AN INITIAL EXAMINATION OF LEADERSHIP AND TEAM COMMUNICATION

BEHAVIORS WITHIN THE ORGANIZATIONAL ENVIRONMENT OF A DENTAL

PRACTICE

by

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ABSTRACT

The purpose of this study was to discover, through qualitative analysis, the current leadership behaviors and team communication practices of today's dentists and their teams. In-depth interviews of the/a dentist, the most senior, and the newest staff member were conducted in each of ten dental practices. Simple thematic analysis found dentist leadership behaviors as consisting of: heirarchical or team-oriented organizational role perspectives, proactive or laissez-faire leadership styles, and autocratic or participative decision-making processes. Findings concluded that the leadership style of the dentist to a great degree affected the types of communication practices employed within the organization. Subsequently, the interview language of each dental team was analyzed using Donnellon's (1996) American model of team work to discover the relationship between decision-making processes and communication patterns and the resulting degrees of team interdependence, identity, social distance, and conflict management style. The examination of the ten offices included in this study, the most significant findings were that the inclusion of staff in the decision-making process along with the facilitation of open communication and accepted methods of collaboration and confrontation as forms of conflict management are the two leadership and communication behaviors that create a real team culture.

Introduction

A small group of productive individuals that enjoy working together to assist one another and their patients is what every young dentist envisions. "In my dreams," was one dentist's response to this scenario in, "Hiring, staffing policies and productivity," a *Journal of the American Dental Association*, *JADA* article (Jupp, 2000, p.647). Jupp goes on to write that it is the "lucky" dentist that enjoys working with his/her team, and that an overwhelming majority of dentists report staff-related issues as the number one stressor in their practice (p.647). It is the "lack of leadership training of dental students [that] makes it hard for them to lead their teams, ensure a happy work environment, and deal with staff issues" (Stone, 2006, p.66). When asked about the subject, Dr. Steve Ratcliff, D.D.S, M.S., Chairman of the Department of Education at The Pankey Institute, explained:

> Our training and selection process favors technologically oriented, introverted, and rigid personality types. There is very little leadership, management or personal growth training in dental schools and as a result we end up in roles for which most of us have little talent and ability, let alone skill sets (personal communication, March 28, 2008).

Very rarely during the eight years of post-secondary education are dental students taught the organizational communication skills necessary for effective staff relations or development of group leadership proficiencies (Jupp, 2000; Kasila, Postkiparta, & Villberg, 2006; Ratcliff, 2008; McGulgan & Eisner, 2006; Stone, 2006). Many dentists believe that the practice management course offered in dental school includes leadership skills training. On the contrary, Stone's (2006) review of such curriculum indicates that these courses focus on office management topics including practice location, hiring, functional aspects of patient management, and clinical

practice systems. As a result, students are trained to be expert clinicians but are not prepared to communicate effectively in a leadership role in order to build effective and sustainable teams.

Larger Significance of the Private Dental Practice

What makes a dental practice worthy of examination? While the purpose of this study is to delineate the most beneficial communication and leadership practices that lead to a real team as opposed to a nominal team environment, one must also put the success of a dental team in a larger context. Each individual dental practice provides the backbone for what is collectively seen as the oral health field. This field makes enormous societal economic and health contributions. According to the Academy of General Dentistry's online report entitled, *2006 Economic Contribution of Dentistry Profession,* the number of workers in the oral health field in the United States as well as the annual payroll of these employees. The map's purpose is to inform lawmakers of the economic impact of the dental industry within each district. In 2006, the number of individuals employed in the field of oral health care totaled 785,301 thousand, with a combined payroll of more than 30 billion dollars (http://www.eyeonwashington.com/agd/).

Beyond the economic impact of the dentistry field, the health impact on Americans who do not seek oral hygiene care is a constant concern for dental associations. According to Oral Health America, "good oral health is essential to good overall health, as the condition of the mouth mirrors the condition of the body" (2000, p. 1). Through routine dental visits, signs and symptoms of larger personal health and social issues may become apparent. Diabetes, bone and joint disease, and oral and pharyngeal cancer, as well as herpes, mononucleosis, or HIV can be detected during oral examinations. Dentists are also able to identify neglect, abuse, and malnutrition in children (Oral Health America, 2003). Financial concerns are not the only reason some Americans forego care. An individual who has a negative experience in a dental office may

not continue to seek oral care and put their overall health at risk. The quality of care patients receive is many times secondary in the mind of an individual to the emotional sense of well-being they experience as a patient (DiMatteo, McBride, & Shugars, 1995). Dimatteo et al.'s (1995) national study, "Public attitudes toward dentists," states that "people who are dissatisfied with the interpersonal aspects of their dentist's treatment [staff encounters included] tend to avoid care and jeopardize their health" (p. 1563). This study reports that the communication skills of the dentist rank among the top three most important factors relating to a patient's satisfaction.

Expert technical skills are not enough for today's dental practices to succeed. In a dynamic industry, such as dentistry, the dentist's leadership and the resulting value placed on communication effects the dental team's ability to work as an interdependent and cohesive unit. This has a direct impact on a team member's ability to serve both the emotional as well as physical needs of their patients. "Results in dentistry are built on many small coordinated team activities that when collectively applied begin to have a significant combined impact on your patients, your profits and on your [the dentist's] fulfillment" (Barry, 2007, para. 2).

The Dentist as a Team Leader

"It is difficult to think of a substantial task within our modern healthcare service organizations that does not require a team, or work group, for its completion" (Rundall & Hetherington, 1988, p.188). A dental practice team must maintain a high degree of professionalism and clinical expertise, while at the same time be must be service oriented in order to build long-term patient relationships. This dynamic and complex system is maintained by teams of individuals. The dentist, or dentists, within each dental practice is the organizational leader and has the responsibility of team creation and maintenance. Unfortunately, even when

initially building the practice team, the dentist(s) tends to hire from a purely functional perspective. The goal is to simply fill all necessary task-related positions. This approach is severely short-sighted and limiting in terms of understanding the relational and cultural aspects of the team.

The members of a dental practice team are by definition a small group, three to 20 individuals, as well as a functional team. "Teams are formal groups consisting of people who work together to achieve common group goals…(and) teams, themselves, rather than a team leader, control group process" (Harris & Sherblom, 2008, p. 149). Dental teams differ from medical office teams, in regards to a higher degree of interdependence and collaboration necessary for task accomplishment. The hygienist, dentist, and assistant rely on the efficiency of shared information and interrelated task-oriented skills due to the fact that they work in tandem to treat patients. The effective accomplishment of teamwork is crucial in this close knit work environment.

It is understood through previous examination of small groups and teams that the role of a leader involves the ability to assemble individuals with complimentary skills and talents and convey through effective communication the values, norms, and goals of the organization. A real team has a high degree of team identification and interdependence among members and their tasks. A team "is a group of people who are necessary to accomplish a task that requires the continuous integration of the expertise distributed among them" (Donnellon, 1996, p.10). Harris and Sherblom (2008), list eight keys of team effectiveness:

1. Clear mission, vision, goals, and purpose
2. Effective Communication
3. Limited size
4. Skill levels appropriate for the complexity of team actions
5. Trust
6. Appropriate and supportive external leadership

7. Defined roles and responsibilities
8. Links between team activities and rewards (p. 149).

All of these factors are linked directly to a leader's mental model of a team, his/her responsibilities to and within the team, and their ability to lead effectively. It has been shown that the most effective teams have a leader who encourages them to adopt a transformational view of the organization, one that employs systems thinking where the parts do not organize the whole, but instead the "whole organizes the parts" (Banner & Gagne, 1995, p. 49). Donnellon's (1996) study makes clear the important distinction between team work and teamwork. She states that team work refers to the functionality of a team, what they do, and reserves the term *teamwork* for teams that "conformed to the ideal of cooperation and sacrifice of individual interests to group goals" (p. 10).

The typical private practice team consists of a primary dentist, a possible associate or partner dentist(s), hygienists, dental assistants, front office personnel, and possibly an office manager. Each of these individuals has a specific role within the functioning of the practice, yet they are highly interrelated and interdependent in overall task accomplishment, patient care and satisfaction (G. Stough, personal communication, March 26, 2008). Each member plays a small, but pivotal role, in contributing to the patient's visit and overall experience. During any dental office visit, the patient comes in contact with and receives information and clinical services from a number of the team members, therefore the office experience is a cumulative one.

Limitations of Current Dental Curriculum

The challenge of leadership and communication proficiency stems from the total exclusion or, in the best cases, a severely limited amount of training in behavioral sciences in dental school. The United Kingdom's General Dental Council included behavioral sciences and communication skills into their guidelines for dental curriculum in 1990, and the United States'

American Association of Dental Schools was soon to follow in 1993 (Hannah, Millichamp, & Ayers, 2004). Although dental schools have begun to recognize the need for the inclusion of behavioral sciences in the dental curriculum, attempts to do so have been inadequate. Research has provided evidence that current curriculum is lacking in both course offerings and in their singular focus on the dentist-patient relationship (Hannah et al., 2004; McGoldrick and Pine, 1999; Stone, 2006; and Yoshida, Milgrom, & Coldwell, 2002).

First, programs that have incorporated communication skills into the curriculum have done so minimally, offering only one course (anywhere from one hour to eight hours in total instruction time) during the four years of dental school. Yoshida et al. (2002) found that only one-third of the forty U.S. and Canadian dental schools surveyed had implemented courses that specifically taught interpersonal communication skills. Secondly, courses including the "soft skills" of communication do so only in the context of the dentist-patient relationship. Dental schools incorporate the 'Standardized Patient' programs with on-site clinics that provide dental services performed by fourth-year students. The students are primarily evaluated for their clinical aptitude by instructors, and at the same time have the opportunity to practice their dentist-patient communication skills.

Along with medical schools, dental schools see improved communication skills as a means of increasing diagnostic accuracy and physician-patient rapport (which leads to patient trust, loyalty, and acceptance of a proposed course of action), and decreasing occurrences of litigation (Hannah et al., 2004). In the medical field, "the inclusion of communication skills as a medical technique is itself a tempering of scientific rationality with 'soft skills,' and constitutes a shift in the way the medical practice is conceptualized" (Islam and Zyphur, 2007, p.784). Dental schools, much like medical schools, are aware of the need for good communication skills in

regard to their patients but neglect to incorporate organizational leadership and communication skills that will enhance the ability of their team to engage in effective teamwork.

Along with this gap in curriculum, there is also a significant gap in research and scholarly literature that investigates the role of organizational communication in dentistry. Currently, communication skills are researched in regards to the dentist-patient relationship or the role of the general dentistry practitioner (GDP) within a larger team of oral health care specialists, or as a member of an interdisciplinary medical team. No other scholarly literature to date has examined the effects of leadership and communication practices of dentists on the dental practice team.

Justification for Study

The value of this study is its originality. Although there are dental trade journal articles on the subject of leadership and communication skills within the dental team, and one trade book Lockard (2007) *The Exceptional Dental Practice*, this subject has yet to be researched from an in-depth scholarly process. Therefore, this will begin a course of research not yet fully examined within this field and aim to have implications for an entire discipline in terms of organizational communication.

At present, individuals graduate from dental school and enter blindly into their role as communicator and leader and instead focus functionally on their undertaking of starting a business, hiring, and managing a work team (Stone, 2006). Many dentists endeavor post-qualification to learn about organizational communication and leadership through dental trade journals such as the *Journal of the American Dental Association (JADA)* and *Dental Practice Management* or through Continuing Education courses. The journal articles are generally written by other dentists or, more often, individuals associated with consulting groups who many times

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have previous work experience in a dental office. These articles are anecdotal and superficial in nature, giving only general recommendations that do not explore intrinsic motives for specific communication practices or methodological disciplines. One example is the article, "A new dentist's guide to jump starting a practice" published in *Dental Practice Management* (2007) offering this advice:

> Acquire non-clinical skills: Work on your organizational, leadership and communication skills. At times, treating patients can become very one-sided. In order to build a successful practice, it is essential to hone your interpersonal skills. Consider joining community groups, public speaking groups or volunteering. Activities such as these will give you the confidence to speak with others [and] will also help you develop your leadership skills (Philp, p.1).

Such advice is aimed solely at the dentist-patient relationship and when has joining a community or public speaking group been proven to build organizational leadership skills? The most directive article discovered discussed more concrete suggestions. In "Habits of effective offices," DePalma (2004) states that effective offices must be; 1) open to continuing education and change, 2) in constant communication with all parties (doctor and staff included), 3) patient-centered in vision or team philosophy, 4) able to provide "red carpet" treatment to patients and to staff in the form of a built in reward system that indicates mutual respect and team member value, and 5) involved as a partner in their community.

The Pankey Institute for Dental Research offers dentists continued education in all areas of dentistry including leadership. When asked about the need for research in the area of leadership and communication within the dental office, The Pankey Institute's Dr. Ratcliff, D.D.S., M.S., stated "I would be curious about the [communication] styles of the highly successful practice" and if the dentist(s) within these practices provide an environment that encourages continuous learning, expresses employee value and recognition of skills, includes training in communication skills, and grants access to necessary resources. "If you find teams

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which can answer these kinds of questions affirmatively, you have a winner of a leader" (S. Ratcliff, personal communication, March 28, 2008).

The dental teams in this study consisted of small groups of individuals whose tasks were interrelated and interdependent. The leadership of these teams was internal and played a major role in the creation and maintenance of team values, norms, and roles. The findings of this study can apply to other small organizational teams that fit a similar leadership and team profile.

Examination

As revealed within this introduction, and to be further shown through the literature review, the scholarly research that has concentrated on organizational communication within the dental office is nonexistent. This study set out to reveal current leadership and communication behaviors within dental offices and their effects on the dental team. With the general personality of the individual accepted into dental school in mind, "technologically oriented, introverted, and rigid personality type," it may stand to reason that dentists would gravitate toward a more traditional style of leadership communication; autocratic, directing attention to the clinical, technical and hierarchical functionality of the office (Ratcliff, personal communication, March 28, 2008). It has shown in a 2003 study that dentists who have a higher degree of emotional intelligence are more successful in the hiring process and experience less turn-over (Becker). A natural predisposition to a higher degree of emotional intelligence may also lead to better interpersonal communication behaviors and leadership that is more collaborative in nature. At this point in time, whichever style of leadership a dentist adopts tends to stem from his/her personal inclinations, an assumed 'common sense' approach to understanding communication and leadership, not trained capacities (Kent and Croucher, 1998).

As "qualitative methods are more suitable than quantitative methods for addressing certain questions about culture, interpretation, and power," ten dental offices were sought to participate in semi-structured interviews that included a dentist, a senior and a newer staff member (Lindlof, 1995, p.10). These three dental team members within each office allowed for a view of the organization that included multiple perspectives. The semi-structured, open-ended questions were designed to inquire as to each member's task-oriented and team-oriented roles as well as the leadership within the office. The questions asked about the communication practices and principles that guided team communication, change and decision-making practices, team culture, the dentist's leadership ability, and the team's ability to communicate effectively. Each dentist was asked about any trained capacities that would have been beneficial to have learned in dental school in regards to communication and/or group leadership.

My analysis of the interviews resulted in numerous and varied themes ranging from the use and acceptance of sexist or juvenile feminine labels and observance of passive personality traits among the most senior staff members to themes concerning leadership, communication practices, and organizational cultures. Simple thematic analysis was sufficient in answering the research questions concerning existing leadership styles, behaviors, and communication practices, however it was necessary to rely on an existing framework, Donnellon's (1996) American model of team work, to guide the analysis of the examination of leadership and the resulting organizational culture in a more structured manner.

Literature Review

Dental Curriculum

Educators and those within the dental field began in the 1970s discussing the need for behavioral sciences instruction for undergraduate dental students (Linton, McCutcheon, & Stevenson, 1975). Since the adoption of behavioral sciences into the U.K. and U.S. dental school curriculums in the early 1990s, only a small percentage have adopted into the curriculum a course directed at interpersonal communications skills. The instruction including interpersonal communication skills is solely directed at the dentist-patient relationship.

Dental curriculum focuses on communication between the dentist and patient for obvious reasons. "Health professionals and dentists in particular, are required to interact with patients on a very intimate level within minutes of meeting" (Hannah et al., 2004, p.976). Studies have shown that those dissatisfied with their dentist's interpersonal skills are more likely to avoid needed dental care, to the point of jeopardizing their health (Dimatteo et al., 1995). A 1995 national random sample survey taken from the U.S. general population assessed the public's attitudes toward dentists and their various roles in terms of importance. A similar survey administered concurrently to practicing dentists, identified skill areas in which dentists might improve and dental schools could focus curriculum. The study found that the top three areas of "most importance" were "ethical conduct, diagnosis/treatment and communication" (Dimatteo et al., 1995, p.1568). Respondents gave use of technology, collaboration with specialists, sensitivity to treatment costs, and sensitivity to pain lesser ratings.

Since the incorporation of behavioral sciences and communication skills into the dental curriculum, several studies have examined the extent of adoption and the methods of instruction of such curriculum. McGoldrick and Pine's (1999) study found that thirteen of the United Kingdom's fourteen dental schools offered courses in behavioral sciences covering communication skills to some degree. Upon examination of the course content and teaching style however, it was revealed that communication was generally taught theoretically via lecture-style, large group format, therefore neglecting skills-based or interactive learning opportunities. The authors concluded that there was an apparent lack of internal resources allocated to the development of communication skills-based training within the U.K. dental schools.

Yoshida et al. (2002) found that only one-third of the forty U.S. and Canadian dental schools surveyed had implemented courses that specifically taught interpersonal communication skills. Their examination of these courses revealed that most were conducted as lectures where students were engaged as passive learners only, and that the curriculum involved only a single course limiting the opportunity for students to learn these skills progressively as they advanced in technical training. Their study concluded that North American dental schools lacked sufficient training in communication skills and that courses offered needed to integrate skills-based learning techniques.

Hannah, Millichamp, and Ayers (2004) state that while the need for communication skills instruction is widely recognized, there has been little research evaluating stylistic differences in instruction to recommend effective teaching styles. Of the studies conducted by ter Horst, Leeds, and Hoogstraten (1984), Davis, Tedesco, Nicosia, Brewer, Harnett, and Ferry (1988), and Koerber and O'Connell (2003) each examined different aspects of current training methodologies. ter Horst et al. (1984) compared a group of dental students who took part in a

three-day program on communication skills with a control group (receiving no training). The students who received training were more likely to summarize and delve more fully into patient responses during dentist-patient interactions. Davis et al. (1988) examined dental students' response to communication skills instruction techniques, whether they practiced and received feedback interpersonally or through video tape methods. They found no significant difference in instruction methods. Each of these studies examined the behavioral science curriculum and evaluated differences in the perceived importance of communication skills as well as students' ability to execute effective communication during scenario-based exercises post instruction. These studies focused on "courses," some as brief as three-day programs with six hours of total instruction, which included interactive skills-based training.

Numerous medical studies have been conducted evaluating communication instruction and have generated recommendations for effective teaching methods. Hannah, Millichamp, and Ayers (2004), include this list of principles in their study published in the *Journal of Dental Education* to preface their own evaluation of a communication skills program offered to third-year dental students in New Zealand.

Medical principles for instruction call for the use of:

1) a skills-based approach (as opposed to a didactic approach), 2) clinically relevant scenarios, 3) self-assessment by students, 4) videotaping methods,

5) simulated patients with expertise in a variety of clinical roles and in the monitoring of student performance and the delivery of feedback, 6) an integrated teaching team comprising health sciences staff and human sciences disciplines, and 7) small groups for optimal learning (p. 971).

Hannah, Millichamp, and Ayers' (2004) study examined the content and practices of the communication skills course offered by the University of Otago's dental school. This course implemented a skills-based approach, enacted realistic clinical scenarios, videotaped students interviewing simulated patients, and employed an integrated team of instructors. It included in-class instruction with students divided into small groups as well as self-directed learning through outside assignments and a workbook and logbook for personal analysis. As positive as the experience was for a majority of the students, who gave the course high scores in a post-course evaluation, the course was extremely limited as it consisted of four, two-hour classes.

Dental student feedback "indicated that they would prefer to have this type of course earlier in their training and continuing throughout subsequent years" and that they viewed communication skills as more important than before they took part in the course (p. 974). This research is helpful in gaining a clear picture of the extent of behavioral sciences curriculum adoption and current pedagogical methods in dental schools, and of the non-existence of organizational communication skills training regarding teamwork and/or leadership. Communication training in the dental context currently focuses on dentist-patient interactions, while development of leadership or team communication skills is neglected. Dentists, while in dental school, are not given any instruction as to the role of communication in constructing their leadership role within the practice, building participative organizational relationships with staff, or principles that guide effective team work. Next, we will explore the available literature concerning the dentist as a member of a team.

Literature on Dentists and Teams

Only a few scholarly articles have examined the dentist as part of a team. In 1995, R.E. Nowjack-Raymer examined the need for dental education to include teamwork and leadership

skills to prepare dentists for possible membership in a collaborative primary health, or multi-professional team. The dentist's role as a member of such a team is to aid in the prevention of oral disease as well as the diagnosis and treatment of existing oral conditions. Nowjack-Raymer includes the World Health Organization's (WHO) definition of a multi-professional team as a "non-hierarchical association of people with different professional backgrounds but with a common objective, which in any given setting is to provide patients and families with the most comprehensive health care practical" (1995, p.100).

Here, the term collaborative team is used in lieu of, or interchangeably with, the terms multidisciplinary or multi-professional teams. A case for participative verses autocratic medical team leadership is made. The author sites previous research by Boerma (1987) and Janson et al. (1992) that found experiences of participative medical teams included: 1) improved decision-making, 2) a higher rate of acceptance of new team members, 3) more comprehensive service packages offered to patients, and 4) treatment of a greater proportion of the population through participative medical services (p.101).

Nowjack-Raymer's article incorporates Beckhard's (1974) model of traditional verses participative teams and adapts it to compare the traditional dental team and the collaborative, multidisciplinary team. His model is used in this study to validate the autocratic and hierarchical leadership methods as traditional ones, as summarized in Table I. He states that within a traditional dental team the following four areas are "most frequently discussed in the literature as causing the most stress and dysfunction to inexperienced and unprepared team members, *i.e.*, personnel function, communication, decision-making, and leadership" (p.101).

Table 1

Characteristics of a Traditional Dental Team

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Characteristic	Description
Purpose	Specific: treat the patient and provide health education.
Priorities	Same for all members.
Tasks	Clearly delineated and limited.
Location	Self-contained environment.
Personnel function	Roles clearly defined.
Communication	One-way. Limited interaction.
Decision-making	Autocratic.
Leadership	Hierarchical.

Note. Table from Nowjack-Raymer (1995)

In the traditional dental team personnel roles and functions are clearly defined by the leader, communication is described as being "a one-way command system with limited verbal interaction among members," and an autocratic, hierarchical approach is employed in decision-making and problem-solving (p.101). Although the article's focus on collaboration is in terms of the creation of primary health care teams, the same principles of collaboration and moving away from traditional leadership can be extended to apply to a private dental practice. Nowjack-Raymer (1995) suggests moving toward personnel functions that are more ambiguous in nature and overlap, communication that encourages group discussion and problem solving, and a more inclusive rather than exclusive power structure. He concludes by suggesting that greater attention to training dentists in the area of teamwork and collaboration must be "improved upon

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substantially" as many dentists "believe that their educational preparation for teamwork was less than ideal" (p.103).

Only one article was discovered in the search for literature regarding the dentist and certain members of the dental team. In the *European Journal of Dental Education*, Morison, Marley, Stevenson, and Milner (2008) discuss inter-professional education (IPE) to be administered during both the undergraduate and professional levels in order to enhance communication between colleagues, thereby affecting team work and the quality of patient care and satisfaction. It is suggested that IPE courses be introduced early in the dental education in order to encourage a better understanding of the shared communication roles and responsibilities of the dental team. "Until relatively recently, the skills of teamwork and communication were not included in the (healthcare) core curriculum and the opportunity for learning these skills with students from other professions was not a requirement" (Morison et al., 2008, p. 23).

The authors draw from medical literature concerned with communication between nurses, physicians, and professionals, to extend this work to the field of dentistry and include the dentist, the dental nurse (assistant), and the hygienist. Dental students' and dental care professionals' attitudes toward IPE and the existing barriers to developing IPE programs were examined. While results suggested that both groups were supportive of IPE programs, barriers included differing perceptions of communication roles and responsibilities between dental, hygiene, and dental nursing students. Each group felt that there was some crossover of communication responsibilities in providing personal care and advising patients.

Dental nurses measured theirs as well as the hygienists' role in communication as taking a supporting or backseat position to that of the dentist. The hygiene students, however, saw themselves as sharing equally with the dentist the same communication tasks that the dental and

nursing students saw as being the sole responsibility of the dentist. Once again, research on the topic of communication skills and practices between the dentist and his/her entire team or of the dentist's leadership role in regards to the team has been overlooked.

Looking beyond dental research, the proliferation in research addressing teams in the context of power struggles and communication occurs within the broader health care context. Here, team research includes hospital (nursing and surgical) teams, psychiatric teams, and multidisciplinary teams. Poole and Real's (2003) literature review of research involving health care groups allowed them to develop a table categorizing 54 studies. Out of the 54 team studies, 11 examined multidisciplinary, 30 interdisciplinary, ten were categorized as "unspecified," and only three examined unidiciplinary teams.

Poole and Real site the three unidisciplinary studies included Bloom and Alexander's (1982) nursing study, Buggs et al.'s (1993) case study of nursing teams, and McCrone et al.'s (1994) study of psychiatric teams. Bloom and Alexander (1982) found that while greater professionalism of staff led to a combination of lateral and hierarchical coordination, the greater the size of the team the greater the need for purely hierarchical coordination (Pool & Real, 2003). Buggs et al. (1993) examined the team approach to nursing and the resulting effects of reduction in infection and costs (Pool & Real, 2003). McCrone et al. (1994) examined the effects of psychiatric team care and reduction in short-term costs (Pool & Real, 2003).

As a result of the review of health care team literature, Poole and Real (2003) make the observations that literature that espouses the team approach and guidelines for working with teams is much more common than systematic investigations of teams themselves. "Only a few studies report group characteristics such as structure, processes, and outcomes so that the impact of team dynamics on outcomes can be explored" (Poole & Real, 2003, p.383). These findings

supported Schofield and Amodeo's (1999) review which found that out of the 224 studies of interdisplinary teams, "38% had little useful content, 25% were descriptive, 23% focused on team processes (mostly anecdotally), 10% reported systematic empirical observations, and only 5% reported the impact of teams or team functioning or outcomes" (p.383). They make a call for more research on health care teams and note that merely creating teams or encouraging teamwork is not enough, that the processes must be examined as "communication is the cement that holds teams together and joins them to the organization" (Poole & Real, 2003, p.396).

Theoretical Approaches to Leadership

Leadership is an essential part of creating and sustaining any organizational endeavor that relies upon the work of a team. It can be defined as, "a process whereby an individual influences a group of individuals to achieve a common goal" (Northouse, 2007, p.3). This influence occurs through unique communicative behaviors and these behaviors define for the group the culture or environment in which they are a part of (Hackman & Johnson, 2004). In the late 1930s, t was Lewin, Lippitt, and White who first studied the impact of varying leadership communication styles including authoritarian, democratic, and laissez-faire. Each of these styles creates different group outcomes. Authoritarian leadership is motivated by the assumption that without strict supervision and a reward or punishment system in place, group members will be unmotivated to work. Authoritarian leadership is a strict, regulating, and hierarchical function that regards the space, or social distance, between the leader and the followers as necessary to indicate and ensure power.

Democratic leaders encourage supportive communication, assume that group members can make informed decisions, that input and collaboration are necessary, and are relationship oriented (O'Hair & Wiemann, 2004). Here, members of the group are regarded valuable assets

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and leadership is shared in that opinions, feedback and participation are encouraged. This system of leadership is empowering to its members as they are involved in decision-making and problem-solving processes. Laissez faire leadership refers to what today are referred to as leaderless groups, because in essence the leader takes a "hands off" approach to the day-to-day management of the group. This leader believes that the group should function independently and offers limited personal involvement and/or direction, only offering to intervene when the group is at a standstill (Myers & Anderson, 2008).

In the mid to later 1900s delineation between task and interpersonal objectives was recognized. Here, Katz and Kahn, and Stodgill and Coons, saw leaders as either initiating structure (task-orientation) or consideration (interpersonal-orientation) in their approaches. With the growing realization that the traditional view of leadership as management did not fulfill the needs of workers as individuals, "you manage things; you lead people," researchers began studying a multitude of different stylistic approaches (Hackman & Johnson, 2000, p.13). While leadership models and theories abound and include: traits theory (Stodgill, 1948), functional approach (Barnard, 1938), situational leadership theory (Fiedler, 1967; Hersey & Blanchard, 1988), path-goal theory (House 1971), normative decision model (Vroom & Yetton, 1973), transactional verses transformational leadership (Burns, 1978; Bass & Avolio, 1994), charismatic leadership (Weber, 1947) and the leader-member exchange theory (Graen & Cashman, 1975), research seems to agree that no one theory or style is appropriate for all occasions or groups. Manning and Robertson (2002), creators of the Dynamic Leadership Inventory, discovered through their extensive leadership observations that "the actual leadership situations people found themselves in were enormously variable and that what was appropriate varied from one situation to another" (p.137). This situational approach has allowed flexibility in the study of

leadership to accommodate situational variations. In his recent book, *The Exceptional Dental Practice*, Lockard states that:

> Good leaders develop their own leadership style, consistent with their values and character. Sometimes they are inspiring and motivating, and other times they must make tough decisions about people and finances without fear of offending. Leaders need to know how and when to adapt their style to fit the situation (2007, p. 47).

Theoretical Approaches to Understanding Organizations and Teams

Traditional organizations were studied functionally and viewed as a structural means by which to accomplish production or provision of services. The classical structural theories of Taylor and Weber (late 1800s - early 1900s) exclusively dealt with the anatomy of formal organizations and directed management accordingly. A structural approach deals with logical relationships among functions in the organization and searches for order, rationality, and regulation of human behavior. They viewed organizations from a machine metaphor. From this perspective, the aim is to discover the correct structure for the organization in order to realize behavior that is predictable, rational and efficient.

As General Systems Theory was introduced to the general scientific field, Bernard (1938) proposed that organizations were people systems (a cooperative system), not mechanically engineered structures, and that people have to be intrinsically willing to follow authority. The Hawthorne Effect study, conducted by Mayo in 1939, was intended to be a scientific experiment about working conditions and productivity. Its conclusions, however, were far from expected as they revealed the importance of communication and the simple act of paying attention to and recognizing employees as motivators producing increased morale and productivity. Bernard and Mayo adopted a behavioral approach to organizations and later began the human relations movement.

Douglas McGregor's (1960) Theory X and Theory Y described two opposing management styles in an attempt to explain views of motivation and behavior. Theory X posited that people were not inherently motivated to work and that for work to be accomplished, managers needed to provide close and strict supervision of employees. This theory saw motivation in terms of coercion and viewed employees as limited resources. Theory Y (the theory recognized as more successful in eliciting good performance from workers) saw an intrinsic need for work and productive learning. This theoretical perspective recognizes that people regard work as natural and normal and therefore respond more productively to recognition and encouragement.

The systems approach to understanding organizations is more prevalent today. Task accomplishment depends on the interdependent and interrelated nature of the team. "Teamwork, then, implies co-operative and co-ordinated effort by individuals working together in the interests of the common cause. It requires the sharing of talent and leadership, the playing of multiple roles" (Harris & Harris, 1996, p. 23). This allows for each individual to be seen as equally valuable and for the compilation of individuals within the organization to be seen as a synergistic force. The primary linking process facilitating co-operative and co-ordinated efforts within any system is communication. As Harris and Nelson (2008) state, "Two perspectives must be understood to develop our organizational communication skills: (1) communication is a process, and (2) organizations can be viewed most usefully as systems of behavior" (p.16).

These concepts have grounded many other organizational communication theoretical advancements, such as Senge's (2000) learning organization model. Pragmatically, systems thinking requires a paradigm shift from individuals as confined to task/role assignments, to individuals being active agents representative of the whole and concerned with shaping and

creating the future of the organization. "Systems are responsive and interactive . . . multi-tiered, with each system part of a larger one" (Harris & Sherblom, 2008, p.29). A system has "interrelated sub-systems designed to balance the requirements of the environment with the internal needs of groups and individuals" (Cameron & Green, 2004, p.90). Even though each division of a team has specific jobs and functions, they must also understand that the complexity of the business calls for all members to rely upon one another for overall task accomplishment.

Within the dental office, each area (*i.e.* hygiene, front office, and assistants) has specific task-related responsibilities and many times subgroups find themselves at odds with other group members. Many times, this is a result of particular members of the team feeling undervalued by the members of the team at large (Stough, personal communication, June 22, 2008). Ultimately, it is the responsibility of the leader to communicate the importance of each member's role and the dependence on the group's interdependence for overall task accomplishment. A leader's power lies within the ability to "create the environment and participate in the social processes of [that] creation" (Pace & Faules, 1994, p.9).

The establishment of organizational processes and systems of behavior create the "organizational culture." Examination of the culture of an organization gained prominence among academics and management consultants in the late 1980s and early 1990s as a means of both explaining as well as controlling some aspects of organizational life (Harris & Nelson, 2008). Within a systems metaphor, we understand that the culture reflects the creation and maintenance of relationships and organizational activities. As an explanation of organizational behavior and the behavior of individuals within organizations, the concept of culture enabled organizational theorists to explain the persistence of organizational practices and routines in a way that rational actor models of organizations could not. "Culture is the connective tissue

knitting together an organization's people so that they can succeed in the face of environmental challenges and opportunities" (Quick, 1992, p. 45).

A cultural perspective moves the organization beyond a Rational Choice Theory paradigm, where an employee operates from a performance-tangible reward exchange, toward one of Social Exchange Theory in which organizational relationships become the intrinsic operational motivation (Barker & Camarata, 1998). Essentially, an organization's culture consists of a set of widely shared ideas and narratives and their associated social practices. The organization is created and sustained by communication and the culture is a by-product of that communication (Hackman & Johnson, 2000). Therefore to enter into a group and understand its' practices, one must investigate the ways in which the group communicates, "the link between group activity and communication is so strong that studying one without the other is virtually impossible" (Hirokawa, Cathcart, Samovar, & Henman, 2003, p.83).

The leader or creator of an organization has the power to shape the culture of the organization through the use of language and symbolism in establishing group goals, norms, and activities. As with any national, religious, or tribal culture, an organization "develops its own language, hierarchy, ceremonies, customs and beliefs" (Hackman and Johnson, 2000, p.233). The assumptions or beliefs, values, and symbols of the organization allow it to operate as a unit to accomplish its mission or goals and to make sense of events or changes occurring within its environment. "Leaders can't always control what happens in organizations, but they can exert significant influence over how events are understood" (p.236). The influence of leadership provides the organizational members' a lens through which to view their personal identification with and interdependency to the group in which they are a part of, as well as judge events that impact the group's organizational environment.

Kasila et al. (2006) conducted a case study of Finnish oral health care concluding that, "little attention has been paid to issues of organizational culture and communication" and that organizational culture "is a concept of primary importance, for describing organizational reality, performance context and change processes" (p. 537). While traditional managers see power and structural systems and procedures as defining the organization, these are secondary to the organizational members' core assumptions and beliefs about the organization. With Nowjack-Raymer (1995) and Beckhard's (1974) model of the traditional dental office team in mind, Lockard, a retired dentist and a faculty member of The Pankey Institute states:

> When I began practicing dentistry, the prevailing management style considered employees as replaceable units that could be plugged into the rigid dogma of managing, organizing and controlling. Their only responsibility was to do as they were told and be quick about it (2007, p.90).

Lockard writes his book about the dental practice as an administrative guide for dentists based upon his own experience of best practices. In his chapter on leadership he states that today, "shared values are the standards used to guide and evaluate the day-to-day behavior [of the team]" (2007, p.90).

Research Questions

With the information discussed in the introduction and literature review in mind, qualitative methods of inquiry were employed to determine current leadership styles and communication practices within dental offices and then to seek to make connections between these behaviors and nominal or real nature of the team. Since this particular subject has yet to be explored from a scholarly perspective, the research questions are somewhat general in nature.

RQ1: Outside of dentist's task-oriented role, how do dentists view their organizational role in regards to the team?

RQ2: What leadership behaviors are present within today's dental practices?

RQ3: How do leadership behaviors affect organizational communication practices?

RQ4: How do leadership behaviors and decision-making processes affect team culture; the real or nominal nature of the team in terms of identity, interdependence, social distance, and conflict management styles?

Methods

Pre-study Survey

To determine if an in-depth study examining the leadership and communication behaviors of today's dental practices was warranted, I began by conducting a pre-study survey. One purpose of the survey was simply to gain a baseline understanding of dentists' current knowledge of communication, leadership, and their attitudes concerning staff relations. I disseminated the questionnaire at the Georgia Academy of General Dentistry's annual meeting in Atlanta, Georgia in January 2008. The questionnaire included questions as to whether or not the dentist had taken any course during his/her time in dental school which focused on communication or leadership, to rank order the qualities (experience, technical, and social/personality) they looked for when hiring new team members, to rank order the factors that contributed to stress in the practice, years in practice and dental school. A statement at the end of the questionnaire explained that if they were interested in including their practice as a possible subject for future communication research, which would include in-depth interviews with the dentist, a more senior and a newer member of the dental staff, they could sign-up at a table in the central lobby.

The questionnaire was inserted into the folders of the approximately 150 practicing dentists in attendance. Sixty-five dentists, receiving degrees from 18 different dental schools representative of all U.S. regions voluntarily completed the questionnaire. Out of the 65 dentists who participated in the survey, 34 signed up to be possible candidates for the qualitative study.

This was an overwhelming response considering that previous studies state that time management is one of the top ten stressors in the dental practice (Stough, 2003).

Information gathered as a result of the questionnaire includes the following. The first question asked, "Did you attend any courses while in dental school that focused on communication skills?" There were 48 "No" and 17 "Yes" responses. Previous literature has shown that if they did receive a communications course while in dental school, it was severely limited. The second question asked, "Have you attended any courses on how to be an effective organizational leader?" Here 39 responded "Yes" and 26 "No." There are two limitations involved in evaluating this response; 1) the question should have specifically asked if they had attended a course during dental school, and 2) a review of dental school curriculums indicate that students are given a course in "practice management" which instructs them about choosing where to locate a practice, scheduling, insurance, and money management (Stone, 2006). This may equate in their minds as a course in leadership. Also, due to the ambiguous nature of the question dentists could have answered "yes" if they had attended a C.E. course on leadership.

Dentists were asked how satisfied they were with their current staff situation. They were given a Likert Scale response option with 1 being "very satisfied" to 5 "not at all." Thirty-five percent of dentists marked 3/neutral, 33 percent marked 2/satisfied, 28 percent marked 1/very satisfied, and nine percent marked 4/somewhat unsatisfied. However, the next question asked them to rate on a scale of 1 to 10, 1 being the greatest and 10 being the least, those factors that contribute to their personal stress. Eight of the ten options were adopted from a previous study conducted by Dr. Gary E. Stough, D.D.S., D.M.D. in 2002, and two were added as factors relating to communication and leadership. The ten included: time constraints, high expectations of self, anxious (fearful) patients, handling complaints or grievances (with staff and/or patients),

staff conflict, fear of failure, motivating employees, turnover/hiring, persuading/selling recommended course of action to patients, and personal leadership ability. Unfortunately, this question was included along with others on the back of the survey and seven dentists neglected to complete them, leaving 58 responses.

In assessing responses most important to this study, I examined how many times the following were listed as one of the top three factors in contributing to the dentist's personal stress level: handling complaints or grievances 53%; staff conflict 38%; turnover/hiring 34%; motivating employees 24%; and personal leadership ability 21%. Each of these factors relates to interpersonal communication and team leadership. These are relatively substantial percentages taking into account that each was marked as one of their top three out of ten stressors. In addition, 45 percent of respondents marked 'time constraints' as the other one of the top three stressors. Dentists, not including required hours for support staff, must themselves complete 20 hours of continuing education outside of their practice per year (Schleyer & Dodell, 2005). This makes the 37 out of 65 dentists who volunteered to take part in the communication research and to take time out of their schedules for interviews even more indicative of a recognized need and a desire for help in this area.

Initial Population

The population of the first part of the pre-study was any dentist in attendance at the Georgia Academy of General Dentistry's annual meeting held in Atlanta, Georgia on January, 2008. This was the convenient, or available, sample in which the pre-study survey was administered. Dr. Gary E. Stough, the 2007-2008 president of the G.A.G.D., agreed to allow the pre-study survey to be included in each of the 150 folders given to the attendees (personal communication, November 11, 2007). One may argue that this population, the members of the

Georgia Academy of General Dentistry, may not be representative of the larger population of those practicing dentistry within the United States, however, the completed surveys showed that the dentists had earned their degrees from 18 different dental schools located throughout the U.S. Dental schools recognized by respondents included; Medical College of Georgia, Emory University, University of Michigan, Temple University, University of Detroit, University of Kentucky, Ohio State, University of Texas in Houston, Northwestern, Suny Stonybrook in New York, Louisiana State University, Marquette University in Milwaukee, Wisconsin, University of Louisville Kentucky, Howard University in Washington, D.C., University of Tennessee in Memphis, and Loma Linda University.

Gaining this convenience sample was somewhat of a coup d'état as professional dental organizations are very guarded with their member's information and access into these organizations can be extremely difficult. In the fall of 2007, I had attempted to speak directly with the Georgia Dental Association and the Alabama Dental Association and found that they were hesitant to allow a researcher entrance into any meeting or to distribute any materials to their members. I discovered that this was due to the large number of consulting firms that work under the guise of conducting "research" only to write dental trade articles in order to tout their services. Dr. Gary Stough, has written trade articles on the issues of stress and staff hiring procedures and was a past editor of the Georgia Academy of General Dentistry newsletter. He allowed me to conduct the survey as this was his outgoing year as president of the G.A.G.D.

Qualitative Methods

In the organizational context, it was necessary to move beyond quantitative numbers and suppositions and to delve into the culture and language that best reflects a team's values and practices. Conducting methods of inquiry "in office" provided the natural setting through which

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to collect data by gathering "words or pictures, analyze them deductively, and focus on meaning of participants" (Creswell, 1998, p.14). Moving from a quantitative validation of the issue to a method that allowed entrance into a small number of private practices in order to examine how leadership and communication practices affect the dental team increased the depth of understanding and provided rich leadership, communication, and resulting team culture data.

Out of the ten offices needed for the qualitative methods, four took part as a result of the pre-study survey. The end of the survey (see Appendix A) stated, "If you would be willing to be a possible subject for future research in organizational communication and receive a staff development program free of charge and at your convenience, please include your contact information on the list at the back of the room." At the sign-up table, a one page explanation of the study's purpose, the interview process, and the approximated time estimated to complete the interviews was available. Of the 64 that completed the survey, 37 signed up. I later sent out letters to the 37 dentists listing dates that I would be able to travel to Georgia for them to take part in the study, four offices were able to schedule a time that was mutually convenient. Of the other six offices that participated, five were located in Alabama, and one in Mississippi. These resulted from referrals from dentists that had been interviewed and through cold calls.

All qualitative inquiry took place on site and at the convenience of each dental office. At each office, one of the practice's dentists, a more senior and a newer staff member were separately interviewed. Each interview took approximately 20 to 30 minutes to complete. In each office I was placed in a convenient location; a break room, office, or empty operatory, and was available for each participant to come and engage in the interview process at their convenience.

The opening statement included the purpose of the interview and answered questions about intent, competency, propriety, and broader impact. The interview was tape recorded and

brief notes were taken during the interview to capture any nonverbal cues or places in the conversation that the participant seemed to be struggling with an answer. The interview questions were used to guide the respondents but every effort was made for the process to feel conversational as additional explanations and example narratives were encouraged. Interview questions included:

1) What is your task-specific role in the dental office?

2) Dentist: How long have you been practicing dentistry?
   Staff Member: How long have you been a member of this team?

3) Outside of your task-specific role, how would you describe your
   role as a member of the team?

4) Can you tell me about the practices and principles that guide
   team communication?

5) If there are going to be changes made that will impact the entire team,
   describe the ways in which the change is discussed, considered, or
   implemented.

6) Are there any current leadership or communication practices that
   you would change or improve upon? How would these changes be beneficial?

7) When anyone has a problem or issue, either task-related or relational, how do
   they go about handling it?

8) Complete this statement: This office is like a(n)

9) On a scale of 1 to 5, 1 being the lowest and 5 being the highest, how would you
   rate the dentist's (your) leadership ability?

10) On the same scale, 1 to 5, with 5 being the highest, how would you rate the
    team's ability to communicate effectively with one another?

(Dentist Only) What, if anything, would have been beneficial for you to have learned in
dental school in regards to running a practice?

Qualitative Analysis Method

As stated earlier, the interviews resulted in numerous and varied themes ranging from the use of sexist or juvenile feminine labels within the organization and the observance of passive personality traits among more senior staff members, to themes concerning leadership, communication practices, and organizational culture. For three out of four research questions (RQ1, RQ2, RQ3) a simple thematic analysis was sufficient. These questions were simplistic and designed to discover direct behaviors of the dentists or the team.

Research question four, however, was more complex as it examined the relationship between leadership behaviors, as examined in RQ1, and team culture. Here it was necessary to rely on an existing framework in which to guide the analysis in a more structured manner. Donnellon's (1996) American model of team work builds upon a solid theoretical foundation and is a compilation of interpersonal and organizational concepts. For this reason, it was seen as the most comprehensive and clearly defined model in which to employ the study's findings.

Donnellon's definition states that a team is "a group of people who are necessary to accomplish a task that requires the continuous integration of the expertise distributed among them" (p.10). This speaks directly to a dental team as each member has functional roles that clearly define their expertise, yet their organizational goals demand that they work in an interrelated and interdependent way. Donnellon's model was a result of her qualitative study that included product development teams in four large U.S. organizations. She analyzed the language of the team members during daily interactions, speaking to one another, in regards to identification, interdependence, power differentiation, social distance, conflict management tactics, and negotiation processes. For each characteristic, or key dimension, Donnellon created a linear scale on which to imagine the team's interactions as indicative of the place along the continuum that distinguishes them as either nominal or real teams. These anchors are guided by

her distinction between team work and *teamwork,* as the first refers to characteristics of a "nominal" or functional unit and the latter refers to a "real" team, one that is highly interdependent in nature, as seen in Figure 1.

Of Donnellon's key dimensions, four were seen as relevant to the examination of the dental team. The following are key dimensions included in this study and their theoretical grounding according to Donnellon: identification (Brown & Gilman, 1960), interdependence (Tannen, 1990; West, 1994; Goodwin, 1980; and Malt & Borker, 1982), social distance (Brown & Gilman, 1978; Brown & Levinson, 1978; Drake & Moberg, 1986), and conflict management tactics (Filley, 1975; Robbins, 1974; Fisher & Ury, 1981; Follett, 1994; Walton & McKersie, 1965) (Donnellon, 1996). Donnellon did include a dimension that dealt with leadership in terms of power. She analyzed power differentiation through the language and language patterns of team members one to another. Furthermore, her study examined parallel teams within the context of larger organizations where the leadership was external in relation to the team. The current study examined language used in in-depth interviews that referred to team leadership and team communication practices. The applicable key dimension for leadership and power resided in the decision-making processes employed by the dentist(s).

Leadership language was assessed using techniques adopted from Donnellon to judge how participants' statements about decision-making indicate inclinations toward either end of the leadership dimensions. The present study employed transcript analysis procedures identical to the procedures used by Donnellon. However, because of the exploratory nature of the present study, dental practices are positioned only in relative rather than numerical terms, so as not to suggest measurement precision that may be unwarranted. The following figure illustrates the four applicable key dimensions of Donnellon as well as one for decision-making process.

Nominal Team		Real Team
Autocratic		Participative
	Decision-making Process	
Functional Identity		Team Identity
	Identification	
Independence		Interdependence
	Interdependence	
Distant		Close
	Social Distance	
Forcing, Accommodating, Avoiding		Confronting, Collaborating
	Conflict Management Tactics	
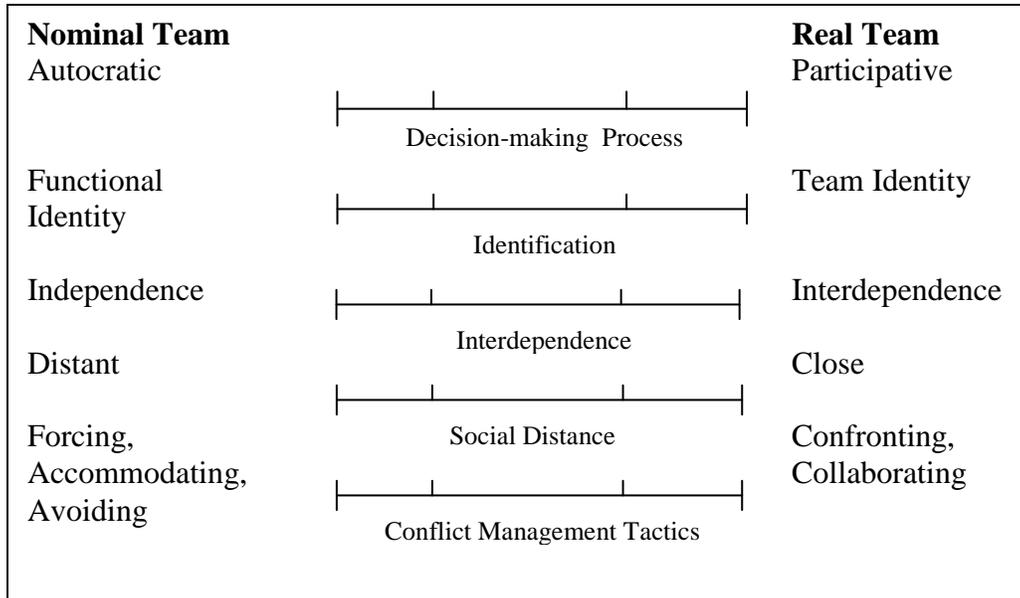
Figure 1. Key dimensions that determine degrees of a team's nominal verses real nature, as adapted from Donnellon, 1996.

Each of these dimensions addresses different cultural aspects of the team. Identification refers to the degree of common or shared identity across functional task assignments or departments. In the dental office this refers to whether team members identify with the group as a whole or compartmentalize themselves into functional groups such as hygiene, front or back office, or even when the staff, often referred to as "the girls," are separated from the dentist. Interdependence "is the central defining characteristic of work teams" and examines the level of shared responsibility and dependence upon one another (Donnellon, 1996, p.34). It is measured by the references to either individual independence or intent indicative of a nominal team, or by the recognition of mutual interests and needs, suggestion of joint action, or explicit expression of the team's interdependence which are indicators of a real team.

Social Distance stems from Social Exchange theory and views language that portrays social closeness or inclusiveness as a measure of the influential power of team members. A real

team expresses social closeness through expressing a "shared identity, a common perception of interdependence and a commitment to the task" where as nominal team members would express social distance through formal and impersonal language (Donnellon, 1996, p.36). Conflict management tactics are critical to the long-term health and success of a team. As conflict is inevitable, it is the real team that understands how to deal with conflict effectively by employing forms of confrontation and collaboration. Here, confrontation is a healthy form of conflict management as the team environment is a safe one that encourages open communication practices. The nominal team indicates methods of force when dealing with conflict including forcing, avoiding, and accommodating.

In making the connection between leadership style and team culture, the key dimension of leadership is added and results from the first research question are so as to make the connection between leadership style and team culture. In examining the transcripts, it became apparent that the major leadership influence that affected the team was the autocratic or participative decision-making processes of an office. At the nominal team end of the scale is an autocratic decision-making style, where team members are excluded from the process, as in the model of the traditional dental team (Beckhard, 1974; Nowjack-Raymer, 1995). Participative decision-making anchors the real team end of the scale and includes language that is indicative of a participative style of leadership including reference of valuing staff input, opinions, and feedback during the decision-making process which empowers employees and creates a high level of reciprocal trust (Senge, 1990; Barker & Camarata, 1998).

The transcripts were then coded according to Donnellon's model of the American team in order to consider the factors indicative of a team's culture, "to expose the intricate interconnections among individuals, teams, and organizations that have shaped the common

experience" (1996, p. 215). Below, Donnellon's table of dimensions, forms, and examples of

"team talk" was modified to exclude the key dimensions of power differentiation and negotiation

and then adapted to include the language of the research at hand. Also, as noted previously,

Donnellon examined the language as it occurred in daily interactions between team members,

therefore a distinction must be made that this study is examining language spoken by team

members about their own role and relationships within the team and about the leader other team

members.

Table 2
Dimensions, Forms, and Examples of Team Talk as Applied to the Study's Dental Offices

I.   Identification

A.   *Functional Identification*

Inclusive pronouns refer to functional groups   "we" "our" "us"

"We basically just work out the principles. We all work together."

Reference to functional groups   "Actually, Lauren and I work up front,"

"We are kind of set up in teams. All the assistants know that if they have a problem, they are supposed to go to the head assistant."

B.   *Team Identification*

Inclusive pronouns referring to team   "we" "our" "us" "family"

"Like he has said, 'we really need to do this'."

II. Interdependence

A.   *Independence Forms*

Explicit reference to independence   "I would love to have someone in place who could manage the staff,

	the team, . . . and then I can step in and do what I do best."
Assertions of individual intent	"I have been focused more on interests outside of the office than inside the office."

B. *Interdependence Forms*

Acknowledgement of mutual interests	"I mean, I treat people here the way I would want to be treated."
Soliciting of others' views and needs	"I definitely have learned to some degree that the team has to buy into it. I always ask for feedback."
Explicit reference to interdependence	"Everybody has to know what is going on. Your right hand has to know what the left hand is doing at all times."
Scheduling Coordinator / Front office:	"I help out everywhere needed. If they need help in the back, to doing x-ray, like, if they cannot step out of the room like that, we will do that. We will go and help clean instruments. Anything that the doctors needs, charts pulled, things like that."

III. Social Distance

A. *Social Distance Forms*

Accounts of using formal language	"I know my role is to be under the doctor and follow what he expects."
Formal forms of address	"Dr."

B. *Social Closeness Forms*

Claiming commonalities in group membership	"We're all part of a team."
Claiming common views	

Displaying concern for others'	"being able to apply my skills where ever needed to help"
Expressions of liking or admiration	"Everybody is friendly to each other and cut up, and we just have a good, good time. We care about each other's lives and what is going on and love each other."
Expressions of reciprocity or cooperation	"I help out everywhere needed. If they need help in the back, to doing x-ray, like if they cannot step out of the room like that, we will do that."
Similar language	"morning huddle" "girls"

IV. Evidence of Conflict Management Tactics

A.	*Forcing/Avoiding/Accommodating*	*"Who wants to speak out if nothing is ever going to be done about implementing it, or if you have to bring it up 3 months in a row before you find out anything. You get to the point you want to say never mind."
B.	*Confronting / Collaborating*	"We ask everybody not to go into another room and fuss about something to somebody who cannot do something about it, but take it to somebody who can take care of the problem." "everybody airs any kind of concerns that they have, and we discuss that. That always runs really smoothly too."

Note: Adapted from Donnellon (1996, p.31).

Results

The amount of information gathered through interviews of the dentist, the most senior and the newest staff member of each office provided a much more holistic picture of the organization than first imagined. While the dentist in each office provided a unique perspective as the leader, there was a much larger discrepancy between the views of the most senior and newer staff members. The senior staff members had become accustomed to and adapted to the dentist's leadership behaviors and the communication practices of the office, as one senior staff member stated, "I don't know what I would change. I don't know. I guess I have been here so long I am comfortable. I can't think of anything." The newer staff members on the other hand, most of who had made the transition from another dental office, were able to easily identify the areas in which the office could make leadership or communication changes that would benefit the team. These divergent views taken together with the dentist's perspective of their own organizational role provided rich data and gave a well-rounded view of each practice's leadership and team communication behaviors.

The study included ten dental offices, four in Georgia, five in Alabama, and one in Mississippi. Three individuals per office participated in the interview process. However, it was necessary to interview both dentists in the tenth office. The dentists in this office were husband and wife with the wife in charge of all staff management. When I visited the office, the husband participated in the interview and admitted that he had no daily leadership role. Upon review of the tape and transcript it was apparent that I would have to contact the wife in order to gain the

correct information in keeping with that of the previous offices. While his responses to the interview were considered in the data, she was viewed as the organizational leader. A phone interview was later conducted with her. This led to a total of 31 individual interviews.

Half of the offices that participated were individual private practices and the other half were dental partnerships with either two or three practicing dentists in-office. Three of the leader-dentists interviewed were female and seven were male. Confidentiality was maintained, in compliance with the Institutional Review Board, as the transcripts were titled numerically by office in order of the interviewed process and with each respondent titled by his/her task-oriented role and years on the job (e.g. Office #1; dentist, 26 years; dental assistant, one year; hygienist, 20 years).

Throughout the interview process, notes were taken and transcripts were continually read to begin to recognize the emergence of common themes. By the fourth office, it was clear that there were many common themes and that they covered a large range of research interests. For three of the four research questions a simple theme emergent analysis was sufficient as the questions examined leadership perspective, styles, and behaviors, and communication practices. When the investigation turned to making connections between leadership style and the resulting team culture, Donnellon's (1996) framework was adopted to aid in the clear construction of comparative analysis of the ten offices. Here the data was examined in terms of language or statements that referred to the identification, interdependency, social distance, conflict management, and leadership style of the dentist. The interview transcripts for each office were read and coded according to the key dimensions.

To ensure reliability in the coding, one other coder, a retired dentist, independently read the transcripts and was asked to code in response to the first research question examining the

dentist's view of their role within the organization (hierarchical / team-oriented), and decision-making processes employed by each dentist (autocratic / participative). He was given coding instructions which included 1) examining each dentist's response to interview question number three, and to categorize each as hierarchical or team-oriented, and 2) to read over each respondents, three per office, response to interview question number five concerning decision-making processes, and to categorize them as autocratic (unilateral decisions-making without input from staff) or participative (decision-making processes that seeks employee input). Inter-coder agreement for the first research question was 90% as the coder felt that seven dentists, as opposed to my coding concluding that six, were team-oriented and the other three were hierarchical. The discrepancy was with office #9. The coder, a retired dentist, felt that the simple mention of delegating to other team members made the response more team-oriented, however, the dentist interviewed goes on to explain that she feels solely responsible for the accomplishment of organizational goals. The entire response is seen on page 47. The inter-coder agreement for decision-making process distinctions was 100%. This may be due to the simpler operational definitions supplied to the coder as to how to categorize autocratic verses participative processes. Autocratic decision-making is evident when the dentist or the staff describes decisions made by the dentist(s) unilaterally, without the solicitation of team member input prior to the final decision.

Descriptive Data

The first research question investigated how dentists view their organizational roles using the transcripts of their responses to the third interview question. The third interview questions asked, "Outside of your task-specific role, how would you describe your organizational role as a member of the team?" This question was formulated in such a way as to not lead the dentist into

answering it in terms of his/her leadership role. Therefore, their answer could include insight into their sense of hierarchical leadership or their sense of identification with the team. Out of the ten offices, four dentists immediately responded about their role as "the leader" and six discussed their roles in a more team-oriented manner as managers of resources and talents, and as a member of the team themselves.

Table 3

Dentists' View of Organizational Role

Leadership Style	# of Dentists
Hierarchical	4
Team Oriented	6

Those that immediately pointed out their role as the leader saw themselves as extricated from the group and spoke in hierarchical terms. Although the following dentist's response is simple and straightforward, Office #2, Male, practicing for 10 years, "All the administration, hiring, firing, planning, management." He further alluded to a hierarchical perspective setting himself apart from the team. As part of his response when asked later in the interview to describe the team he replied, "They are like my kids. Managing them from communication standpoint is like managing my children." Other hierarchical responses included:

Office #2, Male practicing for 18 years:
All the administration, hiring, firing, planning, management.

Office #4, Male practicing for 24 years:
I am the team leader. I am the alpha dog. Other than being the boss and the signer of checks, it means a lot of things. I have to help keep people motivated, focused, on track, organized, excited about what they do everyday, because ultimately that effects my ability to do what I do. It is great what I do, but I am not happy because of the way things are going on and that is not good.

Office #6, Male practicing for 26 years:
I am the bread winner and the paycheck writer. I kind of, out of most people, most of them know what they are doing. I just come in if there is a little friction or something.

Office #9, Female practicing for 9 years:
A little bit of everything. It ultimately comes down to bottom line, me on the whole thing. I try to delegate as much as I can. I do delegate to Jan, the front office what I can, but I find that I have to have a hand and know how to do it all or it does not get done well.

Note that the question asked how they describe their organizational role *as a member of the team*. Absent from these examples is any reference by the dentist to his/her role as a member of the team, but instead to their roles outside of and reference to power over the team.

At the other end of the spectrum, six dentists discussed their roles within the team and as members and managers of the team's talents and resources. These dentists value their integral place within the team as well as the members of the team. Examples include:

Office #1, Female practicing for 16 years:
Co-leader, help resolve issues in the office, encourage, and train.

Office #3, Male practicing for 28 years:
I just have good people working for me and they pretty well run the practice and I do not have to do actually a lot of managerial type things. They get it done. That is nice.

Office #5, Male practicing for 23 years:
I think that certainly our main role is in coordination of the group. I think we have to do our part and actually this is where we fall into line and we have a chair that we sit in and we have a task to complete and everybody else they help us to complete that task.

Office #7, Male practicing for 16 years:
I try to encourage everyone to be productive, to treat people the way they should be treated. Anytime people need to learn something, I am the one who sees to the continuing education forms or the courses for them, trying to get them to be better at their job. So I see myself in that role.

Office #8, Male practicing for one year:
Short of the technicality of me being the dentist, I mean it really, I feel like I am at a party of equals to a certain degree. I mean I treat people here the way I would want to be treated.

Office #10, Female practicing for 8 years:
I hope that they see me as an integral member of the team, part of the team, not over them.

These responses signaled a more participative view of the dentist's organizational role. They referred more to the team as a support system and discussed their role in managing, encouraging and training members of the team. There was a sense of trust in that group members were working toward accomplishing organizational goals unlike the earlier responses.

There were no demographic distinctions between the groups of dentists in this study that exhibited the two divergent views of their organizational role. In each category there were more seasoned and newer dentists as well as male and female dentists. All responses could be placed in one of two categories, 1) those that viewed themselves as separate from the team and demonstrated hierarchical status and power over the team, and 2) those that had a more team-oriented approach to their own role and the management of the team's talents and resources.

Research Questions Two and Three

The second research question inquires as to the leadership behaviors present within today's dental practices and the third then asks how those leadership behaviors affect the organization's communication practices. The findings of research questions two and three were discovered to be highly inter-connected, as the leadership styles and behaviors of the dentists seem to play an integral role in determining team communication practices. Both questions are answered by examining the dentist's response to the third interview question, as in the previous research question, and then all participants' responses to questions four through seven. These questions included:

3) Outside of your task-specific role, how would you describe your role as a member of the team?

4) Can you tell me about the practices and principles that guide office communication?

5) Describe the ways in which organizational change is considered or implemented.

6) Are there any current leadership or communication practices that you would change or improve upon? How would these changes be beneficial?

7) When someone has a problem or issue, either task-related or relational, how do they go about handling it?

Leadership Behaviors and Communication Practices

Leadership behaviors also exhibited themselves through implementation of communication practices, therefore each participant's response was evaluated in terms of themes that indicated leadership behaviors or office activities initiated or established by the dentist. Simple thematic analysis was conducted taking into account remarks made about the dentist's leadership, and the communication practices that occurred in each office. Common leadership categories emerged and included: either proactive/change-agent behaviors or laissez-faire style of leadership that embraces the status quo, either participative or autocratic decision-making processes, the possible employment of and dependence upon an office manager to coordinate and handle staff relations, and focus on instruction or continuing education. Communication practices include implementation of "morning huddles" and/or weekly, monthly, or annual staff meetings. Note that the decision-making processes employed by the dentist can be viewed as leadership behaviors, as well as a communication practice. Figure 2 shows both the leadership style and communication practice themes that emerged from the transcripts of all participants in each office.

Offices	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10
Observed Behaviors										
Proactive leadership	*	*		*		*	*	*		
Laissez-faire leadership			*		*				*	*
Participative Decision-Making		*	*		*	*		*	*	*
Autocratic Decision-Making	*			*			*			
Focus on C.E.		*				*	*			
Office Manager					*	*	*	*		(*)
Morning Huddle	*	*		*		*	*	*		
Regular Staff-Related Meetings	*	*		*		*		*	(*)	(*)
*Mean Leadership Score	**3**	**5**	**3**	**3**	**3**	**5**	**3.5**	**4**	**4**	**5**

Figure 2. Leadership and communication behaviors exhibited in ten dental offices.
* Based on participants' placement of dentist's leadership based on a Likert rating from 1 to 5, with 5 being the highest possible score.

The offices are listed as they occurred in the interview process. Within the responses of all interview participants, there were comments made about the dentist's, or lead dentist's, leadership approach. Thematic analysis concluded that there were two basic approached, proactive and lassez-faire approach to leadership. Proactive examples include:

> Office #1, *Dentist*: I don't think we are stuck in many ruts around here. Daddy [the lead dentist] is always changing stuff. You know, if you find a better way to do something, you change.

> Office #4, *Dentist*: This office is dynamic. It's a living organism, always changing.

Examples of dentists who had a more hands-off approach to leadership did so out of a desire for comfort and were content to maintain the status quo. Responses indicating this type of leadership include:

> Office #3, *Dentist*: It's comfortable.
> *Staff member*: He doesn't really have a lot of change. He is pretty basic. He lets us do things basically the way things have always been done, other than updating new technology. Other than that, there is really not any change.

> Office #6, *Dentist*: Sometimes it seems like it is a drone, just flying itself. Everybody just gets things down without a rudder.

These dentists talk about their comfort level, of everyone knowing what is expected, and being able to just do their job, dentistry. Four out of the ten dentists referred to this type of managerial perspective and felt it was contributing to their ability to enjoy dentistry. As a result, these organizational atmospheres are very laid back and lack formal communication practices. None of these four offices conduct "morning huddles" and two engage in some form of regular staff meetings, although not in a formal manner. This distinction, of less formalized staff meetings, is indicated by placing parentheses around the asterisks in this category for these two offices in Table 4.2.

Morning huddles are a common practice in dental offices. They are 10 to 15 minute, functional team meetings held each morning before the first patients are seen. This meeting time is used to discuss the schedule, any necessary changes in the schedule, patient issues, and basic housekeeping functions. It was surprising to find that none of the four offices engaged in morning huddles. It seems that this is as a result of the dentist's comfort level with the staff and their supposed knowledge about day-to-day operations.

> Office #5, *Dentist*: We do not have weekly or for that matter, monthly meetings. We did at one time. To tell you the truth we have such a good group, we do not have to do that anymore. We do not have to continue to restate those goals and rehash all the things that we used to have to go over all the time.

The communication practices of these offices instead depend on "on the fly" communication interactions and are reliant on a loosely structured, trickle down effect. When asked how changes are made and communicated to his staff, one dentist stated, "Sometimes I bring them together. Sometimes it is just word of mouth. I will tell one person and they will tell somebody else. I do not make a lot of changes. I count on velocity of that." While freeing for the dentist, this lack of formal communication can be disconcerting to the newer members of the staff. In interviewing these newer members one sees where communication complacency becomes an issue. In response to the question asking what communication or leadership changes would be most beneficial, the newest staff member of that same office replied:

> I think we do need some kind of staff meeting, whether it is once a month or whatever, to talk about things that need to change or patients that we need to be with or whatever, rather than it be let go. Well, I think we would all have a better understanding of what is going on and things that we needed to change.

An exception to this finding is office number ten. This office shares in the laid back approach to leadership and change, but not in the characteristic of communication complacency as expressed within the other three. Here, while there are no formal communication practices such as morning huddles or regularly scheduled staff meetings, the communication is described as "open access." When asked, the dentist explained that an "open line" of communication is encouraged throughout the day and that they "tie up any loose ends at the end of each day." This office is no smaller than some of the other offices interviewed, but both dentists expect and encourage their staff members to talk to each other and to them as needed. The two staff members interviewed in this office both gave the dentists the highest leadership rating and neither gave any suggestions when asked of changes that could improve leadership or communications within the office. While this office cannot be considered to have regular staff

meetings, it needed to be counted as meeting with its' staff on a regular basis. To be able to make this distinction, I have placed parentheses around an asterisk in this communication practice category.

On the other side of the spectrum, six of the offices viewed their leader's behaviors as pro-active. Dental leadership that is proactive is concerned with keeping up with current technology, best practices, and staff relations. The data reveals a strong relationship between the proactive nature of leadership and the regularity of team communication. All six of the pro-active offices engage in morning huddles and five of the six hold regular, weekly or monthly, staff meetings. It is important to note that morning huddles tend to be functional with short term goals and implications, whereas most participants described staff meetings as a time to bring up larger issues related to the practice including the "numbers" of new patients and income generated, changes in systems and technology, and staff relations. In these offices, the perceived quality of communication is not based on its regularity but on the participative or autocratic nature of the decision-making processes within the office.

Decision-making processes

The ways in which decisions are made is indicative of leadership behavior. Seven of the ten dentists were categorized as participative and three as autocratic in their decision-making behaviors. These include decisions involving change that will impact the team as a whole. Leadership that is participative takes into consideration the opinions and input of the team. Those that are participative seek and value team input. Some examples include:

> Office #2, *Hygienist*: I mean looking at getting new equipment or something like that, he usually runs it by us to see if we are interested or if we are going to use it, or things like that.

> Office #5, *Office Manager*: Everybody here feels very comfortable, even to the dentists saying, "hey wait a minute, we cannot do it." And then it is taken into consideration.

Then it may be accepted or not accepted, but it is heard and it is given serious thought to. People feel like they have a voice in the office.

Office #10, *Dentist*: I'm all about getting their input on any change because the decision is going to affect them, and then how they feel about it is going to effect me.

Autocratic decision-making processes are made unilaterally by the dentist or dentists. Here, the team is involved after the fact as they are informed of the decision and instructed as to how to proceed. Examples of responses indicating autocratic decision-making processes include:

Office #4, *Dentist*: The decision making is different. I communicate that to them in the staff meetings and morning huddles, things like that. Sometimes I will sit down side by side, like with . . ., and say we are going to change our schedule in the spring, like the hours from this to this.

Staff Member: It is usually not [communicated]. For example, he has line changed the schedule as far as what time we are to be here, what time the first patient is, and not bothered to tell us and he would go in and block himself out for that afternoon and there are patients there, but he failed to communicate it to the front desk so we can reschedule and it just happens sometimes where we see it. That is kind of our biggest issue because he is a computer whiz and he just kind of goes in and makes changes.

Within a dental partnership practice:

Office #7, *Dentist*: When we are making a change, now I talk to . . ., my partner, and we hash it out. Sometimes when we are driving home from work, over the phone, that kind of thing. And then we will say lets talk about it with everybody, usually in the morning huddle, if we make a decision. If we don't make a decision, we will just talk about it until we have a spare moment until we decide.

A point to be discussed in greater detail in the next chapter is that although dentists may view themselves in a hierarchical leadership position in regards to the team, they may be participative in they way they go about making decisions that affect the team. The dentists in offices number two and nine viewed themselves as leaders and spoke in hierarchical terms about their organizational roles, yet seek and value staff input when considering change that will affect the team.

Delegating leadership to an office manager

The next leadership behavior is appointing administrative duties to an office manager. Four out of ten dental offices had an official office manager and the tenth dentist interviewed described his dental associate, his wife, as assuming the role of office manager. A dental office manager's duties may include scheduling, insurance, accounts receivable, payroll, and dealing with staff-related issues. In all of these instances, the dentist referred to the office manager as the individual who was their first line of defense in handling issues related to the staff, allowing them to focus on dentistry. This ability is appealing as seen here when one dentist, who is currently without an office manager, stated:

> Most of us dentists would love to see patients and not have to deal with staff, payroll, and management issues. We just want to show up, do our work, and go home. But because we are a small business we have chosen all that. To be the owner, we have to deal with that. I would have a single person to hire, train, and be able to trust. That is the hard part. Training is easy, the trusting is the difficulty, and that would basically be an office manager who would run the business and allow me to focus on what I do. . . So I think that would be the single thing. I don't think it is just dentistry, most small businesses would love to have someone in place who could manage the staff, the team, the systems that you put in to place, to make sure everything is running right so then I can step in and do what I do best.

Excluding office number ten where the wife-dentist is described as the office manager, the breakdown of office characteristics of the remaining four offices includes the following: three have proactive dental leadership, three engage in morning huddles, two have regular staff meetings, two have leaders that are focused on training and continuing education, and three engage in participative and one in autocratic decision-making processes. None of these observations created any consistent pattern between offices. The only constant theme is that of the office manager's role in management of staff relations and as mediator. The responses to the seventh interview question, "When anyone has a problem or issue, either task-related or relational, how do they go about handling it?" from these four offices included:

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Office #5, *Dentist*: We encourage them to go to the office manager first, but depending on the employee, some of them just feel more comfortable coming to us and we try to be flexible. We try to be flexible. There are different personalities. Sometimes we will refer them back, because we had already had that conversation with the office manager. We have kind of put some guidelines put in place with her so we rather her take care of the situation.

Office #6, *Office Manager*: A lot of times the girls will come to me if there is a problem, [with a] patient or anything else. If I can handle it I will try to handle it. If it is something that he needs to know about, other than trivial, then I will just try to take care of it. If it is somebody is upset, crying, I will go and talk to him. I just try to take care of it. I'm a cheerleader too, because he doesn't really even think about it and I'm actually not going in there and tell him. So when I pass out pay checks, I say, "Keep up the good work."

Office #7, *Dentist*: And it really does depend on the individual for the most part in this office. Sometimes it comes back to me, and it is nice when it doesn't come back to me. It just depends on what it is. If it gets handled without me knowing, then fine. Yeah, that is what my office manager is for. I think we have a person that can do it now.

Office #8, *Office Manager*: It kind of goes through me first. He hired me to be like the office manager, but it hasn't really happened because I kind of do front desk stuff too, well it kind of has happened, but just not as structured as most offices. Like, I mean, he has told everybody to go through me if they have a problem and not go straight to him, and if I cannot sort it out then he and I will sort it out together. It works pretty well for the most part.

In Figure 2, on page 47, you can see that there is no direct observable relationship between the existence of an office manager and the average rating of the dentist as an effective leader. The leadership effectiveness scores for each of these four offices were 3, 3, 5, and 4. This is based on a scale of 1 to 5 with 5 being the highest possible rating. The implementation of an office manager does not seem to have any effect on the practice or team other than allowing the dentist the increased ability to focus on practicing dentistry and less on daily team interactions. Findings from this study conclude that dentists with office managers see them, not as replacing the dentist as leader, but as alleviating the dentist's staff and management responsibilities.

Office #10, *Dentist*: My wife, who is the other dentist, is also the office manager, and she does an artful job at managing everyone, so that I can just come in and enjoy what I do best, dentistry. I am the lead dentist, but she handles everything else.

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Focus on continuing education

The next leadership behavior revealed was a focus on continued training and education. Three of the ten offices mentioned the dentist as an educator or trainer, providing continuing education to the team that best suited its members' needs. These responses included education that developed any type of skills training or understanding of the newest dental technology. It may be important to note that all three of these dentists' leadership behaviors were also viewed as proactive.

All three examples feature the dentists' willingness to help train and provide their staff with opportunities to continue learning about the dental profession. One dentist discussed regularly scheduled meetings that provide his staff with an opportunity for training or to have a speaker tell them about new technological advancements in screening and equipment. In the sixth office, a staff member praises the dentist for his willingness to instruct and to help her be as productive as possible, adding to her overall value as a team member. Finally, the dentist of the seventh office expresses his role as the facilitator of continuing education programs providing for team members' needs on an individual level.

> Office #2, *Dentist*: The second staff meeting that we have each month is what we call our continuing education meeting. Our *Lunch and Learn* yesterday was on some oral cancer screening.

> Office #6, *Assistant*: If you have a question, get ready to do something, like a job or something and do not know how to do it, just ask him and he will show you. If you are willing to learn he will teach you.

> Office #7, *Dentist*: Anytime people need to learn something, I am the one who sees to the continuing education form or the courses for them, trying to get them to be better at their job.

Communication practices

Finally, it was noted earlier that leadership behaviors seem to directly affect the organizational communication practices of the team. Table 3 shows that the pro-active dentists engage in regular formal communication with staff and that conversely, the dentists content to maintain the status quo disregard regular formal team communication. But, do these leadership behaviors and communication practices affect the way that members of the team view the dentist(s)' leadership ability? The ninth interview question was intended to take an informal perceived measure of leadership effectiveness. It asked all interview participants, "On a scale of 1 to 5, 1 being the lowest and 5 being the highest, how would you rate the dentist's (your) ability to lead?" The average of the three responses per office was calculated. Only three out of ten offices gave the dentist(s) an average score of 5. Upon examining the data on leadership behavior and communication practices, two of the three shared many of the same characteristics. Both offices have proactive leaders, engage in morning huddles *and* regular staff meetings, focus on continuing education, and employ participative decision-making processes.

The third office with a leadership rating of 5, office number 10, first seemed like an anomaly. This practice is quite unique as the two partner dentists are husband and wife, are only in the office together two days a week, and all staff managerial duties fall to the wife. When visiting this office I interviewed the husband-dentist who stated, as mentioned earlier, that his wife has freed him from all staff management responsibilities allowing him to focus exclusively on dentistry. As a result he answered all interview questions from a "hands off" viewpoint and when asked the question about rating leadership, his answer reflected his opinion of his wife's leadership, a 5. The score for the office was a 5 overall, but his personal leadership style and

communication practices did not reflect the pattern evident in the other offices with leadership ratings of 5.

It was then assumed that possibly the office did engage in similar activities as the other two, but that by interviewing him exclusively the true leadership and communication practices were not revealed. In an effort to examine this office more completely, I contacted the wife and asked her the same interview questions. She was able to create a more complete picture of the leadership and the communication style of the office. As the primary staff manager, she views herself as an integral part of the team and places a high value on all other team members by trusting and empowering them. During the interview, she gave an illustration that had occurred that day of a disgruntled patient, not with service but with insurance changes, who called and was taking his frustrations out on the employee at the front-desk. The dentist overheard and intervened, taking up for the staff member. She praised her employees throughout the interview and talked about how "lucky" she had been to have such a great team that she could rely upon. She discussed that although the office does not engage in a lot of change, that when a change is necessary she seeks feedback and input from those team members the change is most likely to affect. While the communication style here is less formal, both dentists encourage staff members to access the continuous "open line" of communication between members of the team and the two dentists. Therefore, the similarities between all three offices with leadership ratings of 5 include; regular communication (whether formal or informal), actions that suggest to staff members that they are valued (whether through a willingness to educate or through empowerment), and participative decision-making processes.

Analytical Data

Research question four asked how the style of leadership affects the nature of the team within a dental office. The analysis of this question is analytical in that it builds on the findings of the first two research questions and then analyzes the language of respondents according to Donnellon's (1996) key dimensions of the American model of team work. This question addresses the relationship between leadership decision-making behaviors and the perceived affects on the nominal or real nature of the team. The following key dimensions were chosen in reference to team literature concepts and the perceived cultural characteristics of a dental office team. They include the leader's decision-making behaviors, and the team's sense of identity, interdependence, social distance, and conflict management. Respondents' transcripts within each office were coded to determine a low, mid, to high occurrence of language for each key dimension, helping to demarcate along the created continuum the nominal verses real nature of the team. Donnellon created a visual model that shows a nominal team at one end and a real team at the other end of each key dimension's scale. The elements of each key dimension are not mutually exclusive; therefore the presence of one does not negate the presence of the other.

The analysis of leadership language consisted of statements made by any of the interview participants within each office that referred to the way decisions are made, whether autocratically or participatively. Donnellon's method for linguistic analysis along with examples from this study are presented in Table 3.1, pages 37-39. A model is created demonstrating the leadership and resulting team culture for each office. Each office's findings are then discussed separately in this chapter. Offices 1, 2, 3, 4, 6, 8, 9, and 10 were similar in that the leadership and decision-making processes seemed to directly affect the other key dimensions attributing to team culture.

Offices 5, and 7 did not follow this pattern and the possible mitigating factors will be discussed within the findings.

Results for Office Number One

Nominal Team		Real Team
Autocratic		Participative
Functional Identity		Team Identity
Independence		Interdependence
Distant		Close
Forcing, Accommodating, Avoiding		Confronting, Collaborating
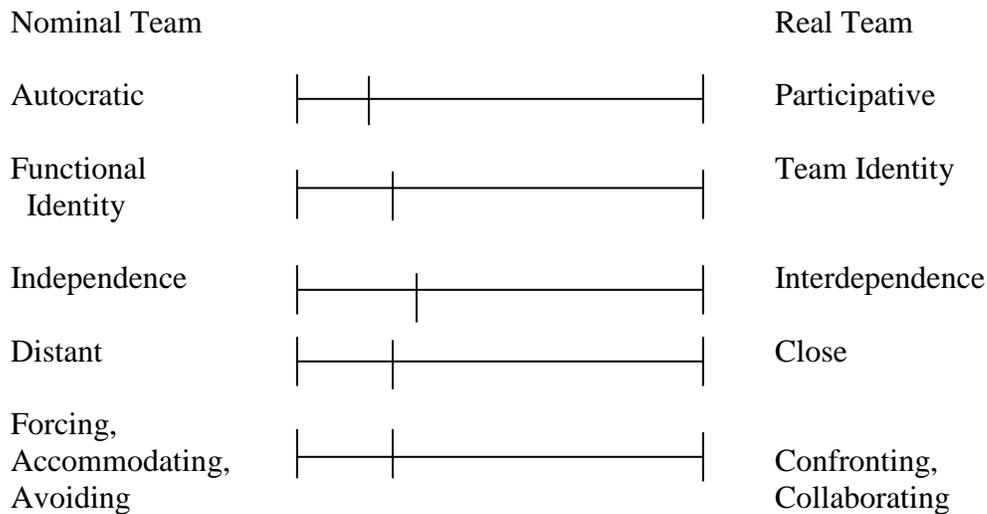
Figure 3. Leadership and the resulting team culture for office number one.

The first office consisted of three dentists; a father, his daughter and son-in-law. I interviewed the daughter-dentist. She had a very positive view of the leadership, communication practices, and the team. It was evident that her father was the central leader figure in the office. Upon interviewing the two staff members, it became apparent that there were communication issues stemming from the three dentists inefficiency with which they communicated with one another, as well as with the staff.

Decision-making process. The dentists' decision-making practices, although they would like to perceive them as participative, are autocratic. There is one mention concerning participative decision-making where team input is said to contribute to office-wide change. However, this can be viewed as discrepant data because this mention by the dentist is later

refuted in the end of the same response, as well as in the responses of both staff members. The

dentist, states:

> We also have monthly meetings with the front office staff and the head assistant, and then the assistants meet once a month, and the hygienists meet once a month. Things come out of that constantly to make things different or better. Pretty much it is done as a team, somewhat, not the whole team, but leaders.

In response to the question addressing change, staff members stated:

> Staff Member #1: Of course there are going to be times when the doctors will just make a decision and it doesn't matter what everybody thinks. I think for the most part, we have team meetings. The hygienists have monthly meeting and the assistants have monthly meetings, so which ever group it affects, it will be brought to them at that meeting and discussed.

> Staff Member #2: Pretty much I think the doctors make the decisions and we just do what they say. . . And then I guess [during meetings] if we have a concern about the office we could bring that up but we never have.

The first staff member's response regarding task-oriented teams where issues are "brought to

them," refers to each group's (hygiene, assistants, front-office) concerns about their personal

work schedule and patient scheduling. Changes resulting from group input in these instances

only affects these specific group members.

The ways in which the leadership engages and values the team input regarding change is

indicative of leadership and impacts the team culture. While the dentist may feel that the

leadership is open to staff input regarding change, staff responses reveal that the dentists are the

primary figures in the decision-making process. As seen above in Figure 4.3, this autocratic

leadership places the office at the nominal team end of the decision-making continuum.

Identity. Using Donnellon's method of exclusive and inclusive pronouns to signify a

functional or team identity, 48 exclusive pronouns and 20 inclusive pronouns were found

throughout the three participants' responses. While "we" may be used inclusively to refer to the

entire group, as used here by the dentist "Everybody is friendly to each other and cuts up, and we

just have a good, good time. We care about each other's lives and what is going on and love each other." It is more often used to separate the dentists from the staff, or to differentiate one functional group from another as seen in the following two responses:

> Dentist: We [the dentists] encourage everybody to be open and honest with any kind of issue whatsoever. We actually have some little agreement spelled out about what to do when something comes up. At staff meetings we pretty much go around the table and if anybody has anything or concern about it, they can voice it.

> Staff Member #1: What we do, each team has like a team leader. Ours is . . . because she has been here the longest for the assistants. So if we have a problem or something, we can just go to her and discuss it.

> The occurrence of exclusive pronouns is 2.4 times greater than that of inclusive pronoun

use. The dentist is the participant that employs the most inclusive language referring to the team as a whole. The two staff members, however, use more exclusive language. An inclusive example from the dentist includes:

> Once a year we close the office and the whole staff gets together for the whole day and it is nothing but brainstorming about all the different areas. We just literally take one of those and just write stuff down. We make suggestions. And we go back… it is fun to go back at the end of the year to see what you did. Pretty much last year we accomplished just about everything we set forth in the goals for the year. That is nice. We have done that for a while.

Note that this one response from the dentist includes seven of the twenty coded inclusive pronouns. The other inclusive pronouns are seen throughout each participant's response to describing what the office "like." Within this key dimension of identity, this office's members identify more with the task-oriented functional groups than as integral members of the team-at-large. This puts the office more toward the nominal end of the identity continuum.

Interdependence. Interdependence is a key ingredient in effective team work. The level of interdependence is a measure of how team members view themselves in relation to one another and in regard to integrated knowledge and skills necessary to accomplish the goal at hand. There

were eight independent statements and five interdependent statements coded within the responses of this office's transcripts. Coding for independence included recognizing explicit reference to independence or assertions of individual intent. Some examples of statements of independence include the dentist stating, "Pretty much it is done as a team, somewhat, not the whole team, but leaders" and "Daddy [lead dentist] is always changing stuff."

The interdependent references include the soliciting of others' views and needs as seen in this staff response:

> Because I have been here so long, people come back and ask me questions of my opinion more as I have been here longer; like how things were done in the past or just to see if there is something that needs to be done.

It is important to recognize that the presence of interdependence and independence can co-exist. The recognition of each simply allows for a measure of the perceived interdependence of the team and a way to visualize the level of the nominal verses real nature of the team itself. In a dental office, the tasks are inherently reliant on team work and interdependent actions of the members, yet the way the team members perceive themselves in relation to the team at large is relevant. Here the number of independent verses interdependent responses places the team more toward the nominal end of the scale.

Social Distance. For this study, forms of social distance included formal language (formality in referring to subgroups) and formal forms of address ("the doctors", Dr.). I make a case for including the references to separate groups as a form of formal language within a dental office as it displays distance between subgroups of individuals and the team. Although these functional groups are examined previously, the formalized reliance of team members within the office on a subset of individuals creates increased social distance apart from the team at large.

There are 15 occurrences of references to social distance. The most senior staff member, a

hygienist, states:

> All the assistants know that if they have a problem, they are supposed to go to the head
> assistant. If they don't feel comfortable to come to one of the doctors to discuss it, then
> talk to her and let her go to the doctor. The front office has a person who they are
> supposed to talk to. It is broken out in groups, that way. Some people are not comfortable
> to go directly to the doctor to discuss it, so you know there are other people you can go
> to.

The social distance is recognized as a contributing factor to the poor communication practices of

the office. All three respondents confirm this in these following statements:

> Dentist: Yeah, we don't always get the word out about things. I don't feel like in enough
> time for it be fair to people. . . We do not really have a good way to make sure that
> everybody has the message.

> Staff Member #1: [Communication is] Kind of haphazard at times because not all of us
> are here every day. So if you happen to be here on the right day you might hear what you
> need to, and if you are not here that day, you may hear it 2-3 weeks later. We have had
> new employees come and have been here and I'm like, who is this? I didn't even know
> we were hiring anybody; that type of thing.

> Staff Member #2: I mean some things around here, I feel are just kind of secret you know
> and by the time it gets around you don't know if that is a rumor or true. So that is
> something our office definitely needs to work on. Especially when it comes to hiring
> different people, or something like last minute you may hear we are going to get
> somebody or something, so it is just kind of weird about stuff about that.

While functional subgroups contribute to increased amount of social distance, the basic

level of interdependency required to complete work within the dental office also creates a degree

of social closeness. Reference to social closeness was found in claiming commonalities with

group membership, claiming common views, displaying knowledge and concern for others,

expressions of liking or admiration, and expressions of reciprocity or cooperation. In total, there

were eight occurrences of social closeness. Examples were predominantly located within

participants responses when asked to complete the sentence, "This office is like a _____."

In response to this, the dentist replied:

Family. We have a great time working together. Everybody helps each other out. We work really well as a team. The group we have right now is probably the best in the practice. Everybody is friendly to each other and cut up, and we just have a good, good time. We care about each other's lives and what is going on and love each other. A lot of us have been together a long time. We spend a lot of time together; more time here than anywhere else.

Taking the numerous examples of social distance with the understanding of the communication practices within this office, it is not surprising that the other two staff members shared a more realistic view of the office's relationships. The more senior staff member stated that the office ran smoothly and while it was somewhat "like a little machine" it was a good place to work and that she had "only considered going somewhere one other time." The newer staff member, like the dentist, said the office was "like a family because we have our disagreements, and do not get along all the time," but said that they work together and care about each other in the end. Once again along the dimension of social distance, this office finds itself closer to the nominal team end of the scale.

Conflict management tactics. There were five references to the avoidance of conflict and two to confronting or collaborating. These two references to confronting and collaborating are discrepant in that they are in reference to how the dentist's would like team members to handle issues, not how things actually handled. While the dentist encourages confrontation and collaboration, the team members seem to avoid conflict. The dentist so aptly illustrated this when she stated:

We ask everybody not to go into another room and fuss about something to somebody who cannot do something about it, but take it to somebody who can take care of the problem. It doesn't always happen… We have had issues before where an employee would all of a sudden leave and there had been problems going on and nobody knew and we cannot help something if we do not know they are there.

The most senior staff member discussed her reluctance to bring issues before the dentists,

So sometimes you have to ask a questions and approach one of the doctors with it [an issue], but in order to get an answer you have to wait 3 weeks, until they all get together.

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> Sometimes things could just fall through the crack and if you don't bring it up again, you may just never find out . . .Who wants to speak out if nothing is ever going to be done about implementing it, or if you have to bring it up 3 months in a row before you find out anything. You get to the point you want to say never mind.

It appears that the functional subgroups hinder the communication process and while the principles of healthy conflict management may be desired by the leaders, the team cannot find appropriate channels in which to express grievances. This office, as seen in figure 3, is placed more toward the nominal team end of the scale.

Results for Office Number Two

Nominal Team   **Real Team**

Autocratic ├──────────────┤──────┤ Participative

Functional Identity ├──────────────┤──────┤ Team Identity

Independence ├────────┤──────────┤ Interdependence

Distant ├────────┤──────────────┤ Close

Forcing, Accommodating, Avoiding ├────────┤──────────┤ Confronting, Collaborating

Figure 4. Leadership and the resulting team culture for office number two

Decision-making process. The second office participating in the study had two practicing dentists. The primary dentist was interviewed. Decision-making processes were both autocratic and participative as all three participants discussed the dentist involving the staff in the change process, yet the staff members acknowledged that the dentist had the power to make "the last and final decision." The dentist while hierarchical in his view of himself as a leader, works to educate and include the staff about possible changes that will affect the team. When asked about change, the dentist stated:

I definitely have learned to some degree that the team has to buy into it. I have a very serious staff, as far as the number of years they have been in dentistry. And they need to buy into many programs, systems that we are doing if it is going to get us back to maximum effectiveness.

While there were two references from the staff concerning the dentist's final say in the decision-making process that were coded for as autocratic, the five collaborative decision-making references place the team more toward the real team end of the scale.

Identity. There were 43 occurrences of language indicating functional identity and 62 indicating team identities. Here the functional identity is due to separation referring to the dentist and the team, and the front office and the team. With a hierarchical view of the dentist as the leader by both the dentist and the team members this is not surprising, however there was a greater occurrence of team identity references. An example of functional identity includes a response from the first staff member, who works in the front-office, "If they need help in the back, to doing x-ray, like if they cannot step out of the room like that, we will do that." The majority of team identity references places this team nearer to the real team end of the identity scale.

Interdependence. There were nine occurrences of language indicating independence and 18 indicating interdependence. The independence, as previously stated, is due to task responsibilities of individuals within separate areas of the team as seen here is the statement, "I take care of cleaning the patient's teeth, the periodontal to make sure they don't have any problems there and just taking care of those patients when they come to my chair." While the team members have some autonomy within the team, they understand the interdependent nature of the dental office. This is evident by the interdependent references outweighed the independent references by 50 percent. As in the earlier response of the first staff member about pitching in where needed, other second staff member interviewed stated:

> Well, I am pretty much in the hygiene but now I have been in the back like cleaning instruments, if something needs to be done back there I can go back there and help, or I can do some things up front if I need to. So essentially just help out where needed.

Once again this measure places this office near the real team end of the interdependent scale.

Social Distance. The findings from this office resulted in the occurrence of six distant, or formal, references and seven referring to social closeness. The staff members view themselves as extremely close and use more formal language when speaking about the dentist, such as, "I know my role is to be under the doctor and follow what he expects." Similarly, the dentist while seeing the office culture in a familial manner, is patriarchal. This is seen in their completion of each participant's response to completing the statement "This office is like _____." The two staff members stated:

> A little family. We all get along. Of course there are times where you don't get along, but it is all solved pretty quickly. I think we all enjoy coming to work. I don't ever hear anybody saying they do not want to.

> It is probably like a little small family or something and sometimes you get in your little squabbles, but we are still here and we work together everyday. I think we are pretty close, most of us. I would compare it to a family.

Now compare the staff responses to that of the dentist:

> They are like another family. They are like my kids. But managing them from communication standpoint is like managing my children. I have 4 children. So yeah, a lot of the times it is.

In this office, the formal view of the dentist's role as leader balances the social distance scale to place the team in the middle between functioning as a nominal and/or real team.

Conflict management tactics. There were four accounts of forcing, accommodating, and avoiding and five accounts of confrontation and collaboration. In this office, personalities contributed to the styles of conflict management more than any other factor. While the team members are given the opportunity to voice concerns there is no formal process. Essentially the

individual's personal conflict style dictates the end result. The first staff member felt that the team members could deal with issues openly and effectively, "I think that everybody gets along well. Not the usual problems that people just don't just come right out and say." The second staff member refers to both confrontation on the office level and her tendency to avoid conflict by stating:
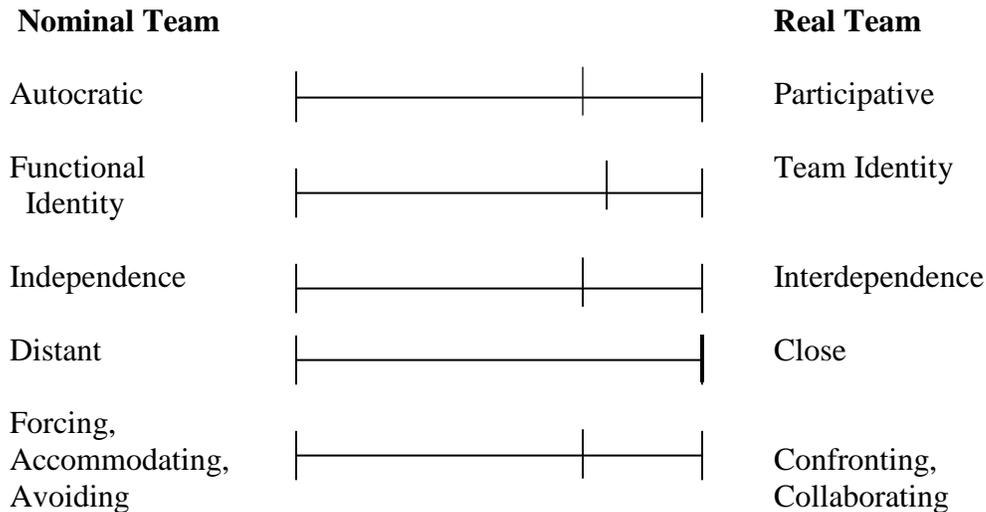
> Usually if somebody has something to say, they usually say it and end up sticking their foot in their mouth. There is no one specifically, set aside that someone goes to, I don't think. Unless they go to Dr. . . . Sometimes they can go to him. But usually they just either keep it inside until it blows up or those type things . . . Most of the time, I'm the one who keeps quiet. I don't talk much as far as things a lot. I hear a lot, but I don't say a lot. I hear a lot, but I keep my mouth closed. Because I don't like to start things up.

The dentist explained that issues can be brought out at any of the monthly meetings, but that he would prefer the team member to discuss it with him first so that he is not "blind-sided." In his response to how conflict within the office is managed he talked about the personalities of each of the team members by saying:

> They will bring it up. Now as far as bring it up ahead of time, if they bring it up ahead of time, normally it has really festered. It has really gotten to a point where it is time to intervene and in dealing with staff, you got to know your players. Some of your players bitch about everything that happens. Some of them rarely say anything, but when they speak you listen.

Here the team is placed toward the middle of the scale in regard to conflict management tactics.

Results for Office Number Three

Nominal Team   **Real Team**

Autocratic |————————————|————————| Participative

Functional
  Identity |————————————————|————| Team Identity

Independence |————————————|————————| Interdependence

Distant |————————————————————| Close

Forcing,
Accommodating, |————————————|————————| Confronting,
Avoiding   Collaborating

Figure 5. Leadership and the resulting team culture for office number three.

Decision-making process. The third office was run by one practicing dentist and a small

team consisting of five staff members. The leadership of this office was laissez-faire as the

dentist explained that he had been practicing for over 28 years and felt that the team and the

practice were the way he wanted them. The dentist's "hands-off" approach limits the

opportunities for change as he stated:

> I have been doing this 28 years, so right now I am pretty cast on the way I like things to
> be, how I like things to go. So what I will do is that I will just say, if there is something
> that you feel like we can do better, if you come tell me and explain to me why, and if you
> can convince me, then we can change it. I do not like them going through and changing
> things without running it by me first. I am just kind of set in a pattern.

Out of all three participant responses, there was only one reference to autocratic and two

references to participative decision-making behavior. The one participative reference was

tempered with a later reference to the dentist valuing the opinion of his staff. While not proactive

in his approach to change, he is somewhat open to ideas about change and seeks team members'

input concerning decisions as seen in this staff member's comment:

He would have meetings. He would say, 'we are going to try it this way, we are going to do something different,' and he would tell us what our responsibilities would be . . . He just does not make a decision. He does ask for us to think about it. He gets our opinion. He does ask opinions at times, so that is good.

This office, along with the fifth office in the study, has a dentist that has been in practice for over twenty years and has a more lassez-faire leadership style. While somewhat resistant to change, they are not resistant to employee input. These accounts place this office more toward the real team end of the scale in regards to decision-making.

Identity. There were 28 accounts of functional identity and 51 of team identity. With the limited size of the team, when referring to the office the pronouns "we" and "us" were inclusive of the entire team. The presence of exclusive pronouns was predominantly, "he" (referring to the dentist) and "they" (used by the dentist at times to refer to the group) as in, "Sometimes I bring them together." The greater number of team identity responses places this office near the real team end of the identity scale.

Interdependence. The occurrences of independent verses interdependent references to the team are somewhat misleading. These findings do not accurately reflect the feelings of the team in that none of the six independent responses were found in the staff transcripts. All six accounts were taken from the dentist's response to an interview question concerning change. I will not say that they are discrepant in that they were made and illustrate the dentist's own sense of identity separate from the team. In this response he continually talks about himself "I" in his assertions of individual intent about resisting change. Part of his response is listed above and other statements of individual intent within that response include, "I do not make a lot of changes. I count on velocity of that." In total, there were 14 accounts of interdependence, 43% more than the number independent references, which numbered six. This placed the office nearer to the real team end of the interdependence scale.

Social distance. There were 10 accounts of social closeness which included claiming group commonalities, common views, liking or admiration, and expressions of reciprocity or cooperation. There were no accounts of social distance. The members of this team, perhaps due to the laid back atmosphere and the team's small size, relate to one another socially, as well as dental team members. Some examples of social closeness include the staff responses, "being part of the team", "we kind of all get along very well", and "We all just kind of come together and we work things as they come along."

Within the dentist's responses to the interview questions there were four references to social closeness including, "I just have good people working for me", and "I am blessed that everybody I have had for so long works well together and everybody helps each other out." The staff members discuss socializing beyond the confines of the dental office, going to lunch and calling to check on one another. These findings justify this team as a real team in regard to the key dimension of social closeness.

Conflict management style. There was just one reference to the avoidance of conflict. The most senior staff member stated, "If something comes up and it is just me or bothering me, I just don't talk about it." An interesting, although not relevant finding to this study's research questions was that many of the most senior staff members throughout all ten offices implied that they had passive personalities and were conflict avoidant. Therefore, in light of other statements made I believe that this can be attributed solely to personality and not office practices or culture. The same staff member goes on to state, "And then if it is between ourselves, we kind of all get along very well, and we would talk about it and kind of look in a way that would fix the problem." In total there were three references to a collaborative approach to conflict, all refer to

open communication and imply a safe environment in which to air grievances. One other

example illustrates this as the staff member states:

> Like I said, if there is a problem, I just go talk to them. In communication the whole thing is talking. Because if you can talk about, you can figure it out and fix it. If you don't talk, if you don't mention it and then it builds up.

The figure 4.4 takes into account the one avoidance reference, but the team is still placed on the

real team end of the conflict management scale. While this team does not have formal methods

of communication, i.e. morning huddles or regularly scheduled staff meetings that would

generally be considered times reserved for staff related issues to be brought to the table, they

have embraced an open communication environment. Most of the members of the team have

worked for the practice for a number of years and have adopted a relational view of their roles

and relationships.

Results for Office Number Four

Nominal Team		**Real Team**
Autocratic		Participative
Functional Identity		Team Identity
Independence		Interdependence
Distant		Close
Forcing, Accommodating, Avoiding		Confronting, Collaborating
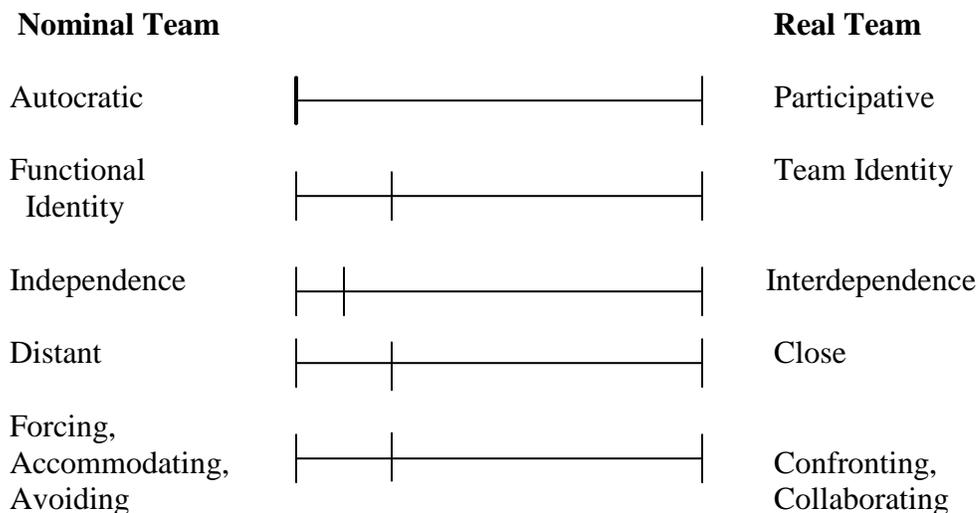
Figure 6. Leadership and the resulting team culture for office number four.
   Decision-making process. The fourth office was run by one practicing dentist and a team

consisting of seven staff members. Here the leadership style is hierarchical, "I am the team

leader. I am the alpha dog," and completely autocratic. This dentist, like dentist #8, recently

bought the practice from a dentist who was retiring. Therefore many of the staff precede the

dentist and are close socially to one another, but with new leadership come new team dynamics.

There were three references made to the autocratic decision-making style of the dentist

and none involving team members in the decision-making process. Not only were references

made to the autocratic nature of the dentist, but were amply elaborated upon as they had created

"animosity" between the dentist and staff and between some staff members themselves. As noted

in the findings of the second research question (p. 50), the dentist changed the office hours

without input from the staff. The change meant that they were to come in and leave thirty

minutes earlier than before. One staff member stated:

> I feel like he should come to us and call us on board. For instance, it starts in the spring, all the way through October of next year, we are to be here at 7, without our input or anything, he goes ahead and changes that . . . And when he does stuff like that, I think it causes a lot of animosity on the team. He could ask us. Everybody could not be willing to do it, but they are much more willing when they are asked.

The dentist himself, when discussing change, never mentioned bringing the rest of the team into

the discussion. He simply stated that:

> Sometimes I will sit down side to side, like with . . ., and say we are going to change our schedule in the spring, like the hours from this to this. I will let her know and then I will discuss it with everybody else and we get it done.

The autocratic decision-making by the dentist places this office on the nominal team end of the

scale. The staff's frustrations are a result of not feeling valued or empowered and since the time

of the interviews, this particular staff member has left the office.

Identity. Within the three interview transcripts for this office, there were 46 functional

group identity references and 28 team identity references. As seen in the following example, the

identity of the team is broken up between functions, front/back office, as well as between the

staff and the dentist.

Staff member: Among ourselves [front-office] and other employees, yes. I would say the doctor sometimes does not communicate with us very well. I am just being honest. But as far as us as a team, we girls are great.

This same staff member uses inclusive pronouns when discussing the office-wide meetings:

Every morning we have a huddle for about 10 minutes before we see any patients. We kind of touch base on what patients are coming in or what problems are happening to our patients. And once a month we have an hour meeting.

The greater functional identity of the team seems to be directly related to the dentist's self-imposed separation from the staff both in his leadership perspective and behavior. The disparity between the occurrence of inclusive verses exclusive pronouns places this team at the nominal end of the scale.

Interdependence. There were 21 explicit references to independence and six references indicating interdependence. Most of the independent statements were found within the dentist's responses to the interview questions.

I have to help keep people motivated, focused, on track, organized, excited about what they do everyday, because ultimately that effects my ability to do what I do and [be] efficient. It is great what I do but I am not happy because of what things are going on and that is not good. But I am happy with what I am doing . . . I am the team leader. I am there at the rudder, getting the ship where we want it to go.

When asked about rating himself as a leader, he gives himself a three out of five and states:

I have been focused more on interests outside of the office than inside the office . . . Trying to keep balance in my life. When I leave here, I leave here. I am not consumed by focusing entirely on right now. But the downside to that is that it probably affects them more than it should.

The interdependent statements were made by the two staff members in relation to other team members. They see themselves as interdependent and as having opportunity to help one another out in task accomplishment. The staff member that worked in the front stated:

What I do is I see a need in the back for assistance, I can clean rooms, I can clean instruments, anything the back needs, I can get up and do, because what I am doing in the front can wait, unless it is one-on-one with the patient. So I try to help with the back.

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The understanding of interdependence is present among the team members, however they see themselves as assisting one another apart from the dentist. This evidence places the office very near the nominal end of the scale which is indicative of member independence.

Social distance. So how does this nominal team view impact perceived social distance between members of the team? The previously examined three offices were closer to the real team end of the spectrum and most often likened the office to a family. The responses in this office to completing the statement, "This office is like a _____." included; a daycare, a family, and organism. Although the first staff member included a reference to social closeness in her response, you can see the difference:

> Wow. Great. Okay, how much time do I have? I don't know. I am thinking. Can I say other things before I say that? I mean all and all it is a great place. *We are a good team.* I am trying to think. I want to say daycare, but it is always. Yeah, it is like a daycare. There is always somebody whining about something and then there is always the one who has to smooth over everything. Sometimes that is me.

The second staff member interviewed was the most senior member of the team, and as mentioned earlier as being a finding among senior members, has a passive personality. She responded by stating:

> Family. Strong people, weak people, noisy people, and quiet people. Whiney, like a family. Everybody cannot be the strong one, and I am not one that tries not to make waves, I am the quite one.

The dentist's response was that the office was like an evolving organism; dynamic and able to adapt. While not a negative response, there is no mention of the relationships within the office. In total there were five references to social distance including, "As far as the doctor communicating to the help, we have an office a meeting every morning for 10 minutes," and three references of social closeness. This finding is less severe, but continues to place the team toward the nominal end of the scale.

Conflict management style. Due to the leadership style and behavior of this dentist, it becomes apparent that there is greater social distance between the staff and the dentist than between the staff members themselves. The staff, to some degree, may try and work out conflict among each other as seen in the above responses describing that some feel freer to express their opinions and resolve issues than others. The dentist, however, has created an operational paradigm limiting the voice of the team by not including them in decision-making processes. There were two references to confrontational conflict management (one which I refute as discrepant data) and five indicating force, accommodation, or avoidance. The senior staff member alludes to her own personal tactic of avoidance which accounts for one occurrence. The dentist admits that he is confrontational, but I argue that this is discrepant data because he is referring to force rather than a healthy form of communication. Within the same statement he then alludes to the fact that he would rather not have to deal with the group's conflict as seen here:

> I think some of them are afraid of hurting one another's feelings. Some of us really like confrontation. People, and my staff tend to be the same way, it is going to be confrontational rather than information [al]. You just want to share information, but sometimes the person on the receiving end does not receive it as information. They receive it as criticism, so then it becomes confrontational and that is when one comes to me and then another one comes later, and I am kind of in the middle, which is back to the office managers, I don't want to deal with that. But I do, which is okay.

I am concluding then that the dentist's reference to confrontation is to be counted as a reference to force in that it has negative intent. Therefore the findings include six references to force, accommodation, and avoidance and one occurrence of confrontation as the senior staff member states, "Some people have to say it and get it out, so it is kind of like a family." This six to one ratio places the team at the far end of the conflict management scale indicating a nominal team culture.

Results for Office Number Five

Nominal Team		**Real Team**
Autocratic	|————————|————————|	Participative
Functional Identity	|—|————————————————|	Team Identity
Independence	|————————————————|——|	Interdependence
Distant	|————————————————|——|	Close
Forcing, Accommodating, Avoiding	|————————————————————|	Confronting, Collaborating
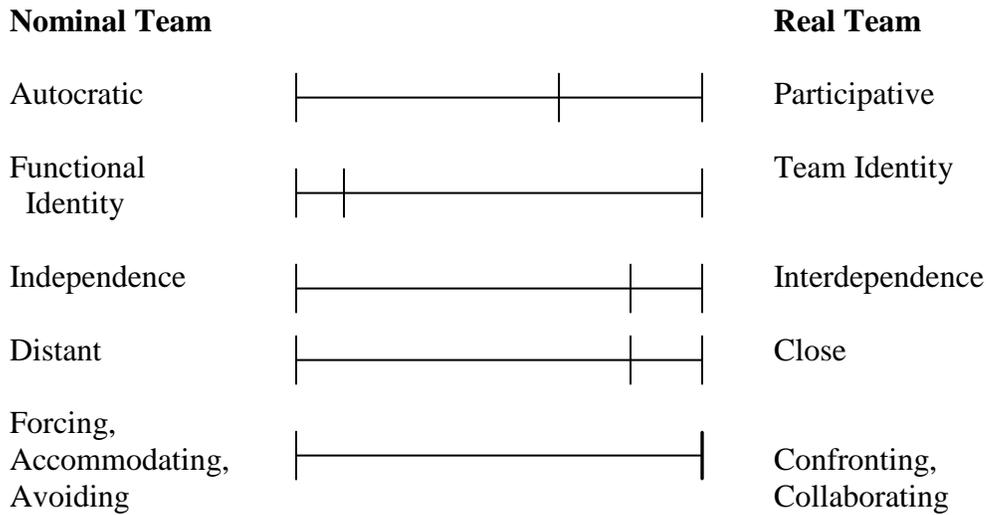
Figure 7. Leadership and the resulting team culture for office number five.

Decision-making process. The fifth office included two practicing dentists, an office

manager, and a staff of seven. The dentist interviewed was the junior dentist, the son-in-law of

the senior dentist. Staff responses indicated that the two had very different leadership

personalities and therefore placed reliance on an office manager to alleviate staff-relations

responsibilities. As with the third, ninth, and tenth offices, the leaders were laissez-faire in their

basic approach to leadership and change and focused the office manager's efforts on

maintenance of policy and procedure, and on finding more productive and lucrative operational

methods. As with the other laissez-faire offices, the communication practices were not highly

structured, as the dentist stated:

> Being in a smaller confined office area, most of the time it [communication practices] is
> just verbal . . . We do not have weekly or for that matter, monthly meetings. We did at
> one time. To tell you the truth we have such a good group, we do not have to do that
> anymore.

Although the office manager referred to having monthly meetings, the newest team member of

four months said, "We really have not had what you call an office meeting since I have been

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here, where the doctor comes in and sits down with the staff and we communicate." It seemed

that the office manager communicated directly to the staff more on a one on one, or by work area

basis. Again much like office number ten, the "openness" of communication allowed them to

feel that they could forego regular meetings. Within the transcripts, two references to autocratic

and four references to participative decision-making processes were found. Findings indicate that

the dentists discuss changes with the office manager first and then inform the staff. However,

decisions are not iron clad and the feedback of the team is taken into consideration as the office

manager explains here:

> We usually have a staff meeting if anything major is going to change, so we'll have a
> meeting and it will be told to everybody. . . Anything is open for discussion. They don't
> say, 'hey our new hours are going to be from M-Th from 8-7, and then that is a closed
> deal.' Everybody here feels very comfortable, even to the dentists saying, 'hey wait a
> minute, we cannot do it.' And then it is taken into consideration.

When asked about changes that affect the team, the dentist responded:

> If the changes are major, obviously we will sit down and talk as the staff. They have a
> lunch. And then we all sit around and talk about issues. We will do that 2-3 times per
> year. If it is just something minor, we will just ask them individually, 'hey how do you
> feel about this,' 'what would work better here,' or something like that. But we always try
> to get their input and not just think, 'oh, okay this is not working, we are going to do
> that.' On some occasions I will just make an executive decision and say that we are going
> to do it this way. Because I have tried other things and it just has not happened, so now it
> is time for me to try my way. So sometimes I will do that too. Generally we try to include
> them in most all of the decision making.

Findings signify that the office is farther toward the participative end of the decision-making

scale which makes it more of a real, rather than nominal, team.

Identity. The findings for identity are affected by the functional position of an office

manager. The office manager sees herself as a member of the team while also separated

positionally from "the girls." This affected the accounts of functional identity. Numerous times

she referred to the rest of the team as "they" and referred to herself and the dentists as "we." The

other staff member interviewed saw herself as identifying with the team and used inclusive

language primarily. The dentist's use of inclusive and exclusive language was equally divided. In

total, there were 56 accounts of exclusive pronoun use and 26 of inclusive pronoun use. This

almost 3:1 ratio places the team nearer to the nominal team end of the scale and indicates team

members possess more of a functional rather than a team identity. Findings suggest that the role

of an office manager, placing a member of the team in charge of personnel issues, imposes

another organizational layer and creates a relational disconnect between the dentists and office

manager, and the team. As seen in the following key dimensions, however, this may not affect

the way the rest of the team sees themselves in terms of interdependence or social distance.

Interdependence. There were four independent statements and 19 interdependent

statements found within the transcripts for the fifth office. While the dentists and office manager

identify with each other as a sometimes separate unit from the team, the organizational goals are

understood within this office as accomplished through genuine teamwork. To illustrate this point

is a statement from the office manager, the member most responsible for the team's functional

identity:

> I think right now we have a good team. We all pitch in and help each other. We are a
> small office as far as the girls. . . There are times that we all have to pitch in if we want to
> get out of here for the day.

While the office manager mentions the team and pitching in, at the end of her statement she

alludes to the fact that this type of teamwork may be sporadic. The other staff member

interviewed sees the interdependent nature of the team work as a constant:

> I may do ortho, lab, sterilization, front office, or assist. I basically run the halls. If I am
> not with a patient doing ortho, if the assistant with the doctor needs something, I will get
> it. Or if in the front they are in a bind, I come up front, work the computer, answer the
> phone, and make appointments. Well, since I know ortho, it is just something that we just
> work together as a team. We are just team oriented.

The dentist's statement is more middle of the line in that he sees himself as having a very specific task-oriented role, but at the same time sees his reliance upon the team for overall task accomplishment:

> I think we have to do our part and actually this is where we fall into line and we have a chair that we sit in and we have a task to complete and everybody else they help us to complete that task.

All ten dentists, at some point in the interview, mention their own task specific function of dentistry within the office. However, the level of explicitly stated interdependence with their team varies from dentist to dentist. Within this office, the independent statements are not negative. The dentist makes one independent statement when talking about having to make a decision after others have not sufficed. The other three are positive in that they only describe the individual's specific role within the office. The dentist explains the presence of independence when he refers to regular staff meetings as unnecessary by noting that, "They work very well together and work very independently too." This office, is placed at the real team end of the scale indicating a high level of interdependence.

Social distance. There were three forms of social distance accounted for and ten accounts of social closeness. Social distance occurred in language that distinguishes certain members of the team apart from or above the rest of the team. Here, all three accounts consisted of referring to "the doctors" as in, "The doctors are really good about having an open door policy . . . they [staff] can come to myself or they can come to the doctor and it is taken care of." Much like what was described earlier, the social distance is in reference to position. The position of office manager adds the extra hierarchical level within the organization.

The ten accounts of social closeness included expressions of liking or admiration and expressions of reciprocity or cooperation. Responses to the question about what the office is
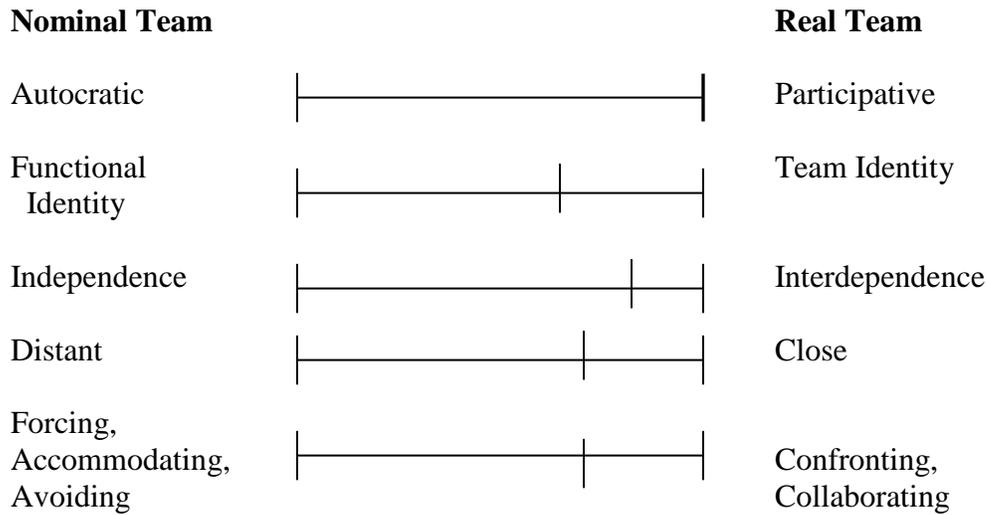
"like", the office manager said, "Family, to each other and to our patients." The other staff

member replied:

> We don't have a lot of "ya ya ness." I am not stressed out with a knot on the back of my
> neck. I get up wanting to come to work. The staff is wonderful here, the staff is very
> good.

The dentist likens the office to "life" because like life you experience good days and bad days.

The statements he makes referring to social closeness are in regards to what a good team he has

and the fact that everyone gets along, he says, "It is a fun place to be because of that." The tone

of the references to social closeness is not as intense as far as admiration and liking concerning

relationships, but instead is one of relief that the environment is uncomplicated. The more than

3:1 ratio of social closeness to social distance places the team at the real team end of the scale.

Conflict management style. There were no indications within the responses of the

participants of this office of forcing, avoiding, or accommodating as methods of managing

conflict. There were five references to the use of confronting or collaborating in resolving issues.

All three participants spoke about the "open door" policy of being able to air grievances to either

the office manager or the dentists. I had the opportunity to go back to this office after the

interviews were conducted and give a presentation on impression management to the entire staff.

Although the observations of the latter visit are not included in the findings of this study, I

happened to observe members of the staff openly express their personal views of possible short

comings of the dentists as well as actions of the office in a non-threatening manner. All feedback

was greeted with discussion and the synthesis of team member ideas. This shows a high degree

of purposeful and positive conflict management ability. As the scale indicates, the office is at the

farthest point and is considered a real team in regard to this key dimension.

Nominal Team   **Real Team**

Autocratic   ├──────────────────────────┤   Participative

Functional
 Identity   ├─────────────────┼────────┤   Team Identity

Independence   ├─────────────────────┼─────┤   Interdependence

Distant   ├──────────────────┼────────┤   Close

Forcing,
Accommodating,   ├──────────────────┼────────┤   Confronting,
Avoiding   Collaborating

Figure 8. Leadership and the resulting team culture for office number six.

Decision-making process. Office number six was a solo practice where the dentist had

been practicing for over 26 years. He was hierarchical, yet his leadership style was laissez-faire,

"I am the bread winner and the paycheck writer. I kind of, out of most people, most of them

know what they are doing. I just come in if there is a little friction or something." He has

employed an office manager to manage the practice and (most importantly) to act as

intermediary in handling all staff relations, as all three interview participants, including the

dentist himself, mentioned that the dentist "doesn't communicate very well" and does not like

confrontation.

During the interview, one staff member mentioned that the dentist is willing to train and

teach her; therefore he is considered to focus on the continuing education of the staff. The

communication practices of the office include morning huddles and monthly staff meetings.

Although the dentist's laissez-faire leadership style may not bring about a lot of change, he is open to a participative discussion regarding change,

> I hope so; I never say "that is a dumb idea." You know, no idea is a dumb idea. It needs to be brought up so we can discuss it. Everybody knows a week before the meeting is coming up and they have time to think about it.

All three references made about the decision-making process within the office indicated participative methods. One staff member stated, "We just got new equipment and we discussed that. If it is not working we discuss that." With all statements referring to the participative nature of the way in which changes are considered, the office is placed at the farthest end of the decision-making scales indicating a real team.

Identity. There were 25 references to functional identity and 47 to team identity. The difference between this office and the previous one is that the office manager was a member of the team prior to advancing to her current managerial position. When talking about her organizational role she stated, "Because I started out in the back and these are my friends, that was kind of a little tough at first." She continues to identify with the team and uses more inclusive pronouns when talking about the office and its communication practices and only used exclusive language when referring to the team when she stated, "I try to get down to their level and say, 'Okay girls, you don't need to be …' you know." Beyond this instance, exclusive pronoun use was limited by all three participants to only referring to the dentist as separate from the group as the newest staff member states, "We [staff] talk to each other. There is no screaming. There is none of that. We have our staff meeting once a month, so we discuss things in the staff meetings with Dr. . ." All three participants used inclusive pronouns to refer to the entire team including the dentist when describing communication practices as in this statement, "Well, we do a morning huddle. Every day we start at 7:30, so at 7:15 everybody is supposed to

be present for the morning huddle, where we go over the schedule." With an almost 2:1 ratio of inclusive pronoun use over exclusive pronoun use, the team is placed closer to the real team end of the scale which indicates a stronger sense of team identity.

Interdependence. There were four references to independence, all expressed within the participants' descriptions of their roles within the office. The office manager's discourse accounted for two of the four references as she explained her unique role in mediating staff tensions,

> Yeah, a lot of times the girls will come to me if there is a problem, patient or anything else. If I can handle it I will try to handle it. If it is something that he needs to know about, other than [something] trivial, then I will just try to take care of it. If it is somebody is upset, crying, I will go and talk to him. I guess I have never thought about it. I just try to take care of it.

Her independence stems from her staff management and resolution responsibilities. The other staff member referenced her independence in a task-oriented manner in that she is solely responsible for ordering the supplies, distributing the supplies and overseeing maintenance, "I order the supplies and make sure they have what they need to work and make sure they fix the equipment." This gives her a specialized task, role, and authority within the team. The dentist, as discussed previously, is hierarchical and expresses independence in his role as "the bread winner and the paycheck writer."

The is a greater number of accounts of interdependence, 22, signifying that although each participant recognized their independent task-oriented role within the office, they saw their larger organizational roles as interdependent with their team's efforts. Even though the office manager has a specialized role and the ability to exercise power over team members, she saw her larger role as facilitative,

> I work in the back as well. If one of the assistants are out, then I am the assistant that day . . . We have a job because of the patients, so I always look at it as the patients are sitting

out there waiting and I can be doing something that can get them in and out quicker, and they can have a good appointment, then I do it.

This second staff member shared this facilitative viewpoint and further explained her job as necessary to the team by stating, "Yes, by making everything work and making sure everybody has everything they need to work, everything flows nicely." The dentist, while the most independent in his organizational role, expresses understanding that the dental office experience for his patients is cumulative and that the team shares this responsibility, "And then I just ask them sometimes, if there is anything we need to discuss or anything we can do to make things better, for us or for our patients." The findings conclude that the interdependent accounts are over five times greater than the independent accounts, placing the team at the far end of the interdependent scale, indicating a real team culture.

Social Distance. There were two accounts of social distance through the use of formal language, both referring to "the doctor," and seven accounts of social closeness. As with the previous offices, I examined how the participants completed the statement, "This office is like a(n)." Both staff members likened the office to a "family." The social closeness within this office is found within the staff members. The "girls" have created a family-like culture among themselves.

Office manager: Family. You know we all know about each other's family and kids, extended family. We are all just real close like that.

Staff member: My second family. Relations, work, helping each other out. If we are not doing anything, make sure everybody is okay, make sure things are running and if they need help with anything. That is what we do. That is what is supposed to be.

Notice, that this familial view of the office has a relational and functional balance. Other offices' family-like comparisons contained elements of affection and conflict, not seen here. A possible reason for this difference will be explained in the next key dimension's section.

The dentist's view of the office is machine-like. He compared it to a drone, and given his "hands-off" approach to staff relations this metaphor makes sense. He has purposely extricated himself from the day to day relational issues and therefore maintains more of an overseer mentality of the organization,

> Sometimes it is seems like it is a drone, just flying itself. Everybody just gets things down without a rudder. I wish it was more organized, regimental, although you don't really want a regimental when you have a small office and everybody going a million different directions. But if everybody knew their job description, . . . it would turn out better.

As discussed in the next section, conflict management, he is conflict avoidant. His personality dictates that things to be free of equivocality. His view of the team is not a dynamic, humanistic one. The women express like and admiration for the dentist, "He is a great doctor. He is easy to work for. He is just a good guy. He has a personality too. He jokes with us sometimes," but foster a more socially edifying atmosphere for one another. The office manager explains this distinction as she states:

> He is wonderful to us. But I think, you know what it is, he doesn't give a lot of praise. And I think that is just how he is. He thinks that when he is not slamming anybody that everything is great. I think the staff needs to get praised. You know, we never know if we have done anything good, so I tend to try to make up for that . . . I'm a cheerleader because he doesn't really even think about it. And I'm actually not going in there and tell him. When I pass out pay checks, I say, "Keep up the good work.

The office manager has taken it upon herself to build and foster the relationships within the team. The social closeness, among the team members, is due to her efforts in making up for the dentist's relational shortcomings. The findings conclude that she is the pivotal team relationship builder. The presence of social closeness accounts are less than in some of the other offices studied, however, the seven accounts of social closeness compared to the two accounts of social distance places the office closer to the real team end of the dimensions' scale.

Conflict management tactics. There were two references to avoidance both referring to the dentist's personal conflict management style, and seven accounts of collaborative conflict management. The office manager notes that the dentist "does not like confrontation." The other staff member when asked what, if any, leadership or communication changes would be beneficial for the team, answered,

> Probably be with the doctor communicating better. If something is not going right or someone is not doing something right, just tell us what it is. That would be better for us. If we are doing something wrong, he can tell us and we can fix it and make it better. That would be helpful.
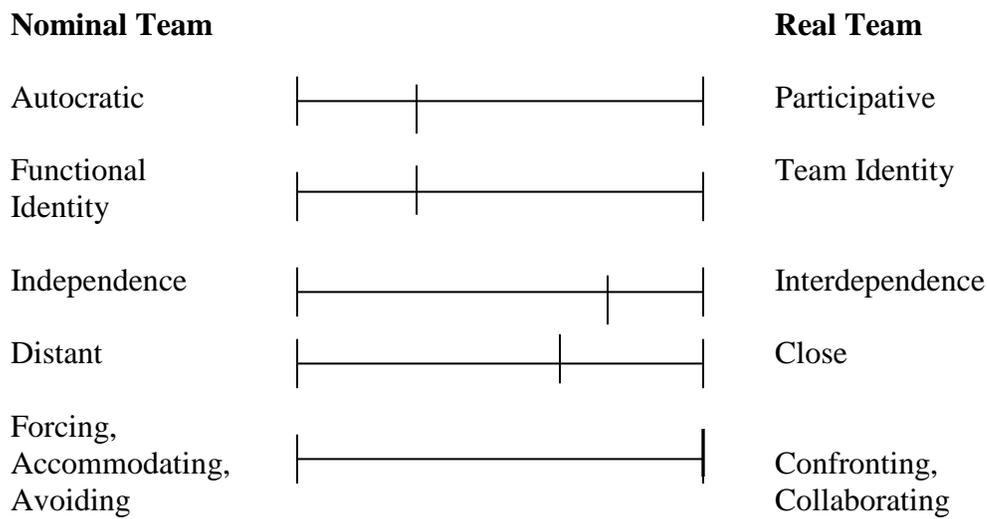
The collaborative efforts in managing conflict are due to the office manager. Within the interview, she talks about her personal tendency to avoid conflict, but that she has had to continually work on confronting the issues to be able to deal effectively with the staff. She encourages an open and communicative atmosphere where the conflict management is dealt with as issues arise.

> I am really a very, I do not like confrontation. This has really been a learning experience for me, office manager, because I worry about people's feelings. I do know the job has to be done . . . We all pretty much tell each other, you know, in the staff meetings, one girl has told another girl, 'it really bothers me that you are late everyday.' It was not ugly. No one got their feelings hurt. That is how it is. And we have, you know, we have one person that is late. She was late today. And two people went to her and said, 'can't you get here on time?'"

This empowerment of the team to confront issues as they occur has allowed them to manage conflict in a healthy way. The newest team member stated, "This is a great office, no drama. We don't talk about each other. We are all open with each other." This statement illustrates a theme among newer staff members interviewed in this study. Many of them discussed leaving their previous employers because of the "drama." In this office, the drama seems to have been eliminated by team members' empowerment and freedom in voicing

opinions and confronting the issues with one another. Healthy conflict management, attributed to the office manger's efforts, was one of the determining factors in this office's positive team environment. The findings place them on the real team end of this key dimensions scale.

Results for Office Number Seven

Nominal Team		Real Team
Autocratic		Participative
Functional Identity		Team Identity
Independence		Interdependence
Distant		Close
Forcing, Accommodating, Avoiding		Confronting, Collaborating

Figure 9. Leadership and the resulting team culture for office number seven.

This office does not follow patterns seen in previous, or in the following, offices. With the other offices, it seems that the decision-making processes dictate to some extent the way in which the office falls along the nominal or real team scale. Within the findings of this particular office, it becomes apparent that the ability to communicate openly staff concerns and grievances, as seen in the last key dimension in Figure 4.8, is the attributing factor to the degree of interdependence and closeness the office experiences.

Decision-making process. The seventh office includes two practicing dentists, a partnership, much like the second office in this study. The office had recently experienced some turnover and the newest member interviewed was the office manager. The dentist interviewed was the initial dentist that began the practice and his personal leadership style is a team-oriented

one. He views his organizational role more as a facilitator, especially in regard to continuing

education and training. Here, however, the dentists seem to make decisions apart from the staff

and then "bring them aboard" ex post facto. The dentist, when asked about how changes within

the office were made explained:

> When we are making a change, now I talk . . . my partner, and we hash it out. Sometimes when we are driving home from work, over the phone, that kind of thing. And then we will say lets talk about it with everybody, usually in the morning huddle, if we make a decision. If we don't make a decision, we will just talk about it until we have a spare moment until we decide. And then you just kind of get everybody on board with it.

> The newest staff member, the office manager, and the dentist made references to

autocratic methods of decision-making. When asked the same question the office manager stated,

"Between the doctors. And once they [have] made the decision to make a change, they usually

let me know and then we will let the staff know." Any negativity stemming from this came not

from the way decisions were made but in the way they were communicated. Although the office

engages in morning huddles, the dentist and the more senior staff member talked about changes

not being communicated properly and that the "fly by the seat of our pants" communication

leaves gaps in information dissemination. The dentist stated, "Yeah, sometimes we decide things

and forget to inform everybody else. That is a real problem with a lot of people. I have staff

members that will point that out to me."

The two references to autocratic decision-making were tempered by the more senior staff

member's response to the question regarding change. She saw change as stemming more from

the staff's realization of an issue and their bringing of that issue to the forefront of organizational

dialog:

> Sometimes we will start to discuss things amongst ourselves if we run into a problem we will ask the closest staff member if they are noticing similar problems, or , is it something that I am having an issue with or is this office-wide issue to be discussed.

This acknowledgement of a team voice from this staff member softens to some extent the autocratic nature of change. With two references to autocratic and one to participative decision-making processes, this office is placed nearer to the nominal team end of the scale for this key dimension.

One could argue that the newest member, only part of the team for three months prior to the interview, saw the decision-making process as autocratic due to her role and its close power distribution ties to the dentists. She had not yet had time to fully understand the extent to which the team may play a role in instigating or bringing about change. Her remarks throughout the interview alluded to a "honeymoon" period. A few of her statements included, "Well, I have only been here since June, but it seems like everybody gets along . . . So far so good. . . it is awesome to wake up in the morning and love to go to work." It would seem reasonable that with time, her view of change and decision-making processes would become more inclusive of possible team involvement.

Identity. There were 75 accounts of exclusive pronoun use, indicating a functional group identity, and 50 inclusive pronouns used to indicate team identity has placed the office nearer to the functional group identity end of the scale. The functional identity of the members emerge as they discuss themselves as part of a select group (e.g. the staff, the dentists, or the office manager and dentists) and refer to the rest of the team as "they" as in the office manager's statement, "if they [the staff] have anything they need to ask or say, they usually say it in the morning huddle." The presence of an office manager and a pair of dentists allows for more functional referencing to occur. The dentist, as with other dentists in this study, uses exclusive pronouns as he talks about he and the other dentist as "we" and the staff as "they" or "them" as illustrated here,

"Anytime people need to learn something, I am the one who seems continuing education form or the courses for them, trying to get them to be better at their job."

Inclusive language was used primarily by each participant when discussing the communication practice of daily morning huddles. In this context, and for the only time during the day, the entire team is gathered together and is engaged in looking over the schedule, and discussing any relevant issues.

> *Office Manager:* We usually open up every day with morning huddle. So anything you have questions about, usually you can address in that.

> *Staff Member:* We huddle every morning and it gives us the opportunity to look over our day, our schedule for the day and discuss special needs for certain patients, things that may need a change about the schedule, to help us plan ahead and be better prepared for the day.

> *Dentist:* In the morning we get her 15 minutes before and we have a morning huddle where we talk. We all have a copy of the day's schedule and we talk about areas that might be pitfalls and areas that, or if a patient has a concern or if a member of their family is sick, just anything that comes up.

Beyond the discussion about communication practices and the later question asking them to tell me what the office is "like," each participant speaks more in functional group terms.

Interdependence. References to independence occurred four times and to interdependence, 22 times. Although the office may operate from more of a functional group perspective, members recognize the need for interdependence in work accomplishment. Like the office manager in office number six, the office manager here views her role as a facilitative one, "Well, basically just making sure everything runs smoothly. Just falling in wherever needed." The dentist discussed the computer paging system that allows someone to call for another team member to come to a certain operatory. The dentist explains that if the person being paged does not happen to see the computer screen, "So our backup system is come run and get me if you need me."

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The senior staff member was the primary source for referring to the interdependence of the team. She stated that, although she is a hygienist, she was a "team player." She discussed reliance upon the office manager (the previous one), on the team members in resolving functional or relational issues, and the interdependent nature of information dissemination. As noted earlier in the findings of this office, there are some gaps in the office's communication. This staff member talked about the need for better methods of communication and would like to have regular staff meetings reinstated. When asked what change she would implement that would be beneficial for the team she stated,

> If we had some type of bulletin board and there was any new information that needed to be known by everybody, just whoever knew it and wanted to share it, should post it, and then if there needed to be discussion about it and wasn't just facts and information, I still think the staff meetings are the best way to do that . . .We use a bulletin board in our sterilization room to get items on that we are running low on that we need to be. We put items on that board for . . . who does our ordering, and that way if she is not always available to talk to you throughout the day, then we have a way of notifying her about information without interrupting her.

The same idea was brought up by the senior staff member in the first office. This speaks to the degree of the rate of change within a dental office and to the need for all parties' to be aware of information as it becomes available. The 22 references, at more than five times the occurrences of statements independence, revolve around "need," needing to help, needing one another's attention, or needing to pass on information. This interdependence allows for this office to be placed closer to the real team end of the scale.

Social distance. There were six accounts referring to social distance and eight to social closeness. Social distance is expressed by the office manager when referring to "the doctors," among other instances, as the "go to" people when issues need to be resolved and by the senior staff member when she states that the staff first takes issues to the office manager in order to "circumvent taking time from the doctors." Both staff members refer to the power distribution

distance between themselves and the dentists. The dentist does not make any reference to social distance and, in this case, does not use the term "the girls" to refer to the team as most other dentists in this study have done.

Social closeness is evident in statements of admiration or liking. The office manager, as previously presumed to be in a "honeymoon" phase with her job, made four of the eight remarks counted as indications of social closeness. These include:

> Everybody has been really nice. . . I think this is the best place I have ever worked, truly, and it is just because everybody here just likes each other. Everybody gets along and nobody really talks about each other. . . They [the dentists] really just seem to be good leaders and I think their employees do better job because they feel they are such good people.

The dentist and the senior staff member each made two references to admiration or relationships with members of the team.

When the office manager was asked to complete the statement "This office is like," she said it was like a well-oiled machine and that it ran smoothly. The dentist and senior staff member compared the office to a family or second home, and while their metaphors for the office were indicative of relationships they were more realistic, not overly sentimental. The dentist replied, "A family. I won't expand on that. Families are different and it is a family." The senior staff member stated that it was like a second home because "when you work closely with people all the time like we do, then when you establish a relationship with people you get attached." The findings of six social distance references and eight social closeness references puts this team more toward the middle to real team end of this key dimension's scale.

Conflict management style. Findings for conflict management give some insight into the moderation of the office's culture, allowing it to be nearer to the real team end of three of the five key dimension scales. The decision-making processes here indicate that while the team is
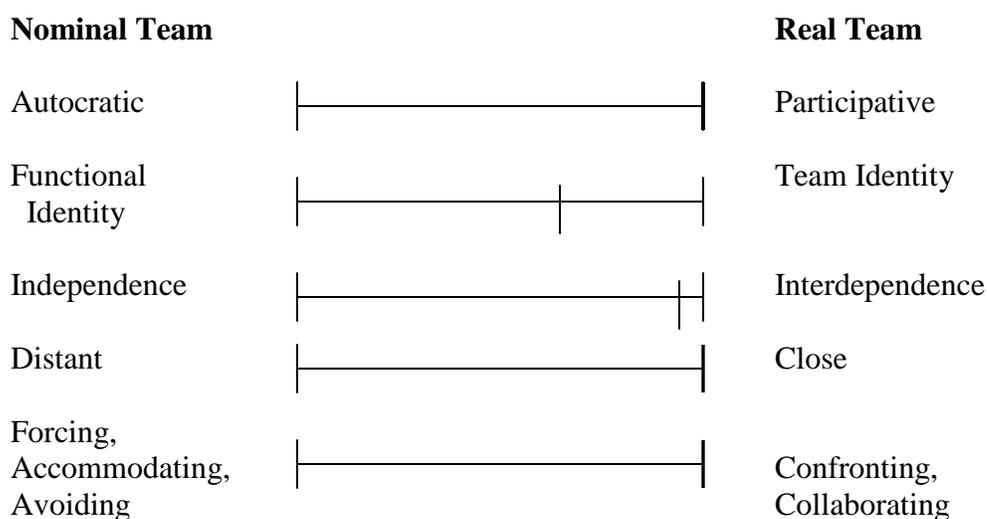
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not participative, they do engage in a collaborative and confrontational conflict management

tactics that empower the staff. There were four accounts of collaboration and confrontation and

none referring to force, avoidance, or accommodation. This places the office at the farthest end

of the scale and indicates that they possess real team characteristics within this dimension. The

senior staff member states,

> Sometimes if there is a personal conflict we have been asked to address it in person. It is
> not going to cause uproar. That is usually done, and sometimes if it is not effective, [we
> go to] the office manager, and then if that is not effective, we do not hesitate to go to the
> doctors if we need to, because it is usually an issue that is going to effect the whole
> office, the entire flow of the office, and our patients, it is best to take care of it.

The office manager referred to the office's communication as open and honest, and the dentist

said that dealing with conflict depends on the team member's personality, that he doesn't mind

handling the conflict but that the office manager is the person the staff should go to first.

Although the office leadership shows more autocratic tendencies and the team operates as more

of a functional group, the staff members appear to feel free to confront and resolve issues in an

open manner enabling healthy dialog that fosters relationships within the office.

Results for Office Number Eight

Nominal Team   **Real Team**

Autocratic   Participative

Functional   Team Identity
  Identity

Independence   Interdependence

Distant   Close

Forcing,
Accommodating,   Confronting,
Avoiding   Collaborating

Figure 10. Leadership and the resulting team culture for office number eight.

The eighth office was different from the other offices in that the dentist had recently graduated from dental school, purchased an existing practice from a retiring dentist, retained many of the staff, and added two new staff members, one being his sister. He had been in practice for one year at the time of the interview. Like offices #3 and #10, the communication is constant rather than constructed. All three participants repeatedly discussed the dentist's learning curve as a leader and his reliance on the more seasoned staff to guide and collaborate with him. The most senior staff member, rather than viewing herself as incorporated into a new team, viewed the dentist as being added to the existing team.

When asked about his leadership ability she stated, "Being newly added, I think he is really improved at that [leadership]. I would say right now he has moved up to a four." The four being a rating with five as the highest possible score. This staff member makes three separate references to the openness of the communication and the dentist's willingness to listen, and while she along with the other senior staff members sees herself in a mentor-type role, she also gives deference to the dentist's positional authority. From the dentist's perspective, "Short of the technicality of me being the dentist, I feel like I am at a party of equals to a certain degree. I mean I treat people here the way I would want to be treated." He sees the senior staff as helping him adjust to his leadership role. The staff's experiential knowledge about the practice and its' patients has allowed him to step into the practice mid-stream and not have to experience a full start-up scenario.

Decision-making process. The one reference to autocratic decision-making was made by the dentist. When he took over the practice, he instituted health insurance for the staff and discontinued their retirement plan. Although at the time he felt it was in their best interests, he continues to deal with the decision, "You know we talk about that on occasion, about why we

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don't have a retirement plan right now, and I think that becomes a little bit of an issue." It could

be argued that this is discrepant data as the examination is concerned with how decisions are

made currently, and this decision was one made prior to working with the team. All comments

from both staff members regarding change were that all decisions are participative.

` The three accounts of participative decision-making processes were inclusive of the

entire team. The most senior staff member talked about the staff and the dentist as having a voice

in managing change,

> As far as having staff meetings, we do not sit down and plan one that often, but if we
> have concerns, everybody will congregate somewhere and we will discuss it and get it all
> figured out right that minute. . . Because in the beginning you really do not know how
> things are going to move and then as you work a little bit longer, he says, 'I really do not
> need to book a patient like at 11:30, because we are running over and we are going to be
> 12:30 before we leave for lunch. I think we should just mark off the 11:30 spots and not
> schedule.' That is kind of how that works too, as you feel your way through.

The newest member of the team, the dentist's sister, stated, "If there is something that is that

drastic, or if there is going to be a big change, we definitely talk about it before he makes a

change on anything." With the one autocratic reference arguably discrepant, the office is placed

at the farthest end of the scale indicating a real team in regards to the decision-making process.

Identity. There were 51 functional group identity and 68 team identity accounts. The

exclusive pronouns used referred to the functional roles of individuals as seen in the senior staff

member's comments about communicating to one another about patients:

> Like with the receptionists, because she greets the patients first, so the communication
> has to be anything that the patients or their parents relay to her she has to relay to us, the
> dentist, or the hygienist right off the bat . . . If she cannot verbally tell us, if we are
> working on a patient, she always writes it on the forms we have.

This is a good example of how the team members rely on the constant flow of communication

from one functional area to another. The functionality of the group is based upon task-oriented

areas (dentist, receptionist, and hygienist) and speaks more, in this office, to the extreme interdependence experienced within such a small group.

The 68 references to team identity were found throughout the participants' transcripts. Note that in the previous quote, "he says, 'I really do not need to book a patient like at 11:30, because we are running over and we are going to be 12:30 before we leave for lunch. I think we should just mark off the 11:30 spots" that the staff member quotes the dentist using inclusive language as he makes a suggestion for scheduling changes. All three participants used inclusive pronouns indicating a team identity. The number of inclusive verses exclusive pronouns places the office approximately at a point two-thirds along the scale in the direction of a team identity.

Interdependence. The findings of interdependence within this team were high, with 54 accounts of interdependence and only three of independence. All participants viewed the team as highly interdependent. The dentist recognized his own dependency on the more senior staff, "And like I said, for me they kind of took me in as their son, the ladies here . . . But most of it is just me learning as I grow and as I am here longer." The newest member of the team talked about her multiple roles and doing "a little bit of everything. I guess I can say a team player." The most senior staff member understood the interdependence of the team in terms of caring for the patients successfully:

> We have to know before we get a patient back, we have to know all of their history and anything; you have to relay everything to each other. Like me and the other hygienists, we have to work together . . . Everybody has to know what is going on. Your right hand has to know what the left hand is doing at all times.

The three independent statements were made by the dentist as he talked about the changes he had implemented since he bought out the practice. One example is, "I probably easily close to doubled the patient load from the get go, just because I was willing to take more patients then she was taking, and because I brought in another hygienist." The dentist takes ownership of the

changes that have affected office productivity, yet sees the daily and relational nature of the team

as highly interdependent. Accounts of interdependence were 18 times greater than those of

independence; this places the team at the far end of the scale indicating a real team.

     Social Distance. The "family" metaphor truly characterized this office. The team

consisted of two literal family members, more senior members that felt maternal about the

practice and new dentist, and one other new staff member who had been a childhood patient of

the previous dentist and therefore had a long-term relationship with the senior staff. There were

21 references to social closeness and none to social distance. Each participant likened the office

to a family:

> *Senior staff member:* A big family. Everybody has to know what is going on . . . We know each other's limits and things like that. But some of us have worked together for a long time. You can just look at each other and say "oops, let me go do this." And like the newer, the assistants and all that he has hired, I just feel like everybody has just been perfect.

> *Newest staff member:* Probably a family, just because . . . and I are siblings, so this is definitely family. But I think we are all pretty close and we all get involved in each other's lives outside the office too. Everybody is very supportive of anything that is going on in my life as far as anything and they are the same with me in theirs. I think we are like a family. I think we work well together and sometimes we have arguments, but we talk about them and get over it.

> *Dentist:* It is more like being a family, but it is more like being a very young family, like where . . . and I are right now with a brand new baby. It is not a very established family, it is still kind of a family where you are feeling your boundaries with each other and kind of like when you are new husband and wife, you are kind of testing each other on how far you can push and how far you will push back. We are just trying to learn all these different roles kind of at the same time. It is not like an established, like we are a big happy family here. But you know, it is new.

Other statements were made referring to liking or admiring the other members of the team apart

from the responses to this one interview question. With the 21 accounts of social closeness the

team is placed at the end of the scale, indicating a real team.

Conflict management style. There were 22 references to collaborating or confronting as methods of conflict management and none to forcing, avoiding, or accommodating. The participants continually discussed the openness and the ability to air issues or grievances with other members of the team, even the dentist. The dentist stated,
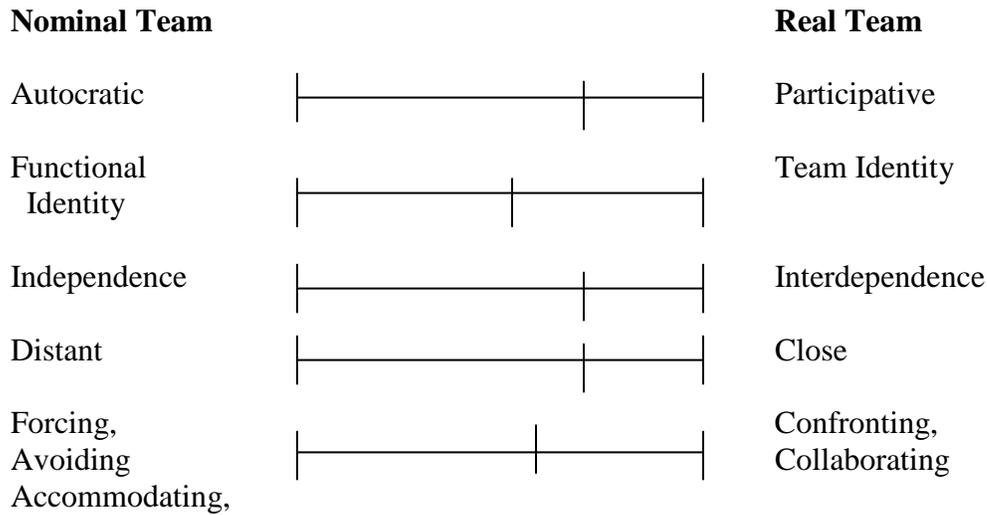
> I do not have a fearful staff when it comes to calling me out on something. If they feel that I did not handle a situation properly, or I am not handling a situation properly kind of in midstream, they know how to kind of grab me on it.

The senior staff member on three different occasions during the interview stated that the staff was opinionated and that the dentist was a good listener, "I think we are all very outspoken about it and he is very good to listen to any concerns we have." His willingness to hear the opinions of the team members and to foster an open forum seems to allow for more immediate resolution and a secure environment relationally. The newest member of the team validated the senior member's views of the confrontational nature of the staff,

> We are very opinionated women so that is difficult at times but at the same time it is good because nothing ever goes unsaid. If somebody has a problem, they pretty much go straight to the person they are having a problem with. If we [the entire staff] have a problem we will sit down and talk about.

These views of the collaborative or confrontational behaviors of the team were reiterated numerous times through the transcripts. This office may be unique in its set-up, as many of the team are more senior members of the practice than the dentists, but the dentist has struck a balance in empowering the team, valuing their input in assuring them that they are heard, and has maintained his formal positional power. This has placed this team closer to the real team end of each of the key dimensions than any other office in this study.

Nominal Team		Real Team
Autocratic		Participative
Functional Identity		Team Identity
Independence		Interdependence
Distant		Close
Forcing, Avoiding Accommodating,		Confronting, Collaborating

Figure 11. Leadership and the resulting team culture for office number nine.

The ninth office was the practice of a female dentist. She had a small staff of five and much like the other offices led by a laissez-faire leadership style, communication was not highly structured, nor was it as constant and open as in office #8. This dentist viewed her position in hierarchical terms, and coined the phrase "female factor" in discussing dealing with the other women in the team. The communication practices of this office were seen as an issue needing improvement by all three interview participants as meetings inclusive of the entire staff were functional and brief, not allowing for full discussions of the issues at hand. The dentist described the normal method of communication as, "my status quo would be like, 'is everything okay up here?' and it's 'uh huh it's fine.'" Themes emerging from the participants remarks suggest that the focus of the office is functionality and "comfort."

Decision-making process. There was one reference to autocratic and three to participative decision-making processes. The one autocratic reference was about the dentist choosing all continuing education courses, as one staff member stated, "she chooses for us." Each of the staff

as well as the dentist made a statement indicating more participative methods for changes that will affect the office. The decision-making is participative, but the staff also expressed understanding of that the dentist has the authority to make the final decision:

> Usually the doctor will bring it up in a meeting and we will all give our opinion on it and then she just goes from there. Usually we all talk about it together first before she makes her decision and that works out for the most part.

The office is placed at a point two-thirds along the scale toward the participative nature of the decision-making process that suggest a real team.

Identity. With 37 accounts of functional identity and 38 accounts of team identity, the office is placed in the middle of the scale for this key dimension. Possibly as a result of the size of the team, the exclusive pronouns were not indicative of functional groups within the team. Instead, most exclusive pronouns used by the two staff members were "us" and "the doctor." From the dentist's point of view, "I" and "they" were used, although very sparingly as she primarily used an inclusive "we."

Interdependence. There were seven independent statements and 20 interdependent ones accounted for. The independent statements were made in regards to functional responsibility, as when the senior staff member stated, "Sometimes I overdo because I like to kind of keep things on a steady stream, flowing smoothly" or the statement by the newer staff member, "I'm the computer whiz." Some of the dentist's independent statements include,

> It ultimately comes down to bottom line, me on the whole thing. I try to delegate as much as I can. I am primarily, obviously doing the dentistry and diagnosing, garnishing relationships with referring dentists. I am a periodontist. I do delegate to Jan, the front office what I can, but I find that I have to have a hand and know how to do it all or it does not get done well.

The dentist, along with the hierarchical view of her position, is independent of the "female factor" that she has to manage. During the interview she spoke about some team conflict that had

arisen and that she was going to have to handle. The issue revolved around, "Because it was

somebody saying 'that is your job…' and to me 'that' is everybody's job." The dentist explained

trying to manage women and communicate to them the need for interdependence, "Yes, you are

supposed to have each your own duties, but when one person is over run…**"**

The participants engaged in three times the interdependent language as independent, as

they talked about being a team and "pitching in." Said one staff member, "We are pretty much a

team around here. I don't think there is any "I." It may seem counter to their independent

language, but I would point to the fact that in a small team each person is known for what they

independently are responsible for while at the same time are called upon to work together. In the

interview, the dentist talked about the struggles with the limited amount of personnel and that the

office would be making a move to a larger facility and gaining one new team member. She

hoped that this change would be an improvement for the team. The newest staff member

summed up the atmosphere of the office's interdependent nature when she said,

> We all try to help each other out as much as possible. Like whenever somebody is busy
> or back to back, and they cannot do this, clean instruments, we will all jump in and do it
> when we get a chance, or just e-mails. If . . . is out, I will go in and do the e-mails on
> Wednesdays when she is not here. We will all try to help each out and do each other's
> roles when they are not here, or they are too busy to do their own.

Findings suggest that the team is more interdependent than independent and therefore the team is

placed toward the real team end of the scale.

Social distance. There were four accounts of social distance and eight of social closeness,

placing the team closer to the real team end of the scale for this key dimension. The distance is

the formal, positional distance between the staff and the dentist as seen in previous offices. The

closeness, mostly taken from the "This office is like" question, is a result of the interdependence

and the "comfort" level of the environment. One staff likened the office to, "Everybody kind of

works together as a team. So it is like a home away from home." Another team member

compared the office to a "lazy chair. It's easy. It's the softness of an easy chair. It is comfortable.

The way we are around here is that we are ourselves." The dentist also talked about the

importance of feeling comfortable in the office, that she wanted her team to feel that way in their

work environment. The dentist, in her response to the same question, did not mention the

relationships within the office but instead talked about what she hoped the office is like for the

patients. The remaining accounts of social closeness were found in comments from the staff

members about the dentist, such as "She is good" and "she is a real good leader and an excellent

person to work for."

Conflict management tactics. "I think the biggest policy is that you try to settle it yourself

and if you cannot, then take it to the doctor to solve. She will be the mediator." This statement

made by the most senior staff member sums up the office's view of conflict management. There

were three accounts of forcing, avoiding or accommodating and four of confronting and

collaborating, placing the team slightly toward the real team end of the scale in this aspect. As

seen in the previous quote, the dentist encourages the team to be open and handle grievances,

especially with one another. Her involvement in conflict results in forcing or accommodating as

seen in her statement,

> I think it is called a female factor. Maybe it could be men too, but if you get enough
> women in the pot, they are going to stir it up. Somebody is going to be upset about
> something. I don't handle the petty stuff, and if you get to where I have to handle it, then
> we are going to have problems. Like somebody and parking. I'm like, you cannot figure
> out who is going to park behind each other and do it in an adult manner, then I will figure
> it out for you and you are not going to like it.

As stated earlier, this office does not engage in regular meetings that include the entire staff or

allow for time to discuss issues relevant to them. This "hands off" approach by the dentist results

in the conflict management style seen here.

Results for Office Number Ten

Nominal Team   **Real Team**

Autocratic ├─────────────────┼──────┤ Participative

Functional
  Identity ├────────────┼─────────┤ Team Identity

Independence ├──────────────┼────┤ Interdependence

Distant ├─────────────────────┼──┤ Close

Forcing,   Confronting,
Avoiding ├──────────────────────────┤ Collaborating
Accommodating

Figure 12. Leadership and the resulting team culture for office number ten.

The tenth office was a husband-wife dental partnership. It consisted of a small team in comparison to other offices in the study. I interviewed the husband when I visited the office, but found that he was very hands-off as far as dealing with staff communication and relations and therefore had to later interview the wife. She shed much more light as to why this was such a happy staff, as they rated both dentists as fives on the leadership scale and seemed to genuinely enjoy the work environment. The husband and wife team are not in the office everyday together, and instead of regular morning huddles or meetings, they rely on an "open access, open line" of communication. One staff member supported this in her statement,

> On a day to day basis, it [communication] is pretty informal, just catch you when you can. Like, I need to tell you something quickly, its pretty just hit and miss, and sometimes we have to catch the doctor, 'wait, you can't go home, we have to talk because this patient called'. . . So it's just grab 'em when you can.

The dentist called this "tying up loose ends at the end of the day" and this seems to work for this small group. The dentists have a very laissez-faire, laid back attitude and as the husband stated,

"I just want to come in and do dentistry." He also stated that he knew he was a strong type A personality and therefore when hiring, made sure he didn't hire any other individuals with strong personalities. This style of leadership and communication appears to work for this group as discussed in the findings for each of the key dimensions.

Decision-making process. There was one reference to autocratic decision-making processes made by a staff member who stated that the "doctors pretty much take control of schedules and so forth." This same staff member stated that there were some group discussions about possible change but that "ultimately the doctors make the decisions." This was counted as participative, because like many offices the team may be included in the process but the team members understand the formal authority of the dentist(s) in making the final decision. There were four references to participative decision-making in total. The wife had a participative viewpoint and said that she asks them, "what do you think about this? Because it's going to affect them, and then it [how it affects them] is going to affect me."
The findings place the team closer to the real team end of the scale for this dimension.

Identity. There were 26 accounts of functional identity and 44 of team identity. As in previous offices studied, the functional identity exclusive pronouns were to distinguish between the doctors and the team. One staff stated about the dentists, "They have strong personalities. They really can communicate with their patients extremely well." There had to be a distinction between the "we" the dentist used to describe her and her husband and the "we" used to describe the entire team inclusive of the dentists. The team identity statements were strong and included statements by the staff of the office as, "We are a pretty informal office. Well, I feel we all try and pitch in and help each other . . . We are very laid back." These findings place the team at the real team end of the identity scale.

Interdependence. There were two references to independence, both resulting from the husband's remarks about his role within the office. He talked about his wife facilitating his ability to be independent and focus on enjoying his role as a dentist. He had relinquished the staff duties to his wife and is willing to re-enter the process when needed to "coach" a team member. The wife and the team all spoke in highly interdependent terms, "we all pitch in to help each other," "everybody works as a team around here," "everybody is willing to help one another." The findings suggest, as far as how the office is run, that by the primary dentist (the husband) taking a more hands-off approach and allowing the secondary dentist (who is not in the office everyday) to manage the staff, the staff understands the need to work together to maintain order and efficiency. This office is placed at the far end of the scale in terms of interdependence.

Social distance. With one account of distance and nine accounts of social closeness, this office is at the very far end of the scale, indicating a real team. The one account was in a remark about the "doctors" making the ultimate decision. In the findings for this office, while I took into account what the first dentist had said during his interview, the wife's statements were the primary ones included in the findings. The reasoning being that he is more of a figure-head and not a leader in relation to managing the staff. Therefore, in examining the findings within social distance, they were extremely high due to the wife's admiration and pleasure in her current staff, "I prayed for each of these women, and I feel blessed to have the group I have . . . They are like my closest friends." The staff responded with comparing the office to a family in very relational and positive terms, "We enjoy each other's company and we laugh a lot together and we have cried a lot together about personal issues. So yeah, I think it's a good family."

Conflict management tactics. Findings concluded that the office engages in the positive conflict management tactics of confrontation and collaboration. The dentist stated that the team

"talks openly, even about disputes" and the staff reiterated with one staff stating, "We try to be very honest with each other and open and just like, 'I really need to tell you this,' and so far so good." With three accounts of collaborative and confrontational tactics, and none indicating force, accommodation or avoidance, this team is placed at the farthest end of the scale indicating a real team.

Summary of Findings

This study examined the dentist's view of their organizational role, leadership styles and behaviors, the team's communication practices, and the effects of these on the nature of the team. Findings include that a dentist's view of his/her organizational role in regards to team membership falls into one of two categories, hierarchical or team-oriented leadership. Either view does not necessarily dictate subsequent leadership behaviors and the nominal or real nature of the team, although one must note that all three dentists who were autocratic in their decision-making processes were also categorized as having hierarchical organizational perspectives.

Thematic analysis found that leadership behaviors manifested themselves in decision-making processes, a focus on continued learning, the intentional hiring of an office manager to become an intermediary between the dentist and the staff, and the formal as well as informal communication practices that ultimately affect conflict management tactics employed by team members. The formal implementation of communication practices such as morning huddles and regularly scheduled staff meetings do not have a direct impact on the nature of the team.

Morning huddles, a widely accepted communication practice within dental offices, are conducted in six of the ten offices and were also mentions by some staff members in offices that do not engage in them as something they would like to see implemented. Their purpose is functionality as they allow for all members to look over the schedule together and prepare for the

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day ahead. They do not, however, have any direct impact on the culture of the team. The regularly scheduled staff meetings are more for allowing larger issues to be discussed, including the adoption of possible changes. Findings suggest that these meetings are beneficial as they allow the entire team time apart from the day's patient schedule to reconnect and communicate about relational issues and upcoming challenges or changes affecting the office team. Once again as noted by examining office ten, the normative behavior of open-access communication can be as successful, if not more so, than many of the offices with formal communication practices in place.

The employment of an office manager was categorized as a leadership style or behavior in that each of the five dentists who had an office manager had done so to create an intermediary position between them and the staff, allowing them to focus more on the task of performing dentistry. It was thought by all five, including office number ten where the office manager was the wife-dentist, that the reliance on an office manager increased their ability to enjoy dentistry. There were no directly related characteristics attributed to offices with office managers as opposed to offices without them.

Value added is the overarching message in leadership behaviors that include a focus on continued training and in participative decision-making processes. These leadership behaviors communicate an organizational-employee relationship and employee ownership and responsibility to the organization. The most significant of the two in terms of affecting the nature of the team is decision-making processes. Findings conclude that offices engaging in participative processes involving team input and feedback have higher degrees of team identity. Dentist(s) that engage in autocratic decision-making processes make decisions that affect the

team without involving, and many times even communicating the changes ahead of time, the members and as a result have teams with higher degrees of functional identity.

In examining conflict management tactics, offices that encourage open communication result in more healthy confrontation and collaboration. These environments are more likely to occur in offices that also engage in participative decision-making processes. Dentists that are autocratic, and with this distinction comes an adoption of a hierarchical positional view of leadership, have higher occurrences of conflict management tactics that include force, accommodation, and avoidance among team members. This results in the team having more nominal team characteristics.

Discussion

This study began a course of research within the dental field on which to build upon and has added to the existing organizational communication literature. As Poole and Real (2003) found, it is not enough for literature to advocate a team approach and discuss guidelines for working with teams, but that systematic investigations of teams themselves is necessary. "Only a few [medical] studies report group characteristics, structure, processes, and outcomes so that the impact of team dynamics on outcomes can be explored" (Poole & Real, 2003, p.383). This study found that while "communication is the cement that holds teams together and joins them to the organization," leadership behaviors are central to the creation of communication practices and therefore directly affect the team, its ties to the organization, and to one another (Poole & Real, 2003, p.396).

A surprising finding prior to collecting data was the willingness of the dentists to participate, beginning with the number of dentists that voluntarily completed the survey and signed up for the study at the Georgia Academy of General Dentistry meeting. Outside of the logistics of finding mutually convenient times, resulting in the small number taken from the pool of subjects, seventy percent of the dentists that I cold-called were willing to participate. The possible factors that contributed to the dentists' willingness to participate will be discussed at the end of the chapter as the study will conclude as it began, with the observation that dental schools are not sufficiently preparing students for team leadership and effective communication practices.

The inquiry began with trying to first gain an understanding of how dentists view themselves in terms of leading the team. They were asked to describe their organizational role as a member of the team, intentionally omitting the use of the term leader. Four dentists discussed their roles from a hierarchical and six from a team-orientation perspective. It was stated, in the beginning of the study, that the personality type of those typically admitted to dental school was, "technologically oriented, introverted, and rigid" (Ratcliff, 2008). Leading one to presume that dentists might be more inclined to adopt a hierarchical view of their organizational role as seen in Nowjack-Raymer's (1995) traditional model of the dental team. This supposition was incorrect.

There were no demographic patterns within the findings that could be attributed to the adoption of either a hierarchical or team-oriented leadership perspective. A dentist who perhaps instinctively has a better understanding of interpersonal communication may lead from a more interpersonal perspective, being team-oriented, as seen in Becker's 2003 study of the effects of emotional intelligence on the hiring practices and staff retention rate of dentists. Therefore, a dentist's perspective on their organizational role is dependent upon personality traits or previously learned capacities. As seen later in the discussion, a dentist's hierarchical or team-oriented perspective does not necessarily influence their leadership style or decision-making processes which both have greater effects on the real or nominal nature of the team.

Linking leadership behaviors and communication practices

No systematic study until now has examined the current leadership behaviors and communication practices of the private dental practice and although two separate research questions were formulated in this regard, it became obvious during the analysis that the two were

inseparable as one is seen to directly affect the other. Not all communication practices are determined by the style of leadership that the dentist has adopted, but definite patterns emerged.

It was discovered that the leadership behaviors exhibited in the offices studied included either proactive or laissez-faire methods, and participative or autocratic decision-making processes. Six of the dentists in the study had proactive methods of leadership. These dentists were either catalysts of change that focused on keeping abreast of new technologies and training methods, as in the dentists of offices #s 1, 2, and 7, or were open to new ideas that would improve current practices as in offices #s 4, 6 and 8. There were no demographic distinctions that set this group apart. A proactive leadership style was not a predictor of decision-making processes, as half were participative and half autocratic, but all three dentists in the study who were autocratic were also proactive in their leadership style. There was a more direct link between leadership style and the communication practices the offices engaged in.

Morning huddles and staff meetings were found to be the two predominant communication practices. As stated earlier, morning huddles are 10 to 15 minute meetings each morning to go over the schedule and any patient or housekeeping information. These meetings are purely functional and are intended to prepare the team for the day ahead. They are based upon the premise that though team members are separated during the day by their functional tasks as well as by physical office space, that the team is dependent on each other for overall task accomplishment. Information concerning the day ahead alleviates equivocality and facilitates needs being met in advance. All six of the dentists that exhibited a proactive leadership style conducted morning huddles with their team. This is significant along with the finding that none of the offices led by a laissez-faire style of leadership engaged in morning huddles.

Five out of the six offices in this proactive category engaged in regularly scheduled staff meetings; weekly, monthly, and some annual meetings in the form of a staff retreat. Staff meetings, are a time to discuss staff related issues and the possibility or implementation of change. Participants from these offices gave examples of staff members using this time to air grievances and make suggestions. The one office that did not engage in staff meetings depended on the morning huddles as the primary time for team communication. However, the dentist stated that the morning huddles were not the place for larger issues as they served a more daily functional purpose. By not engaging in staff meetings, there is no specific time to discuss staff-related issues or upcoming changes with the team. During the interview he stated,

> Yeah, sometimes we [the dentists] decide things and forget to inform everybody else. That is a real problem with a lot of people. I have staff members that will point that out to me, and then the next time I will do it again.

It is important to have some regularly scheduled time to meet with team members outside of morning huddles, whether highly structured or not, as long as dialog concerning larger organizational issues can be engaged in.

Laissez-faire leadership

Four of the dentists were categorized as laissez-fare in their approach to leadership as they were more hands-off in terms of staff management and content with the current operations of the practice. There was no demographic category that these four dentists fit into; two of them were male and had been practicing for over twenty years, one was a female who had been practicing for nine years, and the last office was the husband and wife team who had been in practice for approximately eight years. The main motivation in these practices was comfort; of the patients, employees, and themselves, along with a desire to simply come into the office and

enjoy practicing dentistry. None of the dentists actively sought change, but not all were completely change-resistant as some were open to ideas from the staff.

The team's comfort level was not a predictor of how they rated the dentist as a leader, as some team members acknowledged the lack of formal communication was something that could be improved upon. As noted earlier, these offices did not participate in morning huddles, nor did they engage in regularly scheduled staff meetings. There were two that talked about meeting with the staff regularly, but the meetings are not formalized. Instead, they are times during the day or week that the dentist and team members may, if necessary, briefly go over team issues or changes. When participants in three of the offices were asked what communication practice they would institute or change that would be beneficial to their team, staff members said they would institute morning huddles or regular meetings. One responded, "I would have a staff meeting every morning before the start of the day, discuss the needs that this patient may have, that this assistant worked with the patient last time . . ., just little things." In other office, a staff member replied,

> I think we do need some kind of staff meeting, whether it is once a month or whatever, to talk about things that need to change or patients that we need to be with or whatever. Well, I think we would all have a better understanding of what is going on and things that we needed to change.

The tenth office was the exception, and while not participating in any type of formal meetings, their "open-access" or "constant" communication allowed the team to feel well-informed and gave the dentists the ability to communicate changes when necessary. The staff members in this office offered no suggestions for change.

Autocratic verses participative decision-making processes

Decision-making processes along with the conflict management tactics were the two largest factors in determining the real or nominal nature of the team. For eight of the ten offices,

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both team identity and interdependence followed the approximate placement along the nominal or real team scale as marked in the decision-making dimension. Autocratic decision-making indicated a nominal team and anchored the far left end of the scale. Three dentists engaged in autocratic decision-making processes. In these three offices the team was made aware of the decisions ex post facto, creating resentment and team division. Resentment on the part of the team members toward the dentist for not seeking their input or taking into consideration how the decisions would impact them, and division among team members as some more easily accepted the imposed change than others. In office #4, this became evident as one staff member stated, "he does it without asking our input . . . And when he does stuff like that, I think it causes a lot of animosity in the team." This staff member made other similar comments throughout the interview process reiterating her disgruntledness.

Another negative result of autocratic decision-making is that often the dentist(s) make unilateral decisions and neglect to inform the staff. Because the team was not a part of the change discussion, the dentist(s) may communicate the change to one team member but neglect to go through a formal process of informing the entire team. This leads to team members feeling left out of the information loop. This was evident in all three of the offices; 1, 4, and 7. One newer member stated, "I think the only thing would be the whole secret kind of thing. It does not seem like everybody communicates with each other." Changes had occurred without prior notice resulting in her feeling "in the dark" as she assumed others had received the information. She felt as though she had not been assimilated into the group, when in reality the more senior member had made similar remarks.

The greatest effect that autocratic decision-making had on the team was in regards to identity. All three offices had a greater occurrence of functional rather than team identity

references, and were placed on the far end of the identity scale indicating a nominal team. This type of decision-making confirms the power differential between the dentist and the team. Unlike participative processes that demonstrate team member value, autocracy, as Lockard (2007) stated, was a more traditional method that "considered employees as replaceable units that could be plugged into the rigid dogma of managing, organizing and controlling. Their only responsibility was to do as they were told and be quick about it" (p.90).

Although not a predictor by itself, these dentists also had hierarchical views of their organizational roles. A dentist who adopts a hierarchical perspective along with autocratic decision-making and one-way communication, confirms Nowjack-Raymer's (1995) view of traditional dental leadership. He states that within a traditional dental team these four areas (*i.e.*, personnel function, communication, decision-making, and leadership) are "most frequently discussed in the literature as causing the most stress and dysfunction to inexperienced and unprepared team members," (p.101).

Participative decision-making

Participative decision-making processes indicate a real team and anchor the far right end of the scale. Democratic leaders assume that group members can make informed decisions, that input and collaboration are necessary, and are relationship oriented (O'Hair & Wiemann, 2004). Seven dentists engaged in participative decision-making processes. These offices indicated a greater sense of team identity. Participative decision-making gives the team members a voice and creates a sense of team identity that is inclusive of the dentist. Team members experience a greater sense of ownership in the practice and "buy-in" to the changes necessary to further its' success, distributing the vested interests in overall goal accomplishment. These findings

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corroborate Donnellon's conclusions "that team leaders who are competent and share power are effective because they inspire responsible membership" (p.234).

There was no direct observable connection between a dentist's hierarchical or team-oriented view of his/her organizational role and participative decision-making processes, as three of the seven dentists were hierarchical and four team-oriented. It is important to note that while the team was included in the process, many of these staff members also gave deference to the positional power of the dentist and acknowledged that he/she made the final decision. This system confirms Nowjack-Raymer's (1995) recommendation for dentists to engage in communication that encourages group discussion and problem solving, and to adopt a more inclusive rather than autocratic, hierarchical power structure.

Conflict-management tactics

Conflict management tactics include force, accommodation, and avoidance which are indicative of a nominal team, or collaboration and confrontation, indicative of a real team. Two offices had greater accounts of forcing, accommodating, and avoiding. These dentists, in offices #1 and 4, also engaged in autocratic decision-making processes which resulted in greater functional group identity. The conflict management style is seen to correlate directly with interdependence and social distance as it affects the way the team regards issue resolution and the relationships among team members. One senior staff member stated,

> Who wants to speak out if nothing is ever going to be done about implementing it, or if you have to bring it up 3 months in a row before you find out anything. You get to the point you want to say never mind.

One dentist discussed team members as having a tendency to perceive issue-related communication as "criticism" and stated, "I don't want to deal with that." This is a result of ambiguity in how team members can most effectively bring forth issues and norms for conflict

resolution, creating a disconnect between the staff and the dentist, and allowing tensions to build between team members.

Another possible effect of unproductive conflict management is an increased rate of turn-over. Turn-over of employees was mentioned by members of both offices, and as noted earlier, one participant from office #4 left shortly after I had conducted the interviews. These conflict management tactics along with an autocratic decision-making style create a nominal team culture, proving to be the most unconstructive leadership and communication practices in which to engage in.

Collaboration and confrontation

Collaboration and confrontation are positive in that team members feel free to voice dissenting views to one another as well as to the dentist without fear of negative repercussions. Individuals are afforded appropriate channels or procedures in which to openly discuss issues as they arise. As Hackman and Johnson (2000) realized, the organization is created and sustained by communication and the culture is a by-product of that communication. Within this dimension of organizational communication, it was found that conflict management tactics affected the degree of interdependence and social closeness experienced by the team.

Greater accounts of positive conflict management tactics that include collaboration and confrontation were found in eight of the ten offices. This empowerment of the team to confront or collaborate on issues, allows them to manage conflict in a healthy manner. Nowhere is this more evident than in office #7. When examining figure 4.8 one can see that the office is placed on the nominal end of the scale for decision-making and identity, and then closer to the real team end of the scale for interdependence, social distance and conflict management. The openness with which the team felt they could handle conflict made the difference in the real team aspects

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of their culture, generating and sustaining trust. Trust is the result of behavioral norms created by leadership behavior and expectations that gives members the freedom to voice and accept dissent and the assurance that they can endure times of turbulence within the group process.

In one office, the newest team member stated, "This is a great office, no drama. We don't talk about each other. We are all open with each other." During the interviews I asked the newer members if they had previously worked in other dental offices. Many of them talked about leaving offices because of the "drama" created a result of autocratic decision-making and conflict management tactics that produced in-fighting among team members. For offices with open and non-threatening communication practices, the team members have the ability to express their concerns and feel that they will be listened to. One staff member stated,

> I think it is just really open. I think if there are any concerns anyone has, I think we are all very outspoken about it and he is very good to listen to any concerns we have, so we can all discuss it and come up with the best solution to everything.

Confrontation between team members can be as simple as:

> We all pretty much tell each other, you know, in the staff meetings, one girl has told another girl, "it really bothers me that you are late everyday." It was at the staff meeting. It was not ugly. No one got their feelings hurt. That is how it is.

This type of group communication facilitated relational openness and therefore a greater degree of interdependence and social closeness. Even a dentist who may be conflict avoidant can create a collaborative and confrontational atmosphere. This is accomplished by ensuring team members their concerns are valid and that the team is mutually responsible and accountable to one another. In some cases an office manager was able to facilitate open communication and issue resolution. As Bennis (1997) stated, one secret to great groups is a leader who, "intuitively understands the chemistry of the group and the dynamics of the work process. They encourage dissent and

diversity in the pursuit of a shared vision and understand the difference between healthy, creative dissent and self-serving obstructionism" (p.31).

Retrospective on the gaps in curriculum

As mentioned in the beginning of this chapter, the willingness of dentists to take part in this study was greater than expected. The possible reasons can be found in the dentists' answers to the final interview question which asked them what, if anything, would have been beneficial for them to have learned in dental school in terms of running a dental practice. When asked this question, the third dentist interviewed replied, "Yeah, they just threw us to the wolves." As seen in the literature review, there are not many opportunities for dental students to learn interpersonal communication or business skills, and no existing opportunities at present for them to learn about group or organizational leadership (Ratcliff, 2008). Themes present in the dentists' responses included learning: 1) interpersonal communication skills, 2) how to create "systems" or procedural manuals, 3) hiring, 4) business, and 5) "you just have to learn it the hard way."

Five dentists discussed learning skills that would help them with interpersonal relationships and group leadership. They discussed how development of interpersonal skills may have helped them be able to better clarify goals, motivate, and reduce staff conflict. Responses include:

> Dentist #1: Maybe personality profiling and understanding what makes people work and where they are coming from and why, why sometimes you clash with somebody else.
>
> Dentist #4: Well, part of it would be understanding that you would have to deal with other people, employees, needs, human needs, psychological needs, . . .We [dentists] are usually perfectionists. We are hard on ourselves and because of that we are hard on other people.
>
> Dentist #5: I wish that somebody would have taught me how to teach people from all walks of life and all personalities how to know what I want from them because there are many times over the years that people have told us [the dentists] that "I am not sure of what it is you want from me."

Dentist #7: They don't teach you working with people skills at all. Not much business either. But I think most people are smart enough to get somebody else to run their business, or run it themselves, or learn by trial and error and make mistakes. I do not know that you could take a course on it, but definitely teamwork and those type of things would be probably pretty good to have known.

Dentist #8: I used to feel the big lapse in dental school, and it still is a big lapse, is the kind of business side of things, giving us like a fast track MBA while at the same time we are doing the dental side. But at the same time I think it is a lot more kind of interpersonal communications, more to a sociology side where I am learning how to deal with a bunch of women that are not my wife. Like it is just kind of a sexist thing to say, but it really is the dental office. It is very rare to have another male in the dental office that is not another dentist.

While all of these responses take a different approach to the answer, they all focus on the need for social and group interpersonal skills and awareness. Some of the dentists also mention the lack of business skills taught in dental school, but made the distinction that interpersonal skills were (or are) a more salient issue for them. The eighth dentist brings up the fact that dental offices are female rich environments. While he was the only one to bring the issue up in response to this particular question, other dentists in the study made similar remarks regarding the "female factor."

The second theme was the need for learning to create and implement "systems," written forms of organizational communication. Two of the ten dentists felt it would have been beneficial to learn how to construct explicitly written documents concerning office policies and detailed job descriptions. They felt that more policies and procedural manuals would have aided in staff training and in the reduction of organizational ambiguity.

Dentist #4: But that training is very important, so having systems in place, including handbooks for employees, training manuals would be very important, because that helps take some of the load off of you to implement training so it is not so stressful when people leave, get fired, sick, or whatever. . . I wish I knew then to have all that stuff in place to start and then develop it as you go rather than wait until you hit a crisis stage and then have to dump all that on everybody. Dentists love predictability.

Dentist # 6: They don't teach you staff relations, business. You know, you breeze by it and that is about it. Oh I wish I had gotten out and had everything official. I would have

an office manual that describes every step. You would have everything written down, every procedure, group financial policies, everything written out so anytime you have someone new, they can study it and it is all here.

Although there are only these two examples concerning systems in response to this interview question, two other dentists and one office manager mentioned the need for better systems when asked the question (number six) about changes or improvement in current leadership or communication practices. Their responses, like those of the prior examples, supported the perception that more explicit policies would decrease training time and the occurrences of staff setbacks. The office manager stated,

> Too many times when people start to feel comfortable in an office, the handbook is disregarded and the policies and procedures are not followed through in the way they should be. People start cutting corners and doing little things here and there that do not follow procedure. I think that policy and procedure[s] could make that run smoother.

Business skills were not a predominant theme. As one dentist stated earlier and one below, most dentists hire someone that is capable of handling the business, financial, aspects of the organization. That often includes an office manager or separate front office personnel to handle insurance and bookkeeping. Related to skills needed to run a business, one dentist mentioned hiring and another dentist business principles as being beneficial to have learned in dental school.

> Dentist #3: I guess a lot of the problem is, is not really knowing who to hire. I think a lot times hiring people that are kind of similar to yourself and back then it was kind of as long as they were young and cute they could get a job. But now it is a situation that if they are stable. If they are stable at home and have really good family situations, and have maturity that is important.

> Dentist #9: What I wish I would have learned is more business principles. Because you were so focused as an undergrad on biology and chemistry, you get no business. My last accounting class was in high school. I can understand a debit and a credit, but anything beyond that is just…but that is why you hire someone who knows what they are doing.

Four dentists began their response with the disclaimer that interpersonal and group skills could not have been learned while in dental school. They felt that these skills cannot be taught outside of the dental office environment and that they are only learned experientially.

> Dentist #1: I don't know about that. Talk is that helps. But you really don't have a clue until you get into a mix of a bunch of people.

> Dentist #2: I don't know if until you were put in this pod that you would get the effect which you have now. And I think you have to have a couple years of help with handling staff to have an idea of what you don't know and what you need to learn.

> Dentist #9: Well, they tried to teach us some of that stuff and we didn't listen. We were too focused on passing that test. They tried to teach us some of these things, they'd have day seminars, and whatever. And you hear some of it, and you would be like, "umm, yeah, yeah, I don't get that." So they tell you these things, but you don't know until you get here. I have always learned just by the hard knocks.

> Dentist #10, husband: I just don't know that you could have learned a lot about leadership and communication; you just have to get out and do it.

This was confirmed by Howard Gamble, D.D.S., Fellow of the Academy of General Dentistry, who stated that "they don't know what they don't know" referring to senior dental students in regards to communication and leadership (personal communication, January 30, 2009). This confirms Hannah, Millichamp, Ayers' (2004) study that found a majority of dental students reported communication skills as unnecessary in a pre-study survey. Half of their subjects then took part in a short communications course which resulted in student feedback that "indicated they would prefer to have this type of course earlier in their training and continuing throughout subsequent years" and that they viewed communication skills as more important than prior to taking part in the course (p. 974).

Practical Implications

Many dental students do not feel that there is time, or the need, for a course on interpersonal communication. Once they begin to practice, many feel like the dentist in this study

who stated, "they [dental school] threw us to the wolves." All of the above themes reinforced Dr. Steve Ratcliff's (2008) and Nowjack-Raymer's (1995) statements about the current state of dental curriculum and the dentist's ability post-qualification to lead their team effectively. "There is very little leadership, management or personal growth training in dental schools and as a result we end up in roles for which most of us have little talent and ability, let alone skill sets" (S. Ratcliff, personal communication, March 28, 2008). Nowjack-Raymer (1995) concluded his study on dentists as part of larger multi-disciplinary teams by suggesting that greater attention to training dentists in the area of teamwork and collaboration must be "improved upon substantially" as many dentists "believe that their educational preparation for teamwork was less than ideal" (p.103).

Jupp's (2000) statement that it is the "lucky" dentist that enjoys working with his/her team, and that an overwhelming majority of dentists report staff-related issues as the number one stressor in their practice was confirmed by this study's earlier survey findings (p.647). Revisiting the pre-study survey results, the following were consistently listed as one of the top three out of ten possible factors that contribute to dentists personal stress levels: handling complaints or grievances, staff conflict, turnover/hiring, motivating employees, and personal leadership ability. Both the literature and personal communication confirmed that it is the "lack of leadership training of dental students [that] makes it hard for them to lead their teams, ensure a happy work environment, and deal with staff issues" (Stone, 2006, p.66).

A shift needs to occur in the dental curriculum to include more emphasis on training in interpersonal and team communication and leadership. The practical implications in regard to this area are two-fold. First, administrators of dental curriculum should be made aware of the long-ranging impact that this gap in training has on the relationship between a dentist's

leadership and communication competencies and his/her team culture as well as the level of success the private dental practice experiences. Courses should be more comprehensive than one day seminars or mini courses, and should be offered throughout the four years of formal dental school. The courses must also broaden their approach to include interpersonal communication beyond the dentist-patient relationship and that incorporate principles behind the leadership behaviors that have positive impacts on the real nature of the team. Secondly, a stronger focus needs to be placed in this area post-qualification. Currently, continuing education courses that deal with leadership and team effectiveness do so from a personal perspective, a retired dentist or hygienist or even a self-proclaimed consultant, more so than from a research perspective. Continuing education opportunities that are based upon more objective research findings and as Real and Poole (2003) suggested report group characteristics, structure, processes, and outcomes so that the impact of team dynamics. Practical applications of such would be a far improvement over operating from the long adopted "common sense" approach to leadership which, as witnessed in this study, is mostly determined by the personality of the dentist.

Theoretical Implications

In examining the ten offices in this study, the most significant findings were that the inclusion of staff in the decision-making process along with the facilitation of open communication and accepted methods of collaboration and confrontation as forms of conflict management are the two leadership and communication behaviors that create a real team culture. This finding is validated when one examines the three offices that had a leadership rating of 5, the highest score possible. All three of these offices were participative, collaborative or confrontational, and had open communication practices whether through formalized meetings or the implementation of an "open-access" environment.

The influence of leadership provides the organizational members a lens through which to view their personal identification with and interdependency to the group in which they are a part of, and to judge the events that impact its organizational environment. In Lockard's (2007) book, *The Exceptional Dental Practice*, he states that:

> Good leaders develop their own leadership style, consistent with their values and character. Sometimes they are inspiring and motivating, and other times they must make tough decisions about people and finances without fear of offending. Leaders need to know how and when to adapt their style to fit the situation (2007, p. 47).

Leaders do need to be able to adapt to situational conditions, but moving beyond Dr. Lockard's personal advice on dental leadership, this study has shown that there are certain leadership behaviors that prove to be beneficial in creating a positive team culture. Dental literature, both within scholarly and trade journals need to recognize the impact of this behavioral sciences gap and produce work that offers a more concrete understanding of the leadership process. The findings of this study are in line with Dr. Ratcliff illustrations of successful dental offices. In this quote, he describes a culture that conveys value and empowerment to the members of the team:

> I would be curious about the [communication] styles of the highly successful practice, whether the dentist provides an environment that encourages continuous learning, expresses employee value and recognition of skills, includes training in communication skills, and grants access to necessary resources. If you find teams which can answer these kinds of questions affirmatively, you have a winner of a leader. (personal communication, March 28, 2008).

Another implication of this study is that Donnellon's (1996) American model of team work is useful for other methods of team analysis. Theoretically, this model can be expanded upon to include different types of teams and can be applied to different linguistic analysis methods. Although her study observed live conversations occurring between team members, the principles of her model were transferable and could be applied to the language used in in-depth interviews. Adjustments to the model can be made in order to accommodate the type of team

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under examination. Her key dimensions of identity, interdependence, social distance and conflict

management tactics were applied to the ten dental offices, while the dimensions of power

differentiation and negotiation process were not.

The major change to her model was the inclusion of a scale for leadership in the form of

decision-making processes. Donnellon's analysis included the key dimension of power

differentiation, but this was evaluated in terms of the use of language in interpersonal

interactions of team members which could not be applied to the study at hand. The teams within

Donnellon's study were task or project oriented teams within a larger organization, and with the

top leadership positions external to the team under examination. The dental office teams in this

study required a power or leadership measurement that was indicative of the nature of the

organization. Realizing that the decision-making processes were a chief leadership behavior

provided the rationale to add this particular key dimension. The model worked well and has

helped to provide an illustrative understanding to the relationship between leadership and team

communication behaviors and resulting team cultures.

Limitations

The most significant limitation is that the interview method may have only provided a

partial view of the leadership and team behaviors and environment, rather than what might have

been provided through a more extensive method such as ethnography. The interview questions,

however, were designed to accumulate as much objective information about the current

leadership styles and behaviors, communication practices, and team culture as possible. Through

the analysis of transcripts, I believe that a wealth of team and cultural information was divulged.

It may have been beneficial to have had the ability to include dentists from all areas of

the United States, an even distribution of female to male dentists, and examine any

differentiations between sole or multiple proprietary practices. The study included dentists with practices in Georgia, Alabama, and Mississippi. While I do not believe that geographic location is any predictor of leadership knowledge or ability, and as established in the pre-study survey findings that included dentists from nation-wide dental schools, a wider array of practice locations outside of the southeast would have been more inclusive and negate any assumptions of geographic limitations on the study's findings. Many of the participating dentists in the current study graduated from dental schools located in the southeast: Medical College of Georgia, University of Tennessee, and the University of Alabama at Birmingham.

This study included seven male dentists and three female dentists. Findings did not show any direct relationships between the dentist's sex and their leadership style or the resulting nature the team in terms of identity, interdependence, social distance, or conflict management tactics. Though perhaps a larger study more inclusive of female dentists would have shown differences in leadership perspectives, styles, and behaviors. The some could be said for single dentist verses multiple dentist practices. While no major distinctions could be made between two, it seemed that the office with three dentists had a more difficult time in communicating with each other in a structured manner and then in communicating with the staff as relevant information. This, office number one, had the most references to the lack of communication and information sharing.

Future Research

Research in this area is limitless. There is such a great need for a better understanding of effective leadership and team communication within the private dental practice that both qualitative and quantitative methods could be employed to further this research topic. There are three distinct populations that future research could explore, dental schools and students, practicing dentists, and the dental associations' continuing education programs. Quantitatively,

surveys to larger state and national associations, such as the Academy of General Dentistry and the American Dental Association, could be constructed and distributed in order to seek specific knowledge as to these same research questions asked in this study.

Dental schools and their current students could be surveyed to explore their perspectives on the need for communication and leadership training. Expanding on previous studies, experimental research could be conducted involving classes of dental students, some who are exposed to a course teaching the leadership principles found to be beneficial in this study and control classes unexposed to such courses. Here, long-range research could examine and compare both groups of students post-qualification in the dental office environment.

Both the General Academy of Dentistry and the American Dental Association provide continuing education programs to dentists. A simple content analysis of offered C. E. programs could be conducted to discover the types of courses offered in the area of leadership and communication. A distinction would have to be realized that C.E. courses on practice management do not address leadership and team communication issues. While this area seems to be largely underrepresented in C.E. courses, no formal count or categorization of courses nationally has been conducted.

Final Note

This study was one of discovery and exploration into an area of organizational communication that had not been systematically researched previously. It's findings confirm that there is a lack of communication and team leadership training in the dental curriculum and that dentists operate from a "common sense" approach that is largely constructed by personality dispositions. This research has enabled recommendations to be made for certain leadership and team communication practices which lead to the increasing real nature of a team. As Donnellon

noted, a real team produces teamwork rather than the nominal nature of team work. These recommendations, if taught, can have long-reaching implications for the health of a private dental practice in terms of the dental practitioners' level of frustration and stress with staff relations, turn-over, and the overall effectiveness of the dental team which ultimately affects the patient's perception of the level of care provided.

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Communication Competence enables a leader to "translate her or his relevant knowledge, skills, and situationally appropriate behavior to group members (and patients) in ways they can understand and trust" (Harris and Sherblom, 2008, p.261).

1)   Did you attend any courses while in medical school that focused on communication skills?
            Yes   No

2) Have you attended any courses on how to be an effective organizational leader?
            Yes   No

3) How familiar are you to the concept of communication competence?

Not at all _____ _____ _____ _____ _____ Very Familiar
                (5)   (4)   (3)   (2)   (1)

4) How satisfied are you with your current staff situation?

Not at all _____ _____ _____ _____ _____ Very Satisfied
                (5)   (4)   (3)   (2)   (1)

5) Overall, how satisfied do you perceive your patients to be?

Not at all _____ _____ _____ _____ _____ Very Satisfied
                (5)   (4)   (3)   (2)   (1)

6) Rank the areas you stress as being important to your staff?
 (1─ Most important factor to 8 ─ Least important factor)

_____ Technical Skills
_____   Continuing Education
_____ Sense of Unity / Mission (in the practice)
_____   Appearance
_____   Personality / Social-Communication Skills
_____ Sense of Humor
_____ Selling course of action to patients
_____ Collections / Finances of Office

7) Rank the importance of the following factors in staff recruitment.
 (1─ Most important factor to 8 ─ Least important factor)

_____ Technical Skills
_____   Previous Dental Experience
_____   Level of Education
_____ Salary Expectations
_____   Appearance
_____   Personality / Social-Communication Skills
_____ Sense of Humor
_____ Ability to fit in with current staff

8) Rank the following factors in terms of contributing to your stress level.
  (1 ─ Most stressful to 10─ Least stressful).

_____ Time constraints (running behind schedule)
_____ High expectations of self
_____ Anxious (fearful) patients
_____ Handling complaints or grievances (with staff and/or patients)
_____ Staff conflict
_____ Fear of failure
_____ Motivating employees
_____ Turnover / Hiring
_____ Persuading / selling course of action to patients
_____ Personal leadership ability

Dental School _____

Years in Practice _____

Type of dentistry practiced _____

Would you be willing to receive a communication assessment and consultation of your practice free of charge and at your convenience? Yes   No

If "Yes" please provide your contact information on the sign-up sheet at the back of the room.