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Dealing With Dysfunctional Tutorial Groups

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Background: *The popularization of problem-based learning has introduced management of small groups as a critical skill for medical faculty. Some faculty have found themselves in dysfunctional groups without the skills necessary to correct the learning climate.*
Purpose: *This study was conducted to generate strategies faculty can use to deal with difficult tutorial groups.*
Methods: *Twenty-three experienced tutors were arranged into 5 groups, then rotated through 5 training stations. Each station consisted of 5 students trained to behave according to a dysfunctional scenario. Tutor groups assessed the problem of each station group, planned an intervention, and intervened via one of the group's tutors.*
Results: *Assessments of the difficulties in each group varied according to the particular station group scenario being observed. Interventions were tailored to the specific assessments tending from less invasive (i.e., asking questions while the case is being discussed to influence the direction of discussion) to more invasive (e.g., stopping discussion and invoking ground rules) to address the identified problems.*
Conclusions: *We concluded that (1) establishing ground rules is important to the successful development of groups, (2) tutors and groups should deal with conflict directly as it arises, and (3) tutors should intervene strategically to foster positive group development. A model for strategic intervention is offered.*

What do you do when you realize the group of medical students you are tutoring in the problem-based learning (PBL) curriculm is dysfunctional—that it is "scapegoating a student," or refuses to address learning issues important to the case because "those issues aren't important in preparing for Boards." The popularization of PBL has introduced management of small groups as a critical skill for medical faculty. Social scientists have long known the impact of the small group on individuals and have even applied small-group techniques as a therapeutic tool for individuals. Few medical faculty, however, have been trained to manage small-group dynamics to benefit learning. Some faculty have even found themselves in small groups that actually harm individuals and the learning climate. When such situations occur, they are particularly difficult for students and teachers. Faculty must be trained to deal with dysfunctional groups if we are to avoid these outcomes.

Thus, the focus of this article is to better understand the ways in which faculty (tutors) can intervene in difficult tutorial situations. We began our search for such an understanding by reviewing the literature on dysfunctional groups. The search terms, "dysfunctional," "difficult," "problem," "groups," and "PBL," were used individually and in combinations to search Medline, ERIC, Psychlit, SocioFile, Business Index, and the University library holdings. Four conclusions were reached from this search.

The first conclusion was that no research of dysfunctional PBL groups has appeared in the literature. We were disappointed at not being able to locate any literature explaining either the occurrence or amelioration of dysfunctional groups in PBL. We had observed several difficult groups in our school, since implementing PBL in 1989, and felt reasonably sure that other schools would have had experiences similar to ours. Given the dearth of medical education literature on dealing with difficult groups, conclusions were drawn from studies and theory-based articles and chapters in other fields, most emanating from business and psychotherapy literature bases.

The second conclusion was that conflict is inevitable as groups grow through normal developmental stages. Through the years, theorists have proposed that groups grow through developmental stages as they mature. As early as 1965 Tuckman,[1] having reviewed 55 studies,

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proposed that groups developed through defined stages. Although theorists seem to propose slightly different titles and descriptions for the stages, many similarities exist between the theories. Among these is that groups experience conflict from time to time and it is by working through this conflict that a group matures.[2-6] Our experience has been that many novice tutors believe that when their tutorial runs smoothly (without conflict) it is functional, and that when it has conflict it is dysfunctional; this notion is not supported in the growth-through-stages literature.

The third conclusion was that dysfunctional groups are those that get "stuck" in conflict stages. Keyton (1991)[7] concluded from her study that groups that become dysfunctional do so because they are unable to work through the conflict experienced as a normal course of development; they get stuck in conflict. When such a situation occurs, according to Keyton, the group takes on a particular dynamic or interaction pattern consisting of (a) an individual (primary provoker) in the group (may be the leader or tutor) being blamed as the source of all the group's problem, (b) group members perceiving that the only solution is to "fix" the aberrant member, and (c) group members beginning to express negative emotions about the group and the primary provoker to others outside the group; they just "want out" of the group and "can't wait till the group is over."

The last conclusion reached was that proactive interventions to prevent groups from becoming dysfunctional work best. When groups reach the stage of dysfunction described previously, it is difficult or impossible to get them to function normally again. According to the approach proposed by Friedman[8] called "Upstream Facilitation", one should therefore focus on proactive interventions to keep groups from reaching a dysfunctional status. Two of the strategies proposed seem particularly relevant for PBL tutorial groups: (1) establishing group norms and (2) managing the breakpoints in the group's development.

Setting group norms early in a group's life paves the way for smoother development. A group's beginning is a key moment in its life. Members are eager to orient themselves to a new situation and are open to any direction that will reduce uncertainty. Patterns are set in motion early that continue throughout the life of a group. In this critical time of emerging patterns, Friedman suggests two important interventions to steer the group in positive directions. First, the facilitator (tutor in our case) should make explicit his or her role in the group. Second, group norms (ground rules) should be elicited from group members. Friedman suggests a conscious process of setting group norms developed by Spich and Keleman[9] as a way to prevent later confusion. Group members review 62 behaviors that have been validated as distinguishing between effective and ineffective groups (e.g., do a fair share of work) and are encouraged to pick and choose from the list to identify a subset of the rules, which are relevant to their group.

Friedman's[8] second proposed strategy is called "managing the breakpoints of a groups development." Citing research by Poole,[10] Friedman describes groups as evolving through developmental transitions, called breakpoints. Managing these breakpoints involves the facilitator's use of one of three types of interventions appropriately.

"Forward Interventions" are most appropriate when normal breakpoints occur (i.e., shifts in topic or stage of problem solution). At such points, when the group is making normal progress, the facilitator might say nothing and wait for the group members to move on to the next step, or might summarize what has occurred and offer a suggestion, leading the group toward the next stage of problem solving. When a group reaches a delay breakpoint, (e.g., students cannot synthesize the symptoms of a patient into a coherent understanding of his condition), it is often useful for the facilitator to focus the group's attention on a previous stage of the problem-solving process (e.g., ask the group to make a list of symptoms they would expect to see if each of their hypotheses were correct). Such interventions are termed "backward interventions." "Present-centered interventions" are appropriate when a disruption breakpoint, such as a conflict or impasse, occurs in a group. At such breakpoints, a facilitator should stop the group and focus attention on the here and now in the group (e.g., "let's talk about what is going on this group") until members understand what has occurred, what needs to be done, and progress seems assured.

Armed with the previous information about group functioning but unsure of whether or how it applied to PBL tutorial groups, we launched a study of dysfunctional tutorial groups in our school. The purpose of the study was to generate strategies faculty can use to assess and intervene in difficult tutorial groups. A workshop was organized for our experienced tutors to accomplish this purpose. Our strategies were to (1) teach participants the approaches from the literature previously reviewed, (2) give them opportunities to assess and intervene in typical difficult tutorial scenarios observed in our school, (3) gather feedback from participants on the usefulness of ideas from the literature, and (4) generate further ideas from the experience.

Methods

Faculty experienced as tutors in the PBL curriculum at our school were invited to attend a 1-day advanced tutor-training workshop entitled "Dealing with Dysfunctional Tutorial Groups." Eligibility for attendance at the workshop required faculty to have been trained as tutors via our required tutor training sequence and have tutored at least one group of medical students through one of our curricular units (about 13 weeks).

The 23 faculty registered as participants included 13 clinicians (3 psychiatrists, 4 pediatricians, 2 surgeons, 3 internists, 1 family physician); 6 basic scientists (1 biochemist, 2 anatomists, 2 physiologists, 1 pharmocologist); and 4 with other backgrounds (2 medical technologists, 1 Master of Public Health, 1 Doctor of Education).

The workshop opened with a presentation of the findings from the literature reviewed previously in this article. Participants were then randomly teamed into five groups (three groups of five and two groups of four), and assigned a trainer who remained with them the rest of the day and coordinated their educational experience. Groups of trainees rotated through each of five stations (1 hr each) where students portrayed a difficult tutorial situation taken from a real experience in our school. In each session participants had an opportunity to assess the problem the tutorial group was experiencing, plan an intervention to correct the problem, implement the intervention in the tutorial, and then receive feedback from trainers and students.

Upon entering a station, trainees were given a paragraph describing the tutorial group they were about to observe but the problem to be portrayed was not identified. Each station consisted of five 2nd-year students who had been trained to portray a specific difficult tutorial scenario by a "station manager" who was also a member of our faculty. The station manager served as the tutor as the group portrayed the difficult tutorial situation. When the students had acted out enough of the scenario to display the problem (up to 15 min), the station manager called time out and dismissed the students from the room. The group trainer then led a discussion with the trainees to identify the problem the group was having and to plan an intervention to correct the problem; one trainee was selected to implement the group's intervention when the students returned. Students were then called back into session where the selected trainee served as tutor and tried the intervention planned by the group of trainees. After a short time, the session was halted and a debriefing was held in which students, trainers, and trainees reflected on the experience and the perceived success of the interventions.

The five station scenarios used in the workshop were constructed from actual tutorial experiences at our school observed by the authors. Both authors have ongoing responsibility to observe tutorial groups as part of the faculty development contract we have with faculty at our school. We met and selected the five most typical situations from our collective observation experiences over the previous year. No attempt was made to select student-induced versus tutor-induced problem group situations. In a dynamic small group such as a tutorial, it is difficult and perhaps not important to reliably identify the origin of the problem or who is the cause. The important issue to consider is how tutors can intervene to prevent or correct the problem.

Station 1 consisted of a tutorial group one might characterize as "apathetic." Students were focused on preparing for upcoming Board exams; they were not adequately prepared for tutorials and discussed cases in shallow fashion. Students in Station 2 tutorial focused strictly on the biological aspects of the patient's disease; they resisted dealing with other issues (i.e., psychosocial) important to our curriculum. Station 3 had a dysfunctional member who was frequently absent from tutorials and came late and unprepared to others. The dilemma in Station 4 involved one student becoming a scapegoat; she had developed a reputation as "a student you do not want in your tutorial group", which had been carried into this tutorial by members who ostracized her and reacted incredulously to her comments. The group in Station 5 had a student who divulged case solutions prematurely to her tutorial group, spoiling the learning opportunities for other students; the tutor's confrontation with her caused a crisis in the group.

Station managers served as the recorders for this project. Using a standard protocol constructed by the authors of this study, station managers recorded the various ways tutors assessed the problems portrayed in their station and the interventions tried. Following the workshop, the authors summarized the various assessments and interventions. From this summary a model, which seemed to explain the trends of interventions across the groups, was constructed using logical analysis.

Results

A summary of the problems identified and interventions attempted follows.*

Problems identified in Station 1 (apathetic group) included an inadequate learning procedure (e.g., no use of chalk or white-board, no thinking aloud, not discussing case); a cynicism about the PBL process (e.g., does not prepare students adequately for Boards); and a belief that individuals study and learn best alone. To correct these problems, tutors and participants referred to the ground rules set at the beginning of the group and reminded students that certain tutorial processes (i.e., use of the board, thinking aloud) are nonnegotiable; directly addressed the anxiety of the group over preparation for the Board exams by explaining that students in the past who had prepared well for PBL cases had done well on the Boards; and challenged the notion that individuals learn best alone.

Participants rotating through Station 2 noted that the group focused exclusively on the biological issues of the case and avoided the psychosocial impact of disease on the patient and his family. This problem seemed to

*A complete compilation of these problems and interventions is available from the authors upon request.

stem from a basic rationalization by students that behavioral issues are ambiguous, and that the literature is confusing, difficult to find, and contains conflicting opinions. To address these problems, participants stopped the student discussion of the case to encourage consideration of other perspectives (e.g., impact on the family), personalize the case to students through role play of the physician and patient, and illustrate the bias of the discussion by labeling the various learning issues considered by students.

Problems noted in Station 3 were that Paul, the dysfunctional student, was not "pulling his weight" in the group and that had caused a crisis; other students had become angry and dissatisfied with the group. Participants also noted that the tutor had let the problem go on too long without confrontation, which may have contributed to a continuance of the problem. To correct the problems in the group, participants suggested that the tutor (a) review, reiterate, and redefine the ground rules of the group in writing before continuing the tutorial; (b) have the group confront the problem with the student by engaging students in brainstorming solutions to Paul's professed reasons for absenteeism (i.e., no transportation, had to take a bus); (c) involve an outside mediator in solving the group's problem; (d) refer Paul to others in the school (i.e., Unit Chair, advisor, therapist) for counseling; and (e) encourage students to share learning issues and not depend on Paul for contributions to the group.

In the Station 4 tutorial group, which scapegoated one of its members, participants noted the problems of a passive tutor who had allowed a student to be ignored, and the student's reputation, which had interfered with her acceptance in the group. They also identified the problem as one where both parties (the group and the student) were responsible. The group had isolated the student both verbally and physically (i.e., ignoring her comments, talking away from her to the board). The student had contributed to the problem by being too quiet, disengaged, and making inappropriate comments. Participants attempted to correct the problem by trying to involve the student in the tutorial (i.e., get her to be scribe, invite her into discussion, ask her to read the problem). When that strategy failed, they stopped the tutorial process and confronted the problem directly. They first focused on setting appropriate ground rules for the group (e.g., everyone participates in discussion, all items suggested go on the board, everyone is treated with respect). They then engaged the group in suggesting ways to improve the student's participation (e.g., talk early in the tutorial, do not wait till the most plausible hypotheses have been exhausted).

Participants assessing Station 5 (group with member that divulges diagnoses prematurely), noted that the group was confused over the difference between PBL and traditional problem-solving, was seeking solutions rather than attempting to understand basic mechanisms, had violated the important nonnegotiable ground rule that groups cannot skip steps in the tutorial process, and had denied that a problem existed. These problems stemmed from a dominant student in the group who was frustrated with the slowness of the PBL process and was able to get others to support her shortcut. A variety of strategies were employed to address the problem: (1) review of the purpose and process of PBL with the group; (2) development of explicit ground rules to refer to when the group goes awry; (3) exploration of the rationale for keeping one's options open and considering multiple hypotheses (e.g., comparing it to a physician's clinical decision-making process); (4) getting members to jot down their own hypotheses on paper and then asking for contributions from each; 5) exploring options for how the group can use the member to their advantage; and 6) asking the student to not divulge the diagnosis early.

Conclusions

Several conclusions emerged during the debriefing session with participants at the end of our workshop. The focus of this session was to assess the usefulness of ideas from the literature and generate further ideas from the workshop experience. A proposed intervention model was also constructed by the authors after the workshop. The conclusions reached and the model proposed follow.

Developing Ground Rules Is Important to the Successful Development of Tutorial Groups

A common mistake made by many tutors and new groups is assuming they share a common understanding of the purpose and appropriate process of tutorials. They often discover this lack of agreement only after the group reaches a crisis. Setting ground rules through some deliberate process early in the group's existence, as suggested by Spich and Keleman (1985),[9] serves two important functions. First, ground rules can prevent crises from occurring in the group by establishing common expectations. Second, if and when the group reaches a crisis point, established ground rules can serve as an important reference for the group and tutor to diagnose the problem and decide how to proceed.

Although our faculty agreed on the importance of group participation in the establishment of ground rules for tutorials, they asserted that there are several rules for PBL tutorials that should be nonnegotiable, and that tutors should be explicit in explaining these to students as a new tutorial group is being formed. The purpose of these nonnegotiable ground rules as seen by the faculty is to establish the group as a true PBL learning group. They include the following:

1. Attendance and punctuality are mandatory.
2. Groups must use the chalk or white-board as they study a case.
3. All students in the group must think aloud to allow others to benefit from their reasoning process.
4. Groups cannot skip steps in the deliberation of cases—they must use all the steps (i.e., identification of problems in case, hypothesizing, listing other information needed to confirm hypotheses, identifying learning issues).
5. Groups must evaluate their process as a group and as individuals on a regular basis (e.g., at the close of each tutorial).
6. Groups must study illness as well as disease.

Tutors and Groups Should Deal With Conflict Directly As It Arises in the Group

It is common for tutors to want to avoid dealing with conflict, to assume that if they do not attend to the conflict, it will resolve itself. It is also a common misconception among tutors that groups that run smoothly (without conflict) are functional, wheras groups that have conflict are dysfunctional. Both phenomena influence tutors and groups to avoid confronting conflict when it arises in the group. Our experience as well as the literature on group functioning argue for the opposite strategy. Avoiding conflict in groups runs the risk that the group will become dysfunctional,

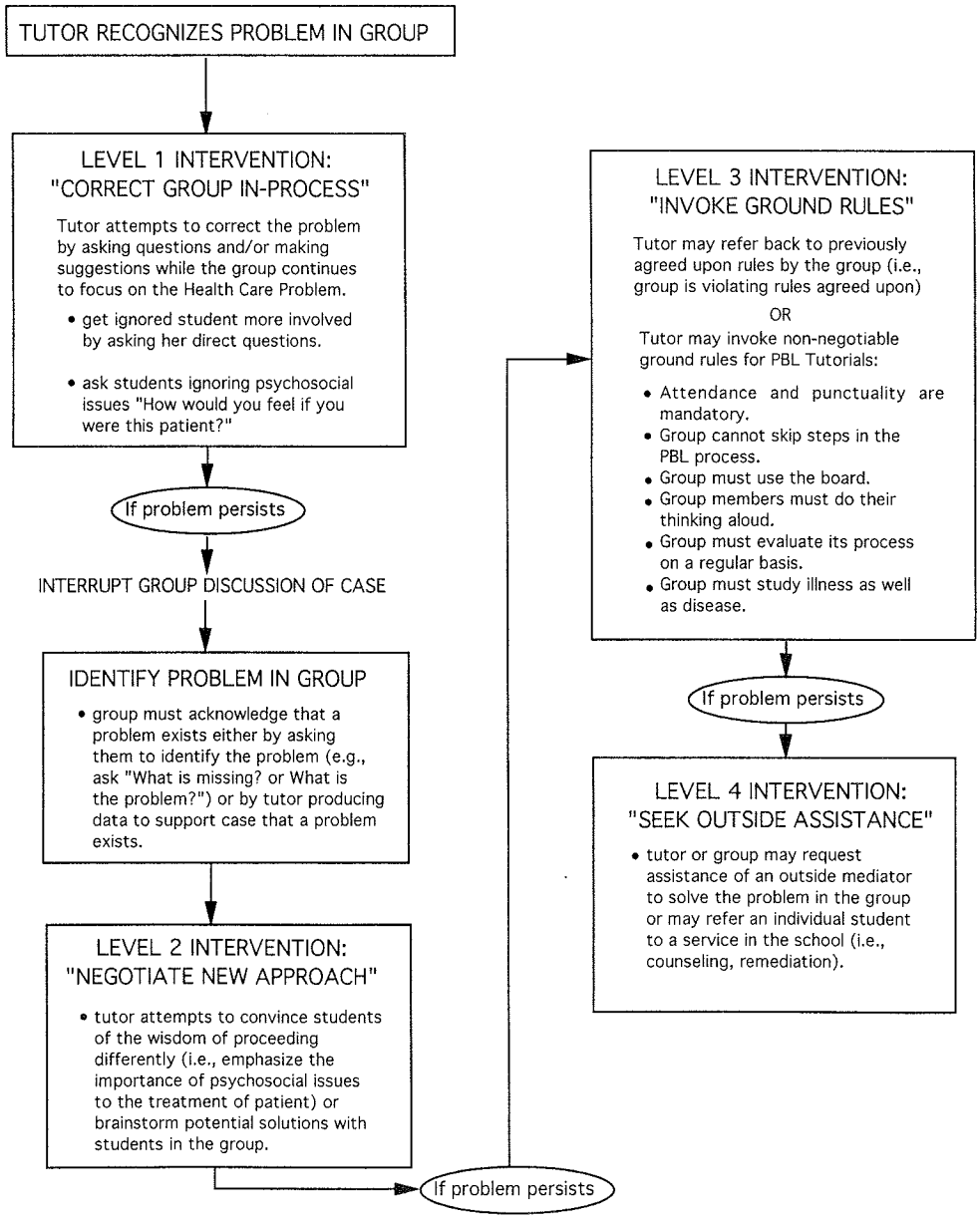

Figure 1. *Dysfunctional tutorial groups intervention model.*

whereas dealing with it directly as it comes up offers the opportunity for growth to greater maturity and satisfaction by the group.

Tutors Need to Intervene Strategically to Foster Positive Development in a Group

The Intervention Model outlined in Figure 1 represents our ideas, based on the experience of this study and workshop, of the strategies tutors should use to intervene in groups that are at risk of becoming dysfunctional. The model is based on a progression of interventions, each level being more intrusive, to address problems identified by the tutor. Level 1 interventions represent attempts by the tutor to correct identified problems while the group is in the process of discussing a case. Examples include asking a disengaged student questions to get her more involved, requesting students to identify information necessary to confirm or reject their hypotheses, and correcting a group trying to jump from listing hypotheses to identification of learning issues. If the problem persists, we suggest a Level 2 intervention in which a tutor interrupts the group's discussion of the case, identifies the problem, and negotiates a new approach with the group. Level 3 interventions involve the tutor invoking ground rules to correct a problem identified in the group—this intervention is more effective if the group previously set explicit ground rules. We acknowledge that the problems in some tutorial groups exceed an individual tutor's and group's ability to solve the problem themselves; in such cases, it would be helpful to have resource people in the school (trained in group process and PBL) to call on for consultation (a Level 4 intervention).

References

1. Tuckman BW. Developmental sequence in small groups. *Psychological Bulletin* 1965;63:384–99.
2. Napier RW, Gershenfeld MK. *Groups: Theory and experience*. Boston: Houghton Mifflin, 1973.
3. Johnson DW, Johnson FP. *Joining together: Group theory and group skills* (5th ed.). Boston: Allyn and Bacon, 1994.
4. Tuckman BW, Jensen MC. Stages of small group development revisited. *Group and Organization Studies* 1977;2:419–25.
5. Worshel S, Coutant-Sassic D, Grossman M. A developmental approach to group dynamics: A model and illustrative research. In S Worshel, W Wood, J Simpson (Eds.), *Group process and productivity* (pp.181–202). Newbury Park, CA: Sage, 1992.
6. Smith KK, Berg DB. *Paradoxes of group life: Understanding conflict, paralysis, and movement in group dynamics*. San Francisco: Jossey-Bass, 1987.
7. Keyton, J. *Who's annoying who? Problems in organizational groups*. Paper presented at the Annual Meeting of the Southern States Communication Association, Tampa, FL, April 1991. (ERIC, ED 332 244)
8. Friedman, PG. Upstream facilitation: A proactive approach to managing problem-solving groups. *Management Communication Quarterly* 1989;3:33–50.
9. Spich RS, Keleman K. Explicit norm structuring process: A strategy for increasing task–group effectiveness. *Group and Organization Studies* 1985;10:37–59.
10. Poole MS. Decision development in small groups III: A multiple-sequence model of group decision development. *Communication Monographs* 1983;50:321–41.

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