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Case Studies for The Four Vital **Team Conditions**

While businesses often require people to work in teams, the team approach often fails. In this issue we will provide actual case studies of teams that performed poorly.

The Viridiant Business Newletter (Vol. 1, No. 2) introduced the "**Four Vital Team Conditions**" required for teams to achieve optimal performance. The "Four Vital Team Conditions" are:

1. **Competence,** including knowledge of the job, is required at all levels of the team.
2. **Communication** must be excellent within, and among, all members of the team.
3. **Checks and Balances** must be in place from the beginning through the end of the project.
4. The team must **practice** together.

This issue will provide actual case studies of teams that performed poorly. The next issue will discuss what went wrong, and how such problems can be prevented in the future.

Case Study: The Law Firm

An individual e-mails to a patent attorney a document describing a new technology. The attorney, a senior partner in the firm, tells a junior associate to put the description into the form of a patent. Two weeks later the associate tells the client the patent is ready to be filed. After reviewing the application, the client is satisfied, and the patent is filed.

One year later the patent office rejects the patent on grounds that there already exists prior art in this area. The associate suggests "argument A" should be made to the patent examiner so she will understand why the new technology is in fact new. The client, who knows the technology intimately, feels that "argument B" would be a better argument and says so. This discussion goes back and forth until the client says, " I would like you to discuss this with the senior law partner." The associate calls back the next day and says the senior partner agreed they should proceed with argument A. Another year passes and the patent office rejects the patent again.

The senior partner and the client fly to Washington to make their case in person. After reviewing the file, the senior partner asks, "Why are you arguing A, you should be arguing B?" The client is dumfounded and says, "That is what I said to your associate last year, but he said he discussed it with you and you felt we should proceed with argument A."

The senior partner and the client, in agreement that argument B is the way to proceed, meet with the patent examiner and explain argument B. The examiner agrees to argument B in thirteen minutes. The patent subsequently issues.

Study Questions:

1. What went wrong in this "Team" that consisted of a senior law partner, a junior associate at the law firm, and the client?
2. What could have been done to prevent these problems?

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"Communication focus groups can be used to improve communication among team members."

3. Which of the "**Four Vital Team Conditions**" were violated?
4. What could be done to prevent such problems in the future?

Case Study: The Hospital

An individual is hospitalized with a serious illness. A nurse discovers the patient is not responsive and calls a "Code," hospital terminology to call a rapid response team to assist a patient who is not breathing and/or has no pulse.

The "Code Team" rapidly arrives. They place a plastic tube in the patient's windpipe to deliver oxygen. They compress his chest to simulate pumping of his heart. They administer drugs to stimulate his heart to beat. In all the excitement someone yells, "Who is this patient?" Someone responds that they will get the patient's chart. The patient begins to respond. His heart begins to beat. The chart is brought from the nursing station. A resident looks through the chart and announces that the patient is a "No Code."

"No Code" is hospital terminology for a patient who should not be resuscitated. Simply put, if a patient is found without a pulse, no effort should be made to revive the patient. This reflects the desire of some patients to let nature take its course. They do not wish to be hooked up to machines. The decision to be a "No Code" is made in conversation with the patient's physician. Once the patient or legal guardian has expressed this desire, it is actually assault—not malpractice—but a criminal offense to resuscitate the patient. That is why when the resident announced the patient was a "No Code," the Code Team slowly walked away from the patient.

With time the patient's heart rate slowed again. Meanwhile, back at the nursing station the patient's nurse was quite upset. She said she was surprised to learn the patient was designated a "No Code." The nurse from the earlier shift who gave her report did not say so. Why did she not speak up? She was a bit timid and the resident who announced the patient was a "No Code" was a brusque know-it-all.

The story ends sadly. The chart that was brought to the bedside belonged to another patient. When the error was recognized another Code was called and the Code Team once again attempted to resuscitate the patient, this time in vain, and the patient died.

Study Questions:

1. What went wrong in this "Team" that consisted of doctors, nurses, a respiratory therapist, a pharmacist and a ward clerk?
2. What could have been done to prevent these problems?
3. Which of the "**Four Vital Team Conditions**" were violated?
4. What could be done to prevent such problems in the future?

The next issue of the newsletter analyzes what went wrong with these teams.

Viridiant is a consulting firm with particular expertise in innovation, strategy, change management, biotechnology, education and healthcare.

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