person on his behavior and general tendency to avoid difficult conversations) Silence becomes cowardice when the occasion demands speaking out the whole truth and acting accordingly - MG
●Use classic management tools – SMART goals (Specific; Measureable; Attainable; Relevant: Time dependent)
Leader role: Say what needs to be said and use SMART goals

Attention to Results

●Unrelenting focus on specific objectives and clearly defined outcomes
●Ask yourself if what you're doing is Second to None!
Leader role: Keep your group focused on specific objectives

APPENDIX D

SHORT HISTORY OF THE U.S. PUBLIC HEALTH SERVICE

The forerunner of the PHS was created in 1798 by President John Adams. Maritime commerce was of such import to the new United States that President Adams signed into law an act that charged the Treasury Department to provide "for the relief and maintenance of disabled seamen." This followed the British model of providing hospitals for the care of sailors and merchant seamen. The act created the Marine Health Fund which was used to establish the Marine Hospital Service, as a series of hospitals in sea and riverine ports around the country. Functionally, they acted as a loose confederation of federally owned and locally controlled hospitals. Merchant seamen, along with members of the Navy and Coast Guard who used the hospitals were charged twenty cents a month. The confederation continued until after the Civil War, when public scandal erupted over mismanagement of the hospitals and a federal investigation found the hospitals disorganized and underfunded. In 1871 the loose confederation of the Marine Hospital Service was consolidated into a federally controlled organization headed by a Supervising Surgeon (later Surgeon General) in Washington, D.C. That Supervising Surgeon, John Maynard Woodworth, had been a medical officer for the Union during the Civil War, and reformed the Service along military lines, with uniforms and entrance examinations for physicians. He created a mobile cadre of medical professionals who could be assigned anywhere needed within the Marine Hospital Service. In 1889, his reforms were formalized by legislation enacted in Congress that established the Commissioned Corps of the Marine Hospital Service as one of the Uniformed Services of

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the United States. The officers commissioned in the Marine Hospital Service were stationed at Marine Hospitals around the country including Boston, MA; Newport, RI; Charleston, SC; Norfolk, VA; San Francisco, CA; New Orleans, LA; Dry Tortugas, FL; Baltimore, MD; Staten Island, NY, Galveston, TX and others. By 1902, the Service's responsibilities had expanded to include disease quarantine duties, mostly for immigration purposes and the name of the Service was changed to the Public Health and Marine Hospital Service. Additional responsibilities in disease epidemiology, investigations and other public health activities led to the 1912 name change to the current Public Health Service. Initially, only medical officers (physicians) were commissioned as PHS officers. As the Service's mission expanded, other medical professionals were also commissioned including nurses, dentists, pharmacists, veterinarians and medically related professionals including engineers and sanitarians. In 1939, PHS was transferred from the Treasury Department to the WWII-era Federal Security Agency. During WWII PHS officers served with the Army, Navy and Coast Guard around the world providing medical care and disease control services. In the post-WWII era, PHS had expanded to more than 50 general hospitals, 135 outpatient clinics, over 100 field stations and 380 quarantine stations in the U.S. and around the world (U.S Department of Health, Education and Welfare, 1965, p. 9). The Federal Security Agency was renamed the Department of Heath, Education and Welfare (DHEW) in 1954. Through the mid-1960s, PHS officers continued staffing Public Health Service Hospitals in ports around the country, performing quarantine duties that prevented spread of communicable diseases (via PHS' Centers for Disease Control (CDC)), conducting

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research at the PHS' National Institutes of Health (NIH), providing medical care to Native Americans via the PHS' Indian Health Service (IHS) and food and drug safety at the Food and Drug Administration (FDA), among others. In general, these agencies were led by PHS officers and officers of various lower ranks served within the agencies alongside civil servants. All PHS officers assigned to those agencies were controlled by the Surgeon General in terms of chain of command, duty station rotation, personnel policy, etc. A reorganization plan implemented in 1968 transferred control of the PHS agencies, functions and officers under the Surgeon General to DHEW which was largely staffed by civil service personnel. The Surgeon General, no longer exercising line authority over PHS officers, became the senior medical advisor in DHEW and the officers came under the line authority of the agencies in which they served. In 1980, with the creation of the Department of Education, DHEW was renamed the Department of Health and Human Services (HHS). The PHS Hospitals were permanently closed in 1981 as part of a government cost cutting measure.

Recent History

Today the 6,500 officers of the Public Health Service Commissioned Corps are assigned to agencies within HHS including NIH, CDC, FDA, and IHS among others. PHS, in keeping with its 200 year history, continues to provide medical care to the U.S. Coast Guard. PHS physicians, dentists, therapists and environmental health officers are among the PHS officers detailed to the Coast Guard. Regardless of the agency to which assigned, officers follow their agency chain of command for purposes of carrying out their agency's mission and their day to day work activities are governed by the agency to

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which they are assigned. Their day to day up or down chain of command may or may not contain other PHS officers. In a system somewhat parallel to the federal civil service system, PHS officers fall under PHS policies for promotions, leave, and pay which mirror those of the other Uniformed Services and all of which are all separate and distinct from those of the civil servants with whom they work. PHS officer rank structure is presented in Table 1. By tradition, PHS officers are known by their equivalent Navy rank.