

INVESTIGATING BARRIERS TO COLLABORATION IN ISLAND HEALTH'S MENTAL HEALTH AND SUBSTANCE USE SERVICES

**Anna Baker, MADR Candidate
School of Public Administration
University of Victoria
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Client: Monica Flexhaug
Project Manager, Island Health Mental Health and Substance Use

Supervisor: Dr. Rebecca Warburton
School of Public Administration, University of Victoria

Second Reader: Dr. Astrid Perez-Pinan
School of Public Administration, University of Victoria

Chair: Dr. Tara Ney
School of Public Administration, University of Victoria

EXECUTIVE SUMMARY

Island Health’s Mental Health and Substance Use (MHSU) provides a range of services for adults with serious mental illness and/or substance use, within the context of a wider support network in the Greater Victoria Area (Island Health, 2015). This project has been prepared for the South Island Review Leadership Council, a multidisciplinary council mandated to provide strategic oversight and direction for the South Island Review (“the Review”), a system-wide quality improvement project.

The South Island Review was initiated in 2015, in response to directives from the Ministry of Health, as well as stakeholder and service feedback that the MHSU system of care was inaccessible, complex, and not client-centred. It is an ongoing long-term initiative, estimated to span approximately 10 years. Despite targeted and ongoing efforts to engage physicians throughout the Review process, there has been both formal and informal communication from physicians expressing a lack of trust and confidence in administrative management, the perception of a lack of meaningful efforts by administration to engage physicians, and limited consideration for physicians’ concerns and opinions in various planning processes in the Review.

The objective of this project is to analyze and recommend solutions to the current problematic organizational culture within Island Health’s MHSU, which is preventing the implementation of quality improvement recommendations resulting from the Review. It seeks to identify current barriers to collaboration and produce tangible next steps to not only address the tensions and distrust of the current physician-administrative relationship, but to also facilitate commitment from administration and physicians to work more effectively and collaboratively in implementing future quality improvement initiatives within the Review and more broadly in the MHSU system. This project is grounded in the following questions.

Primary Research Questions:

- How can administrators and physicians work collaboratively during the Review and future initiatives?
- What specific structures and processes can be implemented to improve collaboration within the organizational context of MHSU?

Secondary Research Questions:

- How deeply rooted and pervasive is the current conflictive culture?
- How has collaboration been defined and operationalized within the organization in the past?

Methodology

This project used a mixed methods approach, employing a survey and semi-structured interviews. The survey was conducted among Department of Psychiatry physicians (17) and MHSU management and coordinators (13), to gain the perceptions, experiences, and perspectives of staff regarding key areas such as collaboration, engagement, and communication. The semi-structured interviews were conducted in person with four MHSU administrative leaders and one Department of Psychiatry physician. Interview questions were focused on physician and administrative perspectives regarding the historical and current nature of MHSU organizational culture and physician-administration relations.

Findings

Survey and interview data indicate that the current problematic relationship is both deeply rooted and pervasive, with implications for the broader organizational culture. Although there is variation regarding

the impact of the relationship on personal wellbeing and staff turnover, it does negatively impact general staff satisfaction.

Current definitions of collaboration and engagement are relatively consistent between physicians and administrators, and across different levels of leadership. Collaboration was defined as a partnership working towards a shared goal or purpose, with shared benefit. Engagement was defined in terms of a commitment to a collaborative process and an active interest and willingness to work towards change. Data presented inconsistencies in how effectively it has been operationalized.

Data analysis resulted in four key themes for improving administrative and physician collaboration:

- Improvements to the relationship
- Communication
- Recognition and navigation of different professional cultures
- Clarity of Roles and Responsibilities

Recommendations

These recommendations, directed to the MHSU Leadership Council, are intended to improve the relationship and communication through meaningful dialogue, opportunities to build personal relationships, and a behavioural accountability framework. They should also help bridge differences in professional cultures, clarify roles and responsibilities, and facilitate commitment from both administration and physicians to work more effectively and collaboratively in future quality improvement initiatives. They consider physician time limits as well as the physician fee-for-service pay structure, which pays more for clinical work than for quality improvement work.

1. Offer facilitated dialogue session with physicians and key MHSU staff at the service level to address assumptions, professional cultures, and areas of distrust.
2. With the use of a facilitator, establish a working group to build a Behavioural Accountability Framework to hold all MHSU staff and physicians accountable to a common standard of behaviour.
3. Encourage formal and informal opportunities for people to get to know each other beyond their role as administrator or physician to mitigate the perception of incompatible collective identities.
4. Apply for funding through the Supporting Facility Engagement Initiative, and invest this funding in activities which will contribute to more sustained improvements to the relationship itself, such as dialogue sessions or physician participation in relevant working groups.
5. Offer in-person joint training opportunities for change management, leadership, and dispute resolution.
6. Explicitly acknowledge and celebrate successful collaboration and engagement within MHSU.
7. Propose a time-limited working group of physicians and MHSU staff to the Department of Psychiatry to address methods of communication between the MHSU Leadership Council and the Department as collective bodies.
8. Utilize physician leadership and the co-leadership structure to explore preferred physician engagement strategies at the individual service level.
9. Encourage informal physician leadership opportunities at multiple levels of the organization; identify champions and diffuse authority and accountability in order to bridge the cultural gap and be more responsive to physician needs.
10. Offer leadership and development training to all physicians.
11. Following recommendations 1,2 and 3, develop an Administrative-Physician compact to explicitly articulate the relationship and explicate reciprocal expectations and responsibilities.

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1 INTRODUCTION

1.1 Project Client and General Problem

Island Health's Mental Health and Substance Use (MHSU) provides a range of services for adults with serious mental illness and/or substance use, within the context of a wider support network in the Greater Victoria Area (Island Health, 2015). This proposal is prepared for the South Island Review Leadership Council, a multidisciplinary council mandated to provide strategic oversight and direction for the South Island Review ("the Review"), a system-wide quality improvement project.

Provincially the demand for mental health and substance use services continues to rise, as does the acuity of clients seen in the South Island MHSU system (Island Health MHSU, 2015). Despite a steadily increasing budget over the last nine fiscal years, the experience of services users has not improved. Instead, service users and families have continued to express frustration with the system, noting the inaccessibility and complexity of services and system transitions.

The BC Ministry of Health has prioritized mental health and substance use as an area of improvement, with concern regarding the capacity of the health system to effectively meet the needs of individuals with severe addictions and/or mental health illnesses (Ministry of Health, 2014). In response to these realities, as well as external reviews of South Island MHSU services and previous stakeholder consultations, Island Health has undertaken a system wide review of the entirety of current South Island MHSU services. This review has the objective of implementing large-scale change in the organization and its operations.

1.2 Research Question and Project Objectives

The objective of this project is to analyze and recommend solutions to the current problematic organizational culture within Island Health's MHSU, which is preventing the implementation of quality improvement recommendations resulting from the Review. It seeks to identify current barriers to collaboration and produce tangible next steps to not only address the tensions and distrust of the current physician-administrative relationship, but to also facilitate commitment from administration and physicians to work more effectively and collaboratively in implementing quality improvement initiatives within the Review and more broadly in the MHSU system.

A survey and in person interviews with MHSU staff and physicians from the Department of Psychiatry was used to investigate and answer the following research questions:

Primary Research Questions:

- How can administrators and physicians work collaboratively during the Review and future initiatives?
- What specific structures and processes can be implemented to improve collaboration within the organizational context of MHSU?

Secondary Research Questions:

- How deeply rooted and pervasive is the current conflictive culture?
- How has collaboration been defined and operationalized within the organization in the past?

1.3 Rationale

The South Island Review processes have highlighted an historic cultural and relational rift between MHSU physicians and administration. This has led to a climate of distrust, disengagement, frustration, and tension. This rift not only negatively impacts the wellbeing of MHSU staff, but has also prevented the progression of work on many quality and system improvement projects, including the Review.

The cultural and relational rift is characterised by fundamental differences in perspectives regarding models of care, organizational and service priorities, staff autonomy, and locations of influence and control within the organization. These perspectives are largely grounded in differences in training, working styles, and culture, and often lead to incompatible perceptions of communication. The cultural differences are exacerbated by limited resources and rapid changes within the health care system, as well as staff consistently working at overcapacity. The rift has been exacerbated by historical conflicts and tension, and has led to stereotyping, collective action to subvert authority, continual disagreements, and disrespectful communication.

Physician participation is essential to successful clinical change practices, which occur through quality improvement initiatives and service user pathway processes throughout the MHSU system, both within and outside of the Review. Thus, recommendations made by the Review and broader system initiatives cannot progress without physician-administration collaboration. Further, the pervasiveness of distrust, miscommunication, and tension has created a residual impact on staff, noted by their disengagement, frustration, and feelings of hopelessness.

Island Health has been mandated by Ministry of Health policy directives to satisfy particular guidelines and requirements for models of care as a Mental Health and Substance Use service (Ministry of Health, 2016). Further, service users, families, service partners, and external reviewers have made recommendations for system improvement through extensive consultation and engagement initiatives. As the Review seeks to address Ministry policy directives and meet consultation recommendations, Island Health cannot meet its mandate without collaboration with physicians. Further, MHSU Executive has provided approval to move forward on recommendation actions, however they are contingent upon engagement with physicians.

Finally, physicians are mandated by the Royal College of Physicians and Surgeons of Canada to possess and exemplify specifically outlined competencies. These include Communicator, Collaborator, and Leader (Frank, Snell, & Sherbino, 2015, pp. 10-11). The current environment is not conducive to developing or exhibiting such competencies.

1.4 Background and Context

The South Island Review was initiated in 2015, in response to directives from the Ministry of Health, as well as stakeholder and service feedback that the MHSU system of care was inaccessible, complex, and not client-centred. Research and implementation planning spanned 2015-2017, and implementation of

recommendations began at the end of 2017 and will continue for approximately eight years. The Review structure and approach sought to provide a forum for cross-service collaboration and a multidisciplinary and inclusive approach to assess the current South Island MHSU continuum of care (Island Health, 2016). As part of the review process, advice and consultation was sought from a number of sources, including physicians. Physician engagement was identified as vital to service user pathways, as well as essential and influential to organizational quality improvement initiatives (Island Health, 2015). Means of engagement included physician consultation and representation in the leadership structure, regular department meetings updates, and special meetings/presentations. Physicians were also co-leads in the Review process structure (Island Health, 2016).

Despite targeted and ongoing efforts to engage physicians throughout the Review process, there has been both formal and informal communication from physicians expressing a lack of trust and confidence in administrative management, the perception of a lack of meaningful efforts by administration to engage physicians, and limited consideration for physicians' concerns and opinions in various planning processes in the Review. Excluding an attempt to reorganize the physician leadership structure, the organization as a whole has not taken a strategic and committed approach to address the cultural rift. However, the Review process itself has committed to supporting meaningful physician engagement. Efforts for open communication, transparent processes, and a facilitated discussion with physicians as part of the Review have made little impact.

Because this project exists within the Review, it seeks to be consistent with the vision, objectives, and work already dedicated to this project. The initial system-wide review of South Island MHSU services identified four core themes that are current challenges and opportunities for improvement within the system of care (Island Health, 2015):

1. System complexity
2. Need for client-centered care
3. Service mandate confusion
4. Organizational culture

These themes are consistent across source type, purpose, and date, and despite past efforts to address the challenges they pose, the underlying service issues have remained unresolved and these themes continue to permeate the South Island MHSU system (Island Health, 2015). This project seeks to specifically contribute to the improvement of Theme 4, as it pertains to the elements of culture most influenced by the quality of physician and administration collaboration.

It also seeks to align with the Ten Strategies for High Performing Systems, identified in the South Island MHSU System Review Project Charter (2015). Relevant strategies include:

- Developing organizational capabilities and skills to support improvement
- Promoting professional cultures that support teamwork, continuous improvement and patient engagement
- Leadership activities that embrace common goals and align activities throughout the organization
- Providing an enabling environmental and buffering short-term factors that undermine success

2 LITERATURE REVIEW

This literature review examines the literature regarding physician engagement in health organizations, including common barriers and facilitators. It also examines how physician engagement intersects with other concepts such as differences in professional cultures and physician leadership. This section also establishes a conceptual framework for this project by drawing on knowledge from the field of alternative dispute resolution.

2.1 Physician Engagement

A review of the available literature, using search terms such as “physician engagement in quality improvement”, “physician-manager relationships”, and “collaboration in health care transformation”, revealed extensive literature and case studies on engaging physicians in quality improvement. Within the literature, it is widely recognized that not only is physician leadership and engagement necessary for organizational change and quality improvement, but that it is also a challenge for health organizations across jurisdictions. Significant themes that emerged from the surveyed literature include: correlations between physician leadership and physician engagement, the relationship between health organization management and physicians, and common barriers and facilitators to effective physician engagement.

Defining physician engagement is essential to a common understanding of the barriers and facilitators of success, as well as in establishing a common vision for quality improvement or system redesign. While several definitions of physician engagement exist, Spurgeon, Mazelan, and Barwell (2008) are widely cited in their definition, including by the Doctors of BC in their policy paper on partnering with physicians (2014). Physician engagement is defined as:

“The active and positive contribution of physicians within their normal working roles to maintain and enhance the performance of the organization, which itself recognizes this commitment by supporting and encouraging high-quality care” (Spurgeon, Mazelan, & Barwell, 2008, p. 214).

This definition is useful because it considers both the cultural and individual components of physician engagement. It accounts for both the perspectives of individual staff members, as well as the crucial role of organizational systems and strategies in creating the cultural conditions for staff propensity to engage (Spurgeon, Mazelan, & Barwell, 2008, p. 214).

Other key characteristics of physician engagement prevalent in the literature include:

- It is a two-way process involving organizations working to engage employees and the latter having a degree of choice as to their response (Clark, 2012, p. 5)
- It is encouraged or inhibited through organizational culture, structures, communication, and processes (Doctors of BC, 2014, p. 2)
- It is positively associated with organizational performance (Spurgeon, Mazelan, & Barwell, 2011, p. 116; Taitz, 2011, p. 722)
- Physicians have significant influence on variation in healthcare outcomes and costs, and are essential in influencing healthcare delivery (Taitz, 2011, p. 724)
- Effective engagement requires relationship building and sustained social processes (Kaissi, 2014, p. 572)
- Physician resistance to engagement and change is common across a number of countries and health systems (Gollop, Whitby, Buchanan, & Ketley, 2004, p. 108)

Erlandson (2003) points to an important discrepancy when discussing physician engagement that is helpful to consider because it can inhibit the improvement of manager-physician relations, organization culture, and quality improvement: when administrators talk about physician engagement, they are generally speaking in code for what they would like physicians to do but cannot get them to do; but when physicians speak about engagement, they are speaking in code for what they already give that is not appreciated, valued, or supported by the administration (p. 28).

2.2 Physician Leadership

Physician leadership, while a separate concept, is central to physician engagement and a number of sources found them to be mutually reinforcing (Denis et. al, 2013; Kaissi, 2014; Swensen, 2016; Atkinson, Spurgeon, Clark, & Armit, 2011; Willis et. al, 2016; Rundall, Kaiser, & Davies, 2004; Baker & Denis, 2011; Doctors of BC, 2014; Bohmer, 2012). Physician representation in formal leadership positions is essential, however without recognition of formal and informal leadership roles at multiple levels of the organization it is insufficient to achieve physician engagement and organizational change.

Kaissi (2014) argues that in building a new integrative framework for physician engagement, managers should create new structures and roles for formal physician leaders (p. 585). Not only do formal positions create opportunities for physicians to be involved in decision-making, but as Bohmer (2012) argues, they also utilize a physician's collegial stature to influence the behaviour of their peers and bridge the knowledge gap between clinical medicine and managerial practice (pp. 4, 24). Stable top-level leadership, with physician voice, enables continuity of vision and can improve communication (Atkinson, Spurgeon, Clark, & Armit, 2011, p. 4).

However, while incorporating physicians into organizational structures is necessary, it is insufficient for engaging physicians in system redesign. Instead, collective and distributed leadership modalities and processes which diffuse leadership authority, accountability, and capability to all levels of the organization are more effective because they foster "organized professionalism", enable the use of informal peer networks, and can accommodate and appreciate differences in care microsystems (Denis et. al, 2013, p. 1; Aguirre, von Post, & Alpern, 2013, p. 10; Bohmer, 2012, p. 26; Baker and Denis, 2011, p. 358). Doctors of BC (2013) argue that top-down approaches to medical leadership run the risk of creating distrust; distributed leadership may mitigate this (p. 5). Willis et. al (2016) also support distributed leadership as more effective in creating sustainable cultural change than top-down approaches (p. 16)

Despite general agreement on the instrumental role of physician leadership there are few suggested strategies for developing such capacities. Those that exist include developing physician compacts, targeting physicians in training opportunities for system thinking and change management, and encouraging leadership at team levels (Denis et. al, 2013, p.1).

2.3 Management and Physician Cultures

Many sources cite strained administrative-physician relations as a common organizational characteristic in healthcare organizations and a primary barrier to physician engagement and quality improvement (Bartunek, 2010; Bohmer, 2012; Kaissi, 2014; Baathe & Norback, 2001; Gollop, Whitby, Buchanan, Ketley, 2004; Guthrie, 2005; Rundall, Kaiser, Davies, & Hodges, 2004). Underlying these relational difficulties are fundamental and pervasive divides in professional identities, communities of practice, and professional cultures (Byrnes, 2015, p. 40; Bartunek, 2010, p. 62). As these aspects influence

perception and behaviour, a necessary precursor to fostering physician engagement and leadership is to first understand how physicians and management differ in values, thinking processes, priorities, and culture.

Bujak (2003) identifies a number of areas where beliefs and attitudes differ between administration and physicians. These include: budget priorities, cultural differences, systemic versus linear perspectives, predisposition of distrust, and “the problem of the apostrophe” (p. 5), explained further below. Kaissi (2014) also points to five domains of differences, including: accountability versus personal autonomy, clinical purists versus financial realists, systemization of clinical work, individuals versus collectives, and power (p. 570). Some of these domains overlap, and many of them are supported more broadly within the literature.

Physicians and administration belong to different professional cultures. Physicians belong to an “expert culture” where decisions are made quickly, founded in expert knowledge based on licensed professional education. Expert cultures tend to be motivated by accomplishment and power (Bujak, 2003, p. 8; Baathe & Norback, 2001, p. 481). In contrast, managers belong to a “collective culture”, where teamwork and interdependency is emphasized, and where the process of decision-making is more important than outcome (Bujak, 2003, p. 8; Baathe & Norback, 2001, p. 481). Managers maintain positional power in controlling resources, while physicians have power of exclusive medical expertise (Baathe & Norback, 2001, p. 481). These cultures have significant implications for perceptions of responsibility, accountability, priorities, and of time, immediacy, and urgency.

Another fundamental difference between administration and physicians is their focus on individuals versus collectives. Bujak (2003) refers to this dichotomy as “the problem of the apostrophe”; physicians act as the patient’s advocate (singular), whereas managers act as the patients’ advocate (plural) (p. 9). This in turn impacts decisions regarding budget and quality and safety. Managers are concerned with budgetary distribution to provide the most benefit for the greatest number of people, while physicians seek to provide the most benefit for individual patients regardless of cost (Rundall, Kaiser, Davies, and Hodges, 2004, p. 252).

Professional identities and cultures carry with them tacit knowledge, shared social identities, assumptions, and behaviours. If there is a perception that these identities and cultures are incompatible, it can lead to thinking that may be harmful to organizational culture and intergroup relations. A lack of information sharing between communities of practice can lead to intergroup biases and stereotyping. This can create entrenched identity conflicts that prevent collaboration and quality improvement. As Baathe and Norback (2013) argue, when identities, mindsets and/or understanding are being challenged this can excite many fears among those involved, resulting in unconscious defensive routines and conscious resistance (p. 487).

2.4 Barriers and Facilitators of Physician Engagement

The surveyed literature is relatively consistent in identifying barriers and enablers of physician engagement. However, while a number of barriers and facilitators are identified, there is limited information on specific strategies and processes that can mitigate barriers and promote facilitators. As Kreindler et al. (2014) argues, strong emphasis on physician engagement is universal, however no strategy represents “best-practice”; rather, different social contexts call for different strategies (p. 54). Tables 1 and 2 summarize the findings from the literature.

Table 1: Common Barriers to Physician Engagement

| Description | Sources |
|---|--|
| Lack of recognition for physician leadership and engagement, and low responsiveness from Administration when expressing ideas | Baathe & Norback, 2013, p. 488; Kaissi, 2014, p. 574; Doctors of BC, 2014, p. 4 |
| Time constraints, including inefficient meetings which do not maximize use of limited physician time | Baathe & Norback, 2013, p. 488; Taitz, Lee, & Sequist, 2011, p. 726 |
| Inappropriate measures such as productivity or production figures, which have little clinical relevance | Baathe & Norback, 2013, p. 488; Lindgren, Baathe, & Dellve, 2013, p. 145 |
| Top-down, bureaucratic approaches to change and centralized decision-making | O’Hare & Kudrle, 2007, p. 40; Kaissi, 2014, p. 574; Doctors of BC, 2014, p. 4; Kreindler et al., 2014, p. 54 |
| Physician desire for autonomy | Taitz, Lee, & Sequist, 2011, p. 726; Doctors of BC, 2014, p. 4 |
| Institutional culture | Taitz, Lee, & Sequist, 2011, p. 726; Kaissi, 2014, p. 574 |
| Insufficient training and general lack of knowledge/skill in quality-improvement, change management, systems thinking | Taitz, Lee, & Sequist, 2011, p. 726; Doctors of BC, 2014, p. 4; Gollop et al., 2004, p. 111 |
| External pressures such as budget cuts, turbulence of the policy environment | Rundall, Kaiser, & Davies, 2004, p. 251 |
| Inadequate resources to support physician engagement | Kaissi, 2014, p. 574; Doctors of BC, 2014, p. 4 |
| Negative past experiences in quality improvement and collaboration | Lindgren, Baathe, & Dellve, 2013, p. 145 |

Table 2: Common Facilitators of Physician Engagement

| Description | Sources |
|---|---|
| Quality data use and sharing | Guthrie, 2005, p. 236-238; Doctors of BC, 2014, p. 7 |
| Leadership that is engaged, visible, available, and stable | Atkinson, Spurgeon, Clark, & Armit, 2011, p. 4; Guthrie, 2005, p. 236-238 |
| Good past quality improvement and engagement experiences | Kaissi, 2014, p. 574 |
| Work environment that is supportive, and aspirational/competitively focussed | Atkinson, Spurgeon, Clark, & Armit, 2011, p. 5; Guthrie, 2005, p. 236-238; Kaissi, 2014, p. 574; Milliken, 2014, p. 245 |
| Strong physician leadership including opportunities for leadership development and support | Atkinson, Spurgeon, Clark, & Armit, 2011, p. 5-6; Guthrie, 2005, p. 236-238 |
| Effective and clear communication including unifying language (particularly regarding goals and vision), plurality of methods, appropriate language for audiences, and drawing on group norms | Atkinson, Spurgeon, Clark, & Armit, 2011, p. 7; Guthrie, 2005, p. 236-238; Kreindler et al, 2014, p. 54 |
| Financial and non-financial incentives | Guthrie, 2005, p. 236-238 |
| Initiatives that are relevant to physicians' interests and work focus | Gollop et al., 2004, p. 111 |
| Potential for professional fulfillment | Lindgren, Baathe, & Dellve, 2013, p. 143 |

2.5 Conceptual Framework: Alternative Dispute Resolution (ADR)

Alternative dispute (conflict) resolution (ADR) refers to a continuum of methods and ideas employed in the management and resolution of disputes. This project draws on the theoretical and practical perspectives of alternative dispute resolution to provide a conceptual framework for the following work.

Conflict is defined as: an expressed struggle between at least two interdependent parties who perceive incompatible goals, scarce resources, and interference from others in achieving their goals (Oetzel & Ting-Toomey, 2006, p. xi). An important initial differentiation to make is that of 'conflict' and 'dispute'. Saundry (2016) cites Dix et al. (2009) in arguing that conflict is defined as discontent arising from a perceived clash of interests. This conflict however, is not always visible. In contrast, disputes are manifest expressions of that discontent (p. 14). Burgess & Burgess (2003) expand this differentiation to address the intractability, or resistance to resolution, of conflicts. Disputes involve interests that are negotiable, while conflicts usually involve non-negotiable issues such as moral or value differences, high-stakes distributional questions, or conflicts regarding power or group domination.

Conceptual separation of conflict and dispute are important for designing conflict management processes, as the mechanisms used to address them vary. In order to design an effective conflict management system within an organization, processes and tools must not only resolve disputes but must also contain approaches to managing the underlying conflict (Saundry, 2016, p. 27).

Another separate concept relevant to this work is intergroup conflict. Drawing on knowledge from social psychology, social identity, ethnocentrism, and organizational psychology, Fisher (2000) defines

intergroup conflict as “two or more parties working to adversarially control or frustrate each other with regard to incompatible goals or activities” (p. 167). Sources of intergroup conflict include values, power, and satisfaction of basic human need (pp. 169-170). However, the conflict goes further than just incompatibility values, power, or human need; they are exacerbated or escalated by perceptual, cognitive, emotional, and behavioural mechanisms of groups and individuals (p. 168).

There are a number of tendencies of groups and individuals which characterize intergroup conflict. For example, individuals often engage in misperceptions that accentuate intergroup differences; individuals and groups develop negative stereotypes of each other which are oversimplified, rigid, and often derogatory (Fisher, 2000, p. 171). Such conceptualizations tend to ignore the potential plurality of outgroup member’s identity. Mutual behaviour such as this leads to a number cognitive biases which see out-groups negatively, and in-groups positively.

Kriesberg (2003) analyzes the central role that identity plays in intergroup conflict. Identity becomes central to a conflict when it is defined in terms of group membership, creating an “us” and “them” construct. This is heavily influenced by ideologies, cultures, and past interactions. Identity-based conflicts are more difficult to resolve due to the deep-rooted nature of identities themselves and can contribute to the intractability of a conflict. However, Fiol, Pratt, and O’Connor (2009) argue that identity dynamics should be central in understanding and improving ongoing negative interactions in organizations (p. 32).

While there is a comprehensive understanding of the nature of intergroup conflict, as well as factors that lead to its intractability, there is limited knowledge on how to manage and resolve intergroup conflict (Fiol, Pratt, & O’Connor, 2009, p. 33). Because intergroup conflict is both an objective and subjective experience, attempts to resolve it must address both aspects. Methods need to address the perceptual, attitudinal, and relationship aspects of a conflict before settling substantive interest differences (Fisher, 2000, p. 176; Malek, 2013).

As LeBaron (2003) argues, different methods and strategies must be employed to effectively and productively address the three dimensions of the conflict: the material-structural (what the conflict is over), the communicative-relational (how the conflict takes place), and the symbolic dimension (where meanings and identities play out through conflict) (p. 111). The material dimension is amenable to analysis, identification of interests, and problem solving (p. 116). The communicative dimension can usually be mitigated through listening and reframing skills which can clarify any misperceptions, misinterpretations, or wrong assumptions (p. 116). The most challenging is the symbolic dynamic, which must be addressed through trust building and navigation of identity and cultural issues to find constructive ways of relating to each other (LeBaron, 2003, p. 114; Fisher, 2000, p. 176).

A key principle of managing or resolving intergroup conflicts involves transforming the relationship and situation such that solutions developed by the parties are sustainable and self-correcting for inevitable future incompatibility. Importantly, conflict resolution does not imply assimilation or homogenization; it implies a mosaic of integrated social groups, cooperating interdependently for mutual benefit (Fisher, 2000, p. 179).

3 METHODOLOGY AND METHODS

3.1 Methodology

This project took a mixed methods approach, using a survey and semi-structured interviews as the methods of data collection. The in-person interviews were used to comprehensively analyze the subjective meaning of MHSU organizational culture and relational rifts, as well as to reveal any latent meanings of the issue. The survey provided a standardized method of data analysis, and provided greater representativeness of project findings by broadening the scope of participation. Refer to Appendices A and B for survey and interview questions.

3.2 Methods: Survey

The first method of data collection was a survey of Department of Psychiatry physicians and MHSU management and coordinators. The survey sought to gain the perceptions, experiences, and perspectives of relevant staff regarding key areas such as collaboration, engagement, and communication. Questions focussed on practical processes which may hinder or foster collaboration within the organizational context. The survey consisted of 12 Likert-scaled questions, two checklist questions, and five open-ended questions (see Appendix A).

The survey was conducted both online and via paper copies. The online survey was conducted using the tool REDCap, which ensured that the data was stored and managed locally by Island Health. The paper survey was provided to physicians during the Department of Psychiatry meeting. This was done to accommodate physician time and working preferences. The survey was first piloted prior to data collection with a small subset of the study target population, including both administration and physician feedback. Survey data collection occurred over a two-month period.

Recruitment, Sample Size, and Response Rates

The recruitment sample was exclusively psychiatrists and administrative leadership, and did not include other MHSU staff such as front-line clinicians and case managers, or administrative support staff. Survey participants were recruited both in-person and via email. In-person recruitment occurred at the MHSU Leadership Council meeting, during which the Principal Investigator provided study information. To avoid overlap, individuals were asked to choose one form of participation, either the survey or an interview. At the Department of Psychiatry meeting the Physician Site Chief provided information on the study and time was allotted for physicians to complete the survey.

Email recruitment for the online survey began with an informational email sent to all MHSU managers and coordinators, and Department of Psychiatry members. Participants were found using the Island Health Global Address List (GAL), accessed by the Principal Investigator. The informational email included consent information, as well as the link to the survey. Follow-up emails were sent periodically after the initial email as a reminder.

Twenty-four MHSU staff were invited to participate in the survey. The response rate was 54%, with 13 responses total. Physicians had a response rate of 27%, with 17 responses submitted from 64 invited.

Consent

When participants accessed the survey link they were presented with consent information, and were informed that their consent was implied by beginning the survey (Appendix B). The survey was anonymous at point of collection, and the only identifiable information requested was whether

participants were MHSU administration or a physician. This allowed for clear comparison of data between the two groups, which was essential for project objectives, while also ensuring respondent anonymity, which was important to the sensitive nature of the project content.

3.3 Methods: In-Person Interviews

The second method of data collection was in-person semi-structured interviews with key informants. Key informants included MHSU managers and Department of Psychiatry physicians. The interviews sought to gather the perspectives of physicians and administrators regarding the historical and current nature of MHSU organizational culture and the administrator-physician relational rift (see Appendix C).

Interviews were conducted by the Principal Investigator. They were held in locations convenient for participants, and every precaution was taken to maintain confidentiality of participants. Interviews were semi-structured, which allowed the researcher to ask follow-up questions as needed throughout the interviews. Interviews were audio recorded and averaged approximately 30-40 minutes in length.

Recruitment, Sample Size, and Response Rates

Recruitment of interview participants also occurred in-person and via email. The in-person recruitment process occurred simultaneously with recruitment for the survey, at the MHSU Leadership Council meeting. Emails were also sent to key informants. Individuals were chosen using purposive sampling, which draws on researcher knowledge about a particular group to select participants who represent the population (Berg & Lune, 2012, p. 52).

Recruitment sought to achieve equal representation of physicians and administration, and thus more physicians were invited to participate under the prediction that response rates would be significantly lower. Individuals were chosen for recruitment with the goal of achieving representation from different program areas within MHSU, as well as varying degrees of experience with MHSU and Island Health. For the interviews, five administrators and 12 physicians were contacted to participate. Of those, four administrative and one physician interview was conducted.

Five MHSU leadership staff were asked to participate in interviews, and four were conducted (80% response rate). As expected, it was difficult to recruit physicians for interviews; of the 12 that were invited, one interview was conducted (8.3%).

Consent

Upon expression of interest to participate, individuals were sent consent information (Appendix D). If individuals committed to participate, interview times and locations were arranged by the Principal Investigator directly. Consent forms were signed in person, after review of the consent information and the opportunity for participants to have any questions or concerns addressed by the Principal Investigator.

3.4 Ethical Review

All aspects of the research project were first approved by the Island Health Research Ethics Board (HREB) (Appendices E and F). Because this project involved both Island Health and the University of Victoria, it qualified for the BC Ethics Harmonization Initiative, which is a streamlined multi-jurisdictional ethics application process. Island Health HREB was the primary institution for the ethics application process, however the application was also reviewed and approved by the University of Victoria. In response to difficulties recruiting physician participants for the online survey, an amendment request was submitted

to allow for the paper-based survey option. This amendment received approval from the Island Health HREB also (Appendix G).

3.5 Data Analysis

Survey Data

Survey data was analyzed using data reports created by the REDCap application, and paper-copy survey responses were then manually added to the data report by the Principal Investigator. Surveys were first grouped into administration and physician responses. An initial review of the data was conducted to identify significant themes or prominent trends; because the sample size was relatively small, the researcher was able to hypothesize some conclusions at this stage.

The REDCap data report automatically coded the ordinal data by assigning a number value to each answer. Some questions had higher scores for positive indicators, and some had higher scores for negative indicators. The questions which had a higher score for positive indicators (question 2, 6, 7, 9-12) were reverse scaled in order to accurately analyze prior to statistical analysis. For questions where respondents chose not to answer, the n value was adjusted accordingly when calculating the mean and in representing the data.

The administrative staff mean and the physician mean were calculated for each scaled variable. A t-test was then performed to assess whether the two populations were statistically different (Appendix H). A null hypothesis of no difference was used, with a 95% confidence level. A t-test result with a p-value lower than 0.05 indicates that each population's answers are different. For the check-list questions, the proportion of responses for each group were calculated for each barrier and facilitator as a percentage of the total respondents in each group. A z-test for two proportions was then performed to assess whether the two populations were statistically different. A null hypothesis of no difference was also used, with a 95% confidence level. The z-test level is interpreted in the same way as a t-test p-value.

For the two questions containing a checklist of barriers and facilitators, conclusions were drawn based on the frequency of variables being chosen. Finally, within each group, responses to open-ended questions were analyzed through thematic analysis; identifying general themes and noteworthy exceptions. Findings are supported through the use of direct quotes, which will be identified as physician or administration responses, for the purposes of comparison.

Interview Data

An inductive method was used to analyze interview data. It followed the process outlined by Berg and Lune (2012, p. 352): following data collection, interviews were transcribed; from the transcripts, codes were identified as meaningful or pertinent ideas or concepts; codes were then organized into categorical themes; themes were indexed and then applied to the interview data. Finally, the sorted materials were examined to isolate meaningful patterns, relationships, commonalities, and disparities. Units of analysis were sentence fragments, as responses sometimes contained multiple ideas or concepts. The patterns were then considered in light of previous research on the topic. Key findings will be supported and illustrated through the use of direct quotes. Because it is possible, perhaps even likely, that some MHSU staff and physicians know which physician participated, confidentiality will be protected by not identifying individual participants as administrative staff or physician.

3.6 Limitations

Selection bias is a potential concern due to the use of purposive sampling; the project sample was selected based on researcher knowledge of the population in order to obtain expert opinions. This limitation was deemed acceptable as participant experience of the topic was essential to obtain desired information. Purposive sampling also limits the validity of statistical testing, and the generalizability of this study and its findings; however, this does not prevent the project from achieving its purpose of identifying barriers to collaboration within MHSU specifically.

The strength of qualitative data obtained through this project was dependent on physician and administration willingness to engage in the project. This project was vulnerable to the very problem it sought to address, which is a lack of physician engagement. While physician participation in the survey was achieved, physician interview participation was significantly limited, and was disproportionate to administrative participation. It is possible that the opinions expressed in the interview are not entirely representative of the broader Department of Psychiatry.

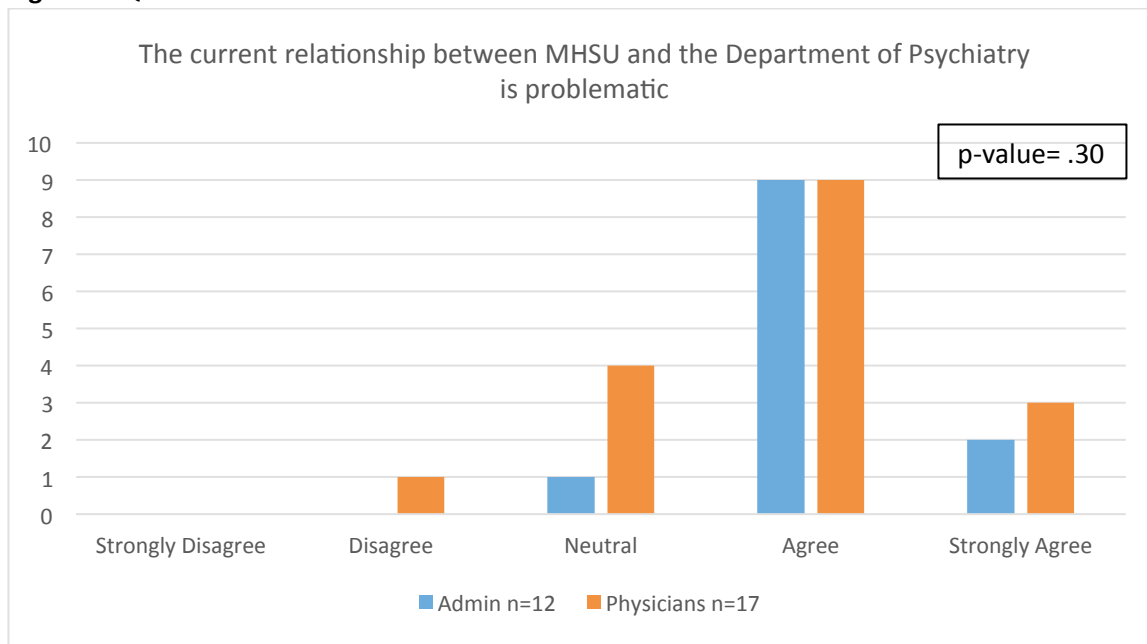
4 FINDINGS

This section will discuss the findings of analysis from both survey and interview data. Survey data is first discussed as it provides greater representativeness, and then interview data is used to further explore key findings. For the survey, data from each group was analyzed separately and then compared, which allowed for differences and consistencies to be identified and explored.

4.1 Survey Data

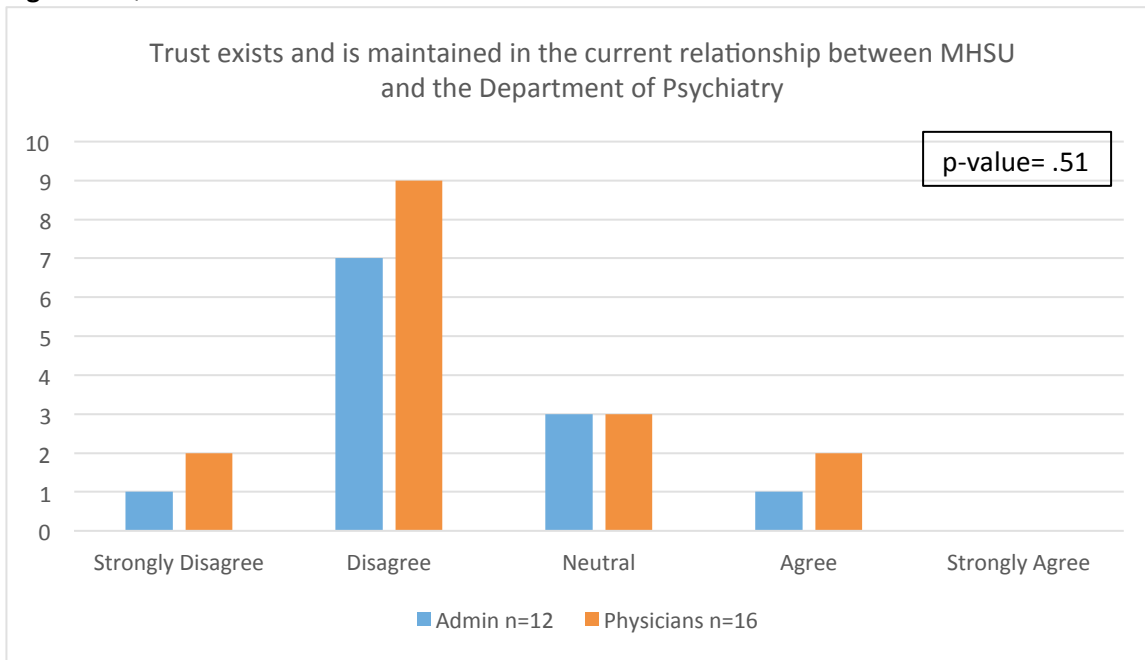
Figures 1-12 show the results for each question. The figures are followed by results for the open-ended questions, and some general comments on the results. A t-test conducted during data analysis resulted in an overall p-value of 0.91 which suggests that the two populations are not statistically different. T-tests were also conducted for each variable, and are identified in each graph. Variables with statistically significant differences are noted.

Figure 1: Question 1



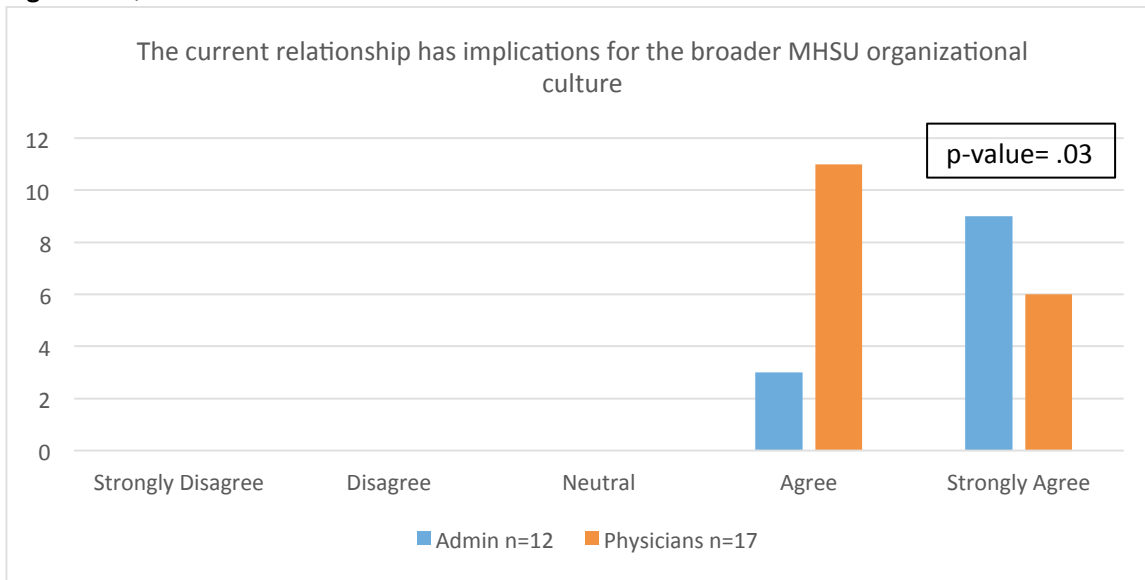
The majority of physicians and administrators indicated that the current relationship is problematic.

Figure 2: Question 2



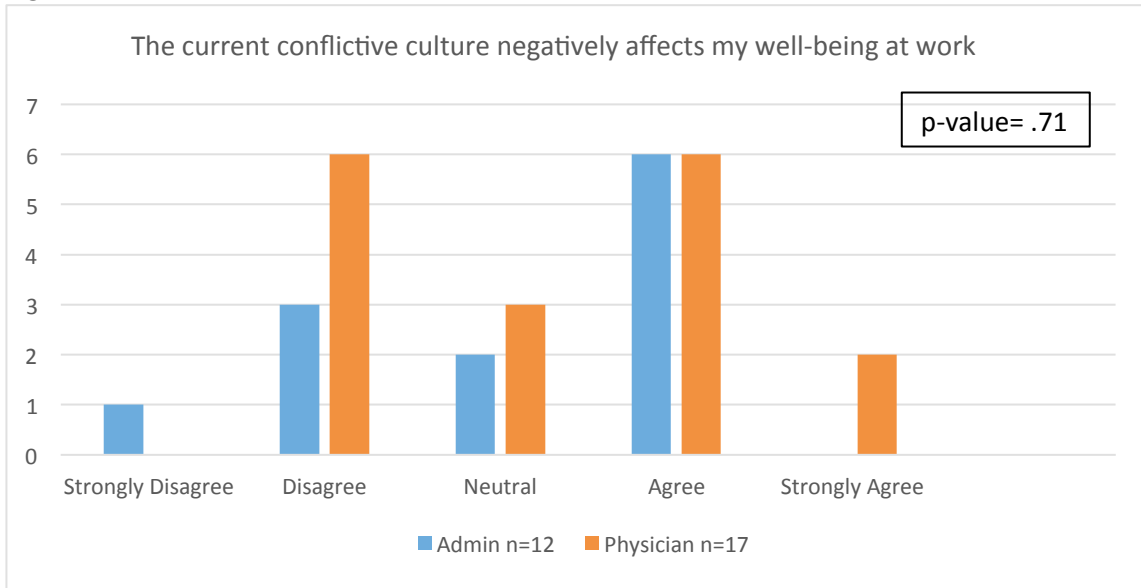
The majority of both physicians and administrators indicated that trust is currently lacking.

Figure 3: Question 3



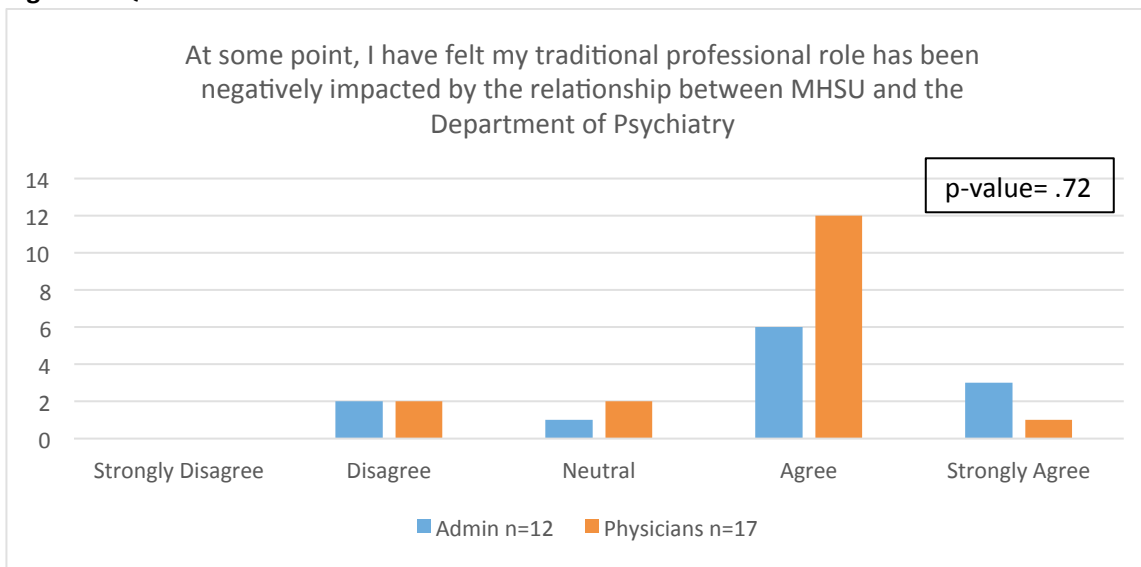
The p-value indicates that the two populations were statistically different, but it is striking that all respondents indicated that the current relationship has implications for the broader organizational culture. Administrators agreed more strongly and the difference is statistically significant.

Figure 4: Question 4



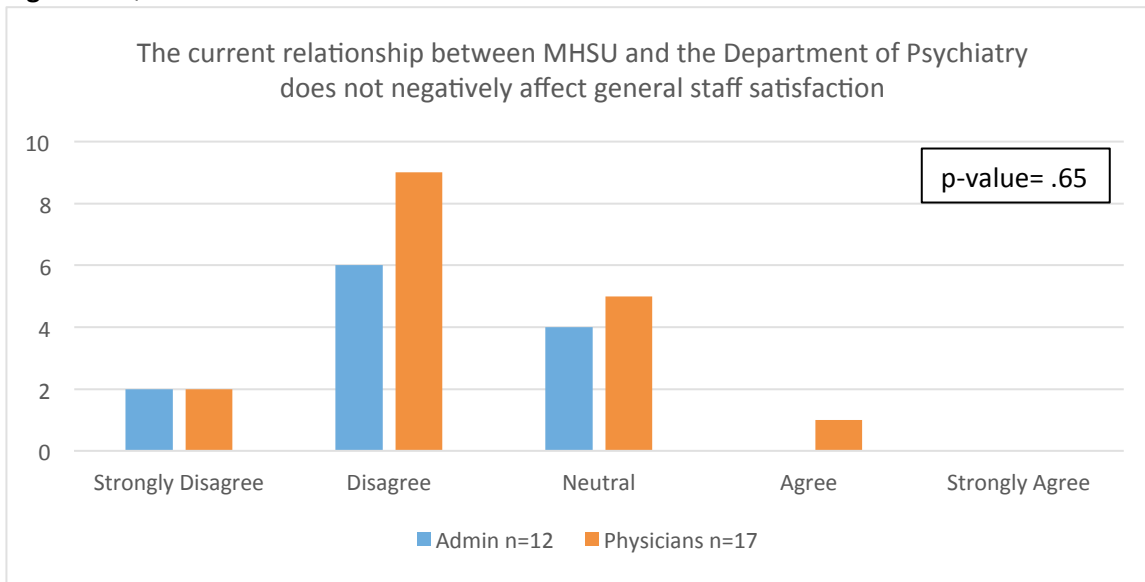
This question had variation in responses, with respondents in both groups divided.

Figure 5: Question 5



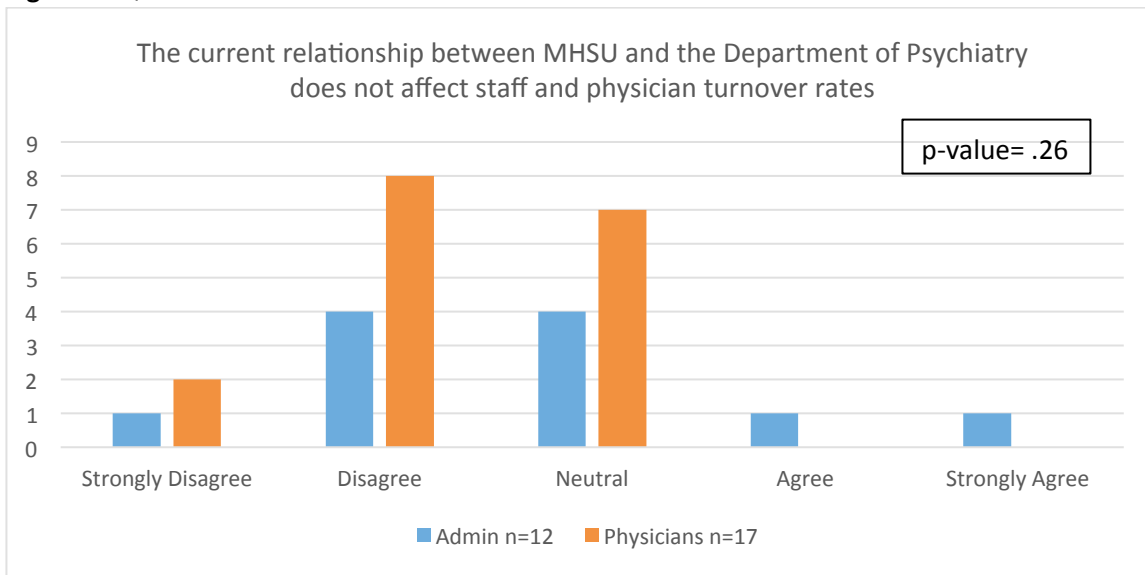
Most administrators (75%) and physicians (76%) felt their traditional professional role has been negatively impacted.

Figure 6: Question 6



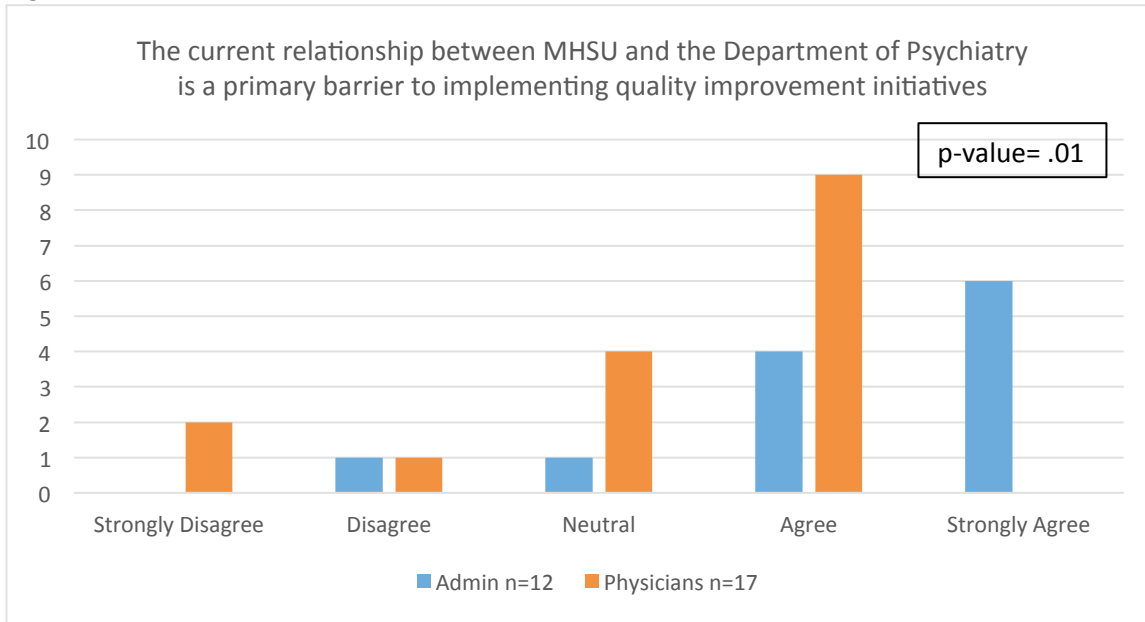
The majority of both physicians (65%) and administrators (62%) felt that general staff satisfaction is negatively affected.

Figure 7: Question 7



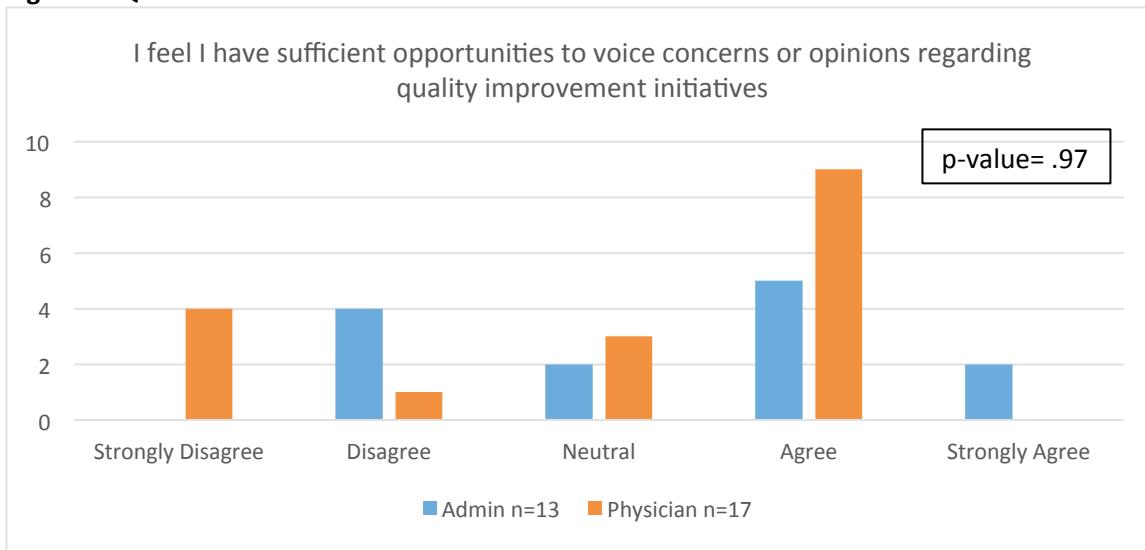
There was variation in responses regarding the impact of the relationship on staff turnover rates, particularly among administrators.

Figure 8: Question 8



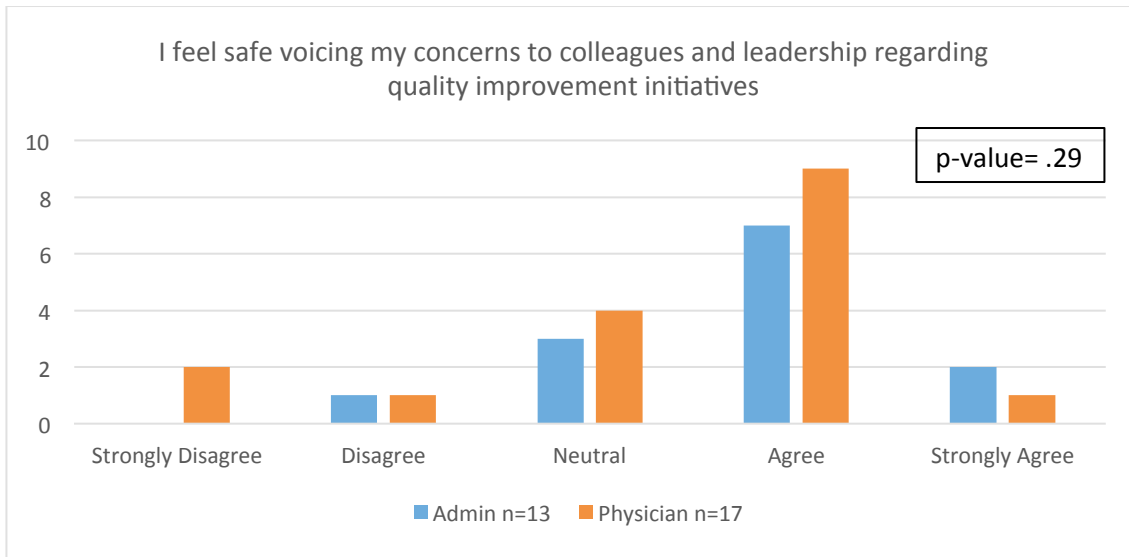
While the majority of both administrators and physicians felt the current relationship between MHSU and the Department of Psychiatry is a primary barrier to implementing quality improvement initiatives, some physicians (and no administrators) strongly disagreed, and some administrators (but no physicians) strongly agreed. This difference is reflected in the t-test p-value of 0.01, which indicates statistically relevant differences between the groups.

Figure 9: Question 9



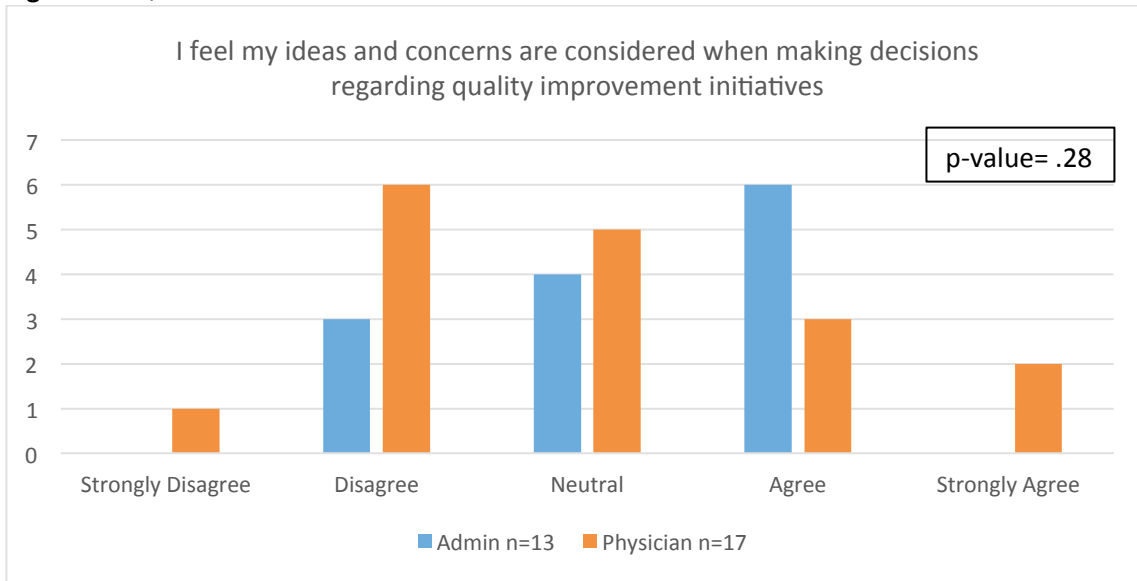
Responses regarding opportunity to voice concerns and opinions were also divided, with over half indicating they have sufficient opportunities to do so.

Figure 10: Question 10



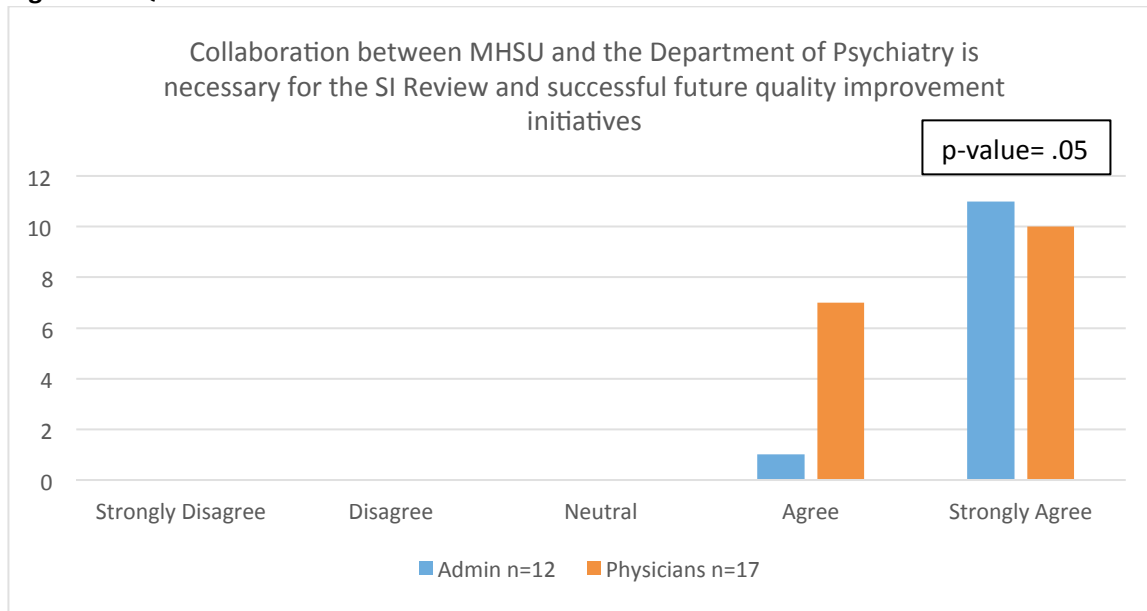
Most respondents feel safe voicing their concerns to colleagues and leadership regarding quality improvement.

Figure 11: Question 11



Administrator and physician answers differed regarding whether they felt their ideas and concerns are considered during decision making; almost half of physicians did not feel their ideas are considered, while a quarter of administrators felt the same. Physician responses spanned all answers from strongly disagree to strongly agree, while administrators chose more neutral answers.

Figure 12: Question 12



All survey participants indicated that collaboration between MHSU and the Department of Psychiatry is necessary for the SI Review and future quality improvement initiatives, but administrators' agreement was statistically significantly stronger (91.7% strongly agreed vs 58.8% of physicians).

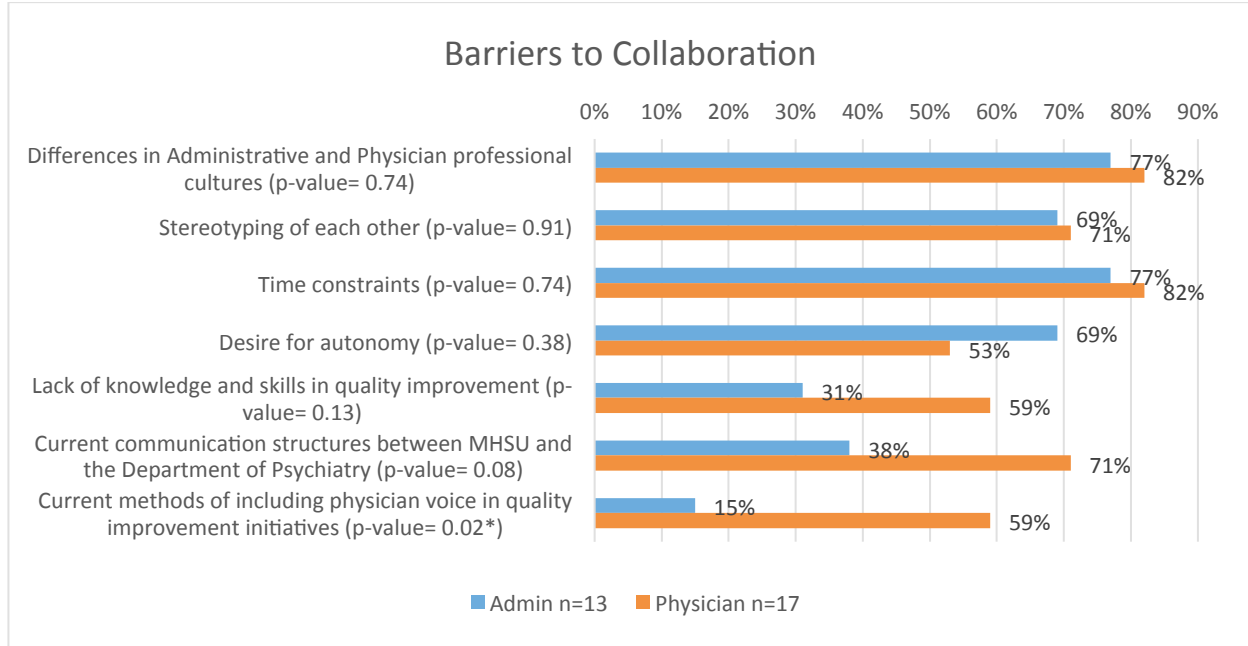
Survey data indicates that the current relationship between MHSU staff and Physicians is problematic and has implications for broader organizational culture. It also indicates that to varying degrees it impacts factors such as overall staff satisfaction, staff and physician turnover, and wellbeing. There is variation both within and between groups, but only three questions showed statistically significant differences between the groups.

Survey Checklist Questions

Survey respondents were asked to identify barriers and facilitators to collaboration within MHSU using a checklist. These questions sought to identify specific processes and structures which could be implemented to mitigate barriers and implement facilitators to collaboration. Responses to the barriers and facilitators checklists are presented in Figure 13 and Figure 14 (see Appendix I for full data analysis).

For each question the proportion of administrators and physicians who indicated the variable as a barrier was calculated (represented as a percentage). A z-test for two proportions was then performed for each variable to assess whether the two populations were statistically different. A null hypothesis of no difference was used, with a 95% confidence level. The z-test p-value is interpreted in the same way as a t-test p-value; a p-value less than 0.05 indicates a statistically significant difference between the populations.

Figure 13: Barriers to Collaboration

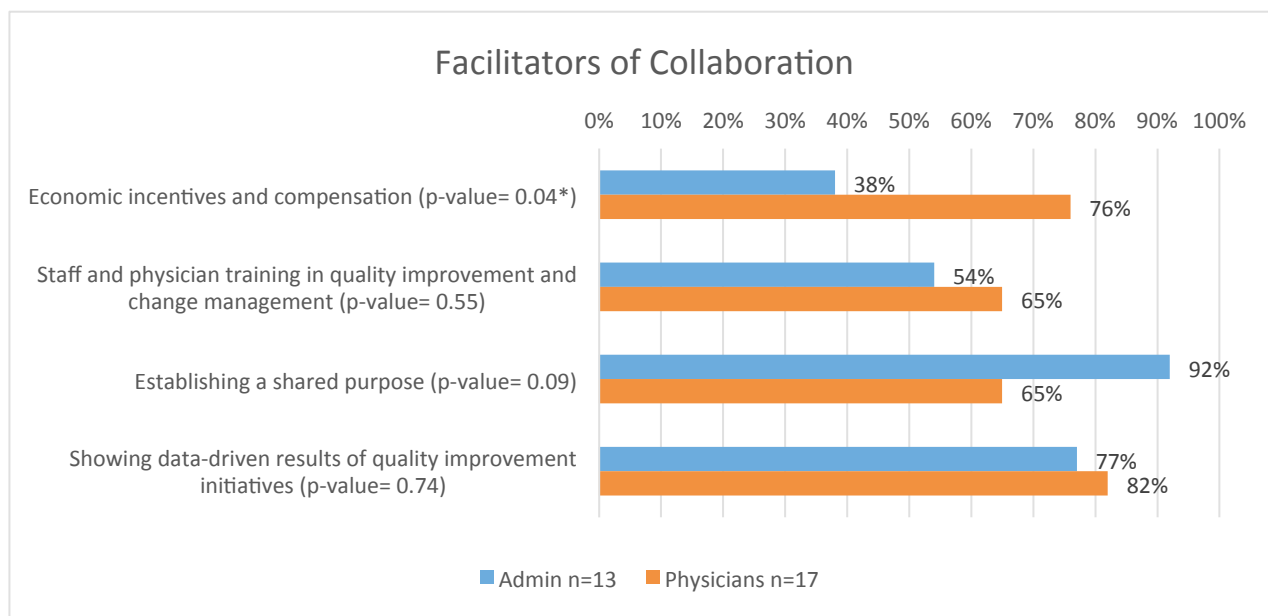


*Statistically significant at 95% confidence level

Differences in professional culture, stereotyping, and time constraints were three of the top four barriers by both administrators and physicians, however administrators’ fourth-rated barrier was desire for autonomy, while for physicians’ was current communication structures.

Physicians and administrators only showed statistically significant differences with regard to one barrier, current methods of including physician voice, with 59% of physicians but only 15% of administrators citing it. This suggests incongruence in how administrators are currently engaging physicians, and how physicians want to be engaged.

Figure 14: Facilitators of Collaboration



*Statistically significant at 95% confidence level

With regard to facilitators, administrators and physicians showed a statistically significant difference in only one response; more physicians felt economic incentives and compensation would be a facilitator of collaboration. A greater proportion of administrators felt that establishing a shared purpose would be a facilitator; however, the majority of physicians still indicated a shared purpose as a facilitator as well. Most survey respondents in both groups felt training and data-driven results would improve collaboration and engagement.

Open-Ended Survey Questions

Following question 13 and 14, survey participants were given the opportunity to identify additional barriers and facilitators in an open-ended format, which asked: if other, please specify. Responses for additional barriers included:

- Resource issues which place significant pressure on physician workload
- Negative intergroup and intragroup relations with physicians
- Lack of clinical content knowledge by some decision makers
- Culture within the Department that is resistant to change
- Insufficient sessional funding for physicians to participate in teams and leadership
- Difference in philosophy of care, specifically regarding substance use services, which **impedes** treatment
- No accountability mechanism to enforce psychiatrist participation in voluntary quality improvement initiatives

Responses regarding additional facilitators included:

- Using quality data as a foundation for decisions regarding how and what to implement
- Providing physicians with greater decision-making capacity regarding service decisions

- Financial incentives to participate in meetings and projects, including physicians informing themselves on initiatives
- Apply transparent and fair methods of performance evaluation to physician, clinician, and administrative decisions and practices.
- Ensuring quality improvement initiatives are person-centered for both clients and clinicians
- More background data

Survey respondents were also asked three open-ended questions regarding engagement and collaboration (see Appendix A). First, respondents were asked: Within the context of MHSU, define “collaboration” and “engagement”. Responses from both physicians and administrators were consistent with each other and overwhelmingly defined collaboration as a partnership working towards a shared goal or purpose, with shared benefit. Other responses included:

“Shared/agreed upon goals and ongoing participation of all parties in pursuing those goals” – MHSU Participant 7

“Considering one another’s points of view and constraints, and trying to account for these while creatively searching for and weighing potential solutions” – Physician Participant 10

“Sharing ideas and actively working together” – MHSU Participant 15

Engagement was consistently defined in terms of a commitment to a collaborative process and an active interest and willingness to work towards change.

The second open-ended question asked: What is your preferred method for engaging and collaborating? Responses from both administrators and physicians consistently noted face to face communication, on a personal or one-to-one basis. One participant also responded:

“The best kind of collaboration I have experienced with large, complex groups is having educated, informed people generate understandings of the problems, constraints and potential solutions, and then having the larger body collaborate on debating and choosing among those. ‘Collaborating’ at too broad a level leads to feelings of being uninformed and making decisions emotionally.” – Physician Participant 10

In the final open-ended question, survey respondents were asked: What do you see as keys to successful collaboration and engagement? Responses identified major themes including communication, relationship-building, training in quality improvement and physician leadership, clarity around roles and responsibilities, and resources for physician participation:

“Openness, mindfulness, respect, supportive attitude, willingness to work together” – MHSU Participant 8

“Physicians need to be compensated to do some planning and project management work for QI to work. A few key physicians also need enough training to help shape the group. A skilled facilitator to help influence culture of the organization/relationship” – Physician Participant 10

4.2 Interview Data

Interview questions sought to draw on the experiences of key informants to expand on survey data and provide a more in-depth analysis of the issue. For this section, interview questions are presented by topic, rather than in the order they were asked in the interview, to allow for a more logical presentation of results. However, the numbering has remained consistent with the order from the interview for clarity. Participants were asked similar questions to survey participants in order to gather information on how pervasive and deep rooted the current culture is.

The following questions were asked to better understand the scope and impact of the issue:

1. From your perspective, please describe the nature of the current relationship between MHSU Administration and the South Island Department of Psychiatry
2. Do you feel that this relationship affects the organizational culture of MHSU more broadly? If so, can you please explain further
3. Do you feel the current relationship (and resulting organizational culture) impact your wellbeing at work? If so, in what ways?
4. Can you help me better understand the history of the relationship between MHSU and the Department of Psychiatry?

Interview responses were consistent across physicians and administrative staff regarding the nature of the relationship. Most participants (4 of 5) made two significant characterizations. The first that the relationship is changing; while there is still lack of trust, as well as a culture of “us vs. them”, respondents felt that there have been recent shifts toward greater collaboration:

“I think it’s changing...I think we’re still quite a ways apart but we’re slowly coming together, slowly getting closer” – Participant A

“There’s an evolved us vs. them mentality or concept. I feel that’s improved over time, but I think it’s still a relationship that isn’t sufficiently collaborative or productive” – Participant E

The relationship was also characterized by most (3 of 5) as variable, specifically contrasting the strength of individual relationships with the distrustful and dysfunctional relationship between the Department of Psychiatry and MHSU Administration as larger bodies:

“I would say that in many ways it’s very dysfunctional, and at the same time I would say on a one-to-one basis the relationships are solid...but with the Department as a whole there seems to be a tremendous amount of mistrust.”- Participant C

With reference to scope, interview participants noted that the problematic relationship is primarily focussed in the South Island region, but there is recognition by the broader system that the relationship is dysfunctional. Two interview participants felt that this contributes to a cynical view of South Island MHSU by other programs in the region and by other departments of Island Health. All interview participants felt that the current relationship does permeate the overall organizational culture, and it was noted that it impacts service-level function and the implementation of initiatives:

“I think that does affect culture and can cause people to feel demoralized and disengaged. And that spreads from there to less workplace satisfaction and problems like that. And it does have an impact on how things go at the service delivery level because change that would be productive hasn’t happened in a timely fashion.” – Participant E

“It’s kind of the elephant in the room, like everybody knows that that’s been an issue and that’s historically been an issue but it seems like it’s never been fully resolved.”- Participant B

“Because everybody is aware of it, and it always feels like there’s kind of a climate of us versus them”- Participant D

Where responses diverged, between physician and administration and within administration, was with regard to the impact of the relationship on personal wellbeing. Three participants felt that the relationship has contributed to their stress levels or has been hurtful, while two participants expressed frustration in the tension but did not feel that the relationship impacted their wellbeing:

“In the past I would say particular relationships caused a great deal of anxiety, and actually would be barriers to work.”- Participant C

“I think wellbeing may be too strong of a term. I think my wellbeing at work is very closely linked to the relationships I have with the people that I directly work with, which isn’t necessarily affected that much by this broader question of the relationship.” – Participant E

Despite this variation, most respondents expressed that current positive individual relationships outweighed the negativity of the more general relationship. Variance in interview data was consistent with variance in survey data regarding this topic.

With regard to history, interview data revealed that the current relationship has been dysfunctional for approximately 10-15 years. One respondent said:

“We’ve been going around this for a decade or more, and things haven’t changed. Topics have changed, but the actual undercurrent hasn’t changed in all that time” - Participant C

Further, all respondents noted that the relational issues began before they came to Island Health, which indicates that the issues are deeply rooted and persistent enough to be perpetuated through staff turnover.

Interview participants were then asked to discuss collaboration and engagement:

6. Can you tell me about what collaboration means to you in the context of MHSU?
7. Can you tell me about what engagement means to you in the context of MHSU?

Responses were relatively consistent among interview participants. Participants noted that collaboration exists on a spectrum, with varying degrees of involvement and influence depending on the issue. Engagement was often identified as a precedent to collaboration, with the purpose of garnering interest in the shared benefit and achievement potential of collaboration. Three participants also noted that

engagement is often seen as an action item, but that it is actually an ongoing two-way process which requires an effort to understand what the other party needs, as well as a sustained effort to maintain the relationship:

“Engagement is really about trying to understand from the other person what they need. And I think that’s sometimes the missed point of engagement, is that we go and we reach out to somebody and we think that our job is done” – Participant C

“It might be a step, in some cases, before you can start collaborating...reaching out to people...selling them on the vision or the point of developing a collaborative relationship. And as you are collaborating with people you need to continue to engage”
– Participant E

Most participants used the word “partnership” in defining collaboration, and referenced collective identification of issues and priorities, collective and consensual decision-making, and collective problem-solving. Establishing a shared vision or common goal was also fundamental to the concept of partnership. It was emphasized that collaboration needs to be grounded in some degree of personal relationship that is characterized by a commitment to build trust and get to know each other as individuals, as well as by open communication, and transparency. Curiosity and a willingness to avoid assumptions were also noted. Finally, three participants noted the importance of safety, referencing safety to disagree and debate, safety to innovate and fail, and safety to raise concerns with confidence they will be heard and valued.

There was greater reliance on interview participants than survey participants to gather information to address the future collaboration of physicians and administration. Participants were asked the following questions:

5. My project is overcoming barriers to collaboration and engagement between MHSU and the Department of Psychiatry. What do you feel are the barriers to collaboration and engagement occurring or being successful?
 - a. Is there anything that could be done to improve this?
8. Can you describe a negative experience between MHSU and Physicians?
 - a. In your opinion what were the factors which contributed to this?
9. Can you provide me with examples where you’ve seen collaboration or engagement happen in a positive way?
 - a. In your opinion what contributed to this?
10. What do you see as keys to successful engagement and collaboration?
11. What do you think are ways to make the conversation about collaboration and engagement more successful?
13. If there is a positive change, describe what the future working relationship between MHSU and the Department of Psychiatry would look like?

In order to formulate recommendations on how physicians and administrators can work collaboratively in the future, broader themes were drawn from interview data. Interview participants tended to discuss barriers and facilitators on a broader level, however specific changes were recommended such as being

creative in engaging physicians. For example, engaging physicians in one-on-one sessions that include an executive summary, key questions, and an attached action item.

“Physicians generally make their money by working to see patients clinically, fee for service, so they’re not really well compensated at all to go to meetings and that. And furthermore, they’re not often temperamentally interested in sitting around doing meetings, it’s not necessarily an interest or a skill set” – Participant E

Major themes were largely consistent with those identified by survey participants, and included: focussing on the relationship; recognizing differences in professional culture, training, and values; and clarity of organizational structures. The administration-physician relationship was identified as a primary barrier by all interview participants. Interview participants identified specific factors which contribute to the strained relationship including stereotyping and generalizing, making assumptions, lack of conflict resolution skills, and focussing on areas of divergence instead of common goals.

When discussing ways to improve the relationship participants focussed on establishing a common goal or purpose and letting go of the past. One participant noted:

“Just recognize that we really are all genuinely here because we want to do good work...we’re here because we want to make a difference in some positive way. And I think sometimes people lose sight of that. If we could just hold that closer and acknowledge that, maybe more visibly acknowledge that, then I think that that might also help” – Participant B

Another participant said:

“I know the past always influences current decisions...but it doesn’t need to bind us. And so people just need to just let go, and trust that this is difficult work but we can make something happen” – Participant D

Finally, several participants (3 of 5) stated that the ground rules for respectful behaviour should be collectively agreed to and that all members should feel empowered to hold each other accountable to behavioural standards. Disrespectful behaviour was identified as both damaging and unproductive, and participants stated that a mechanism for maintaining respectful communication is paramount:

“Having some commonly accepted standards, ground rules for how we relate to each other, and holding each other accountable to that.” – Participant B

Communication was emphasized by most participants as a key to improving the relationship and to successful collaboration and engagement. This included consistent and regular contact, effective listening, openness to other perspectives, promoting healthy debate, respect, curiosity, and proactive engagement.

Although a distinct theme, lack of explicit recognition of the cultural differences between administration and physicians also contributes to the relational issues. Multiple interview participants noted that physicians and administrators often have differences in priorities, working styles, and problem solving. This can foster miscommunication and perceptions of incompatibility, deter engagement, and lead to mistrust. Tailoring engagement methods to be congruent with physician training and cultural orientation was suggested by two interview participants.

Another key theme noted by most interview participants (4 of 5) was lack of clarity around roles and responsibilities. Interview participants felt the decision-making structure is unclear, including who has ultimate decision-making responsibility. Most of the participants saw the co-leadership structure as having both real and potential benefits for improving collaboration by providing physician-to-physician engagement and increasing leadership responsiveness to physician needs. However, challenges in filling the physician co-lead positions was identified as a significant barrier.

5 DISCUSSION

This section describes how the research results answer the research questions, placing the results within the ADR conceptual framework and applying knowledge drawn from the literature. Considerations explored in this section informed the recommendations presented in the next section.

The research questions are:

Primary Research Questions:

- How can administrators and physicians work collaboratively during the Review and future initiatives?
- What specific structures and processes can be implemented to improve collaboration within the organizational context of MHSU?

Secondary Research Questions:

- How deeply rooted and pervasive is the current conflictive culture?
- How has collaboration been defined and operationalized within the organization in the past?

The research results are more directly responsive to the Secondary Research Questions, which concern the past, so they will be discussed first. Based on those results, the sources of conflict will be described, to provide background for the discussion of the Primary Research Questions, which concern the future, and directly drive the recommendations.

5.1 How deeply rooted and pervasive is the current conflictive culture?

Based on the results, it is apparent that the relationship between physicians and administration is problematic, and is both deeply rooted and pervasive. Characteristics of the current culture and admin-physician relationship include:

- Conflict has become engrained in the MHSU narrative and into the group identities of both parties
- It has implications for the broader organizational culture, and to varying degrees negatively impacts well-being and satisfaction on individual levels
- The impact of the relationship goes beyond MHSU to impact its reputation with the rest of the Island Health system.

The nature of the conflict at MHSU is consistent with characteristics of intractable conflict, defined in the literature review. The current state of the relationship involves non-negotiable issues such as values and identities, and has been escalated by repeated instances of hurtful or disrespectful behaviour and lack of systematic mechanisms to address them.

These characteristics suggest that the conflict may be resistant to resolution. Acknowledging intractability is not to suggest hopelessness; it is instead an important step in developing strategies that will be effective in improving the situation by being responsive to the underlying issues. Even if full resolution cannot be reached, positive actions can be taken to transform the conflict from destructive to constructive, and can increase the likelihood of long-term improvement.

5.1 How has collaboration been defined and operationalized within the organization in the past?

The current conceptual understanding and definition of collaboration was relatively consistent among physician interview and survey respondents. Responses from physicians and administrators were also consistent with each other and overwhelmingly defined collaboration as a partnership working towards a shared goal or purpose, with shared benefit. Ideas around collective identification of issues, decision-making, and problem solving were also frequently referenced, as was a degree of personal relationship. Engagement was consistently defined in terms of a commitment to a collaborative process and an active interest and willingness to work towards change.

In contrast to the conceptual understanding of collaboration and engagement, the operationalization of these two concepts within MHSU is a source of division. Survey responses (Question 13) indicate that the majority of physicians feel that current communication structures and methods of including physician voice are barriers to successful collaboration and engagement. Conversely, the minority of administrators feel these are barriers. This implies a disparity in how administrators and physicians feel effective collaboration and engagement should and is taking place.

5.2 Sources of Conflict

Resource cutbacks in areas of South Island MHSU were identified as the primary source of historical conflict within the organization. Profound disagreement around these past decisions created animosity and mistrust which continues to impact current relationships. This tension has been entrenched by instances of hurtful or disrespectful behaviour, and has been impacted by leadership turnover, which has impeded effective and sustained conflict management.

Differences in the professional orientation of administration and physicians, and ineffective navigation of these differences, is also a source of tension that has created distrust around decision-making and intentions. The division in professional identities, communities of practice, and professional cultures is widely supported by the literature as a barrier to physician engagement. As these aspects influence perception and behaviour, a necessary precursor to fostering physician engagement and leadership is to first understand how physicians and management differ in values, thinking processes, priorities, and culture.

While physicians tend to prioritize the care of individual patients, administration is tasked with creating equity throughout the system. As such, past resource decisions made with a systems lens may have been perceived as not client-centred or care focussed, and in fact as damaging to client care. Interview data also suggested that past instances of ineffective or insufficient engagement prior to implementing changes that impacted physician work have further solidified distrust in the decision-making process.

Further to this point, administrators and physicians often take different approaches to decision making, engagement, and problem solving. This is outlined in the literature and was also indicated in interview data; large or long group meetings are not well suited to physician fee-for-service pay structure or professional orientation but is an effective means for administration to ensure breadth of discussion and feedback on decisions and initiatives. This incompatibility is a deterrent to engagement.

Finally, differing expectations or perceptions of incompatibility are exacerbated by lack of clarity around roles and responsibility and decision making. Lack of clarity and agreement brings into question the

extent to which individuals can and should be involved in decision making processes, as well as how much authority individuals possess in making and enacting decisions. Misunderstanding in this area limits feelings of empowerment and discourages engagement. It can also contribute to distrust insofar as individuals may feel their voices are not genuinely considered or equally weighted in decision-making. Clear information sharing between communities of practice are necessary to reduce negative intergroup relations, biases, and stereotyping.

5.3 How can administrators and physicians work collaboratively during the Review and in future initiatives?

Both survey data and interview data consistently emphasized communication and improving the relationship as priorities in building MHSU's collaborative capacity. There is a significant need within MHSU to address historical grievances and develop new and productive ways of relating with each other, and change the perceptions of the conflict itself. Effective conflict resolution mechanisms offer opportunities to achieve this.

Dialogue

Facilitated dialogue is one of the very few methods of communication that permits people to bring assumptions into the open and confront them in an effective manner (Yankelovich, 1999, p. 46). Unexamined assumptions are a classic route to misunderstandings and errors of judgement. They create prejudice, fear, and polarization, which are detrimental to building positive relationships. Dialogue seeks to explore differences with others, by identifying assumptions, working to build common ground, and getting to the root of misunderstandings (Maiese, 2003). See Appendices J and K for characteristics and strategies of dialogue.

Within the context of MHSU, facilitated dialogue offers an opportunity to improve the relationship itself by addressing historical grievances, sources of distrust, and areas of miscommunication and misinterpretation. It would also allow for both parties to better understand the professional culture and orientation differences (and the assumptions that come with them) that are currently a primary barrier to collaboration. Finally, it would mitigate tendencies of poor communication, which exacerbate conflict, such as listening simply to rebut another's position. Dialogue would begin to build a relational foundation for physicians and administration to effectively establish collaborative structures and processes.

Moving away from us vs. them

The administrative-physician relationship at MHSU is currently characterized by collective identities which are perceived to be incompatible. This is illustrated by the "us vs. them" climate which permeates the organizational culture. Further, the research data indicates that MHSU physician-administration intergroup communication is consistent with negative intergroup behaviours such as stereotyping, assumptions, deindividuation, and depersonalization (see Appendix L for definitions).

The salience of collective identities and negative intergroup behaviours can both be mitigated by creating opportunities for individuals to perceive themselves and each other at an individual level, in terms of individual traits (Hogg and Terry, 2001, p. 54). Interpersonal interactions lead to attitude and stereotype change that is extended from the individual to other members of their group.

There are currently examples of this occurring within MHSU, namely with the co-management structure. Interview participants noted the real and potential benefits of the co-management structure because it offers the opportunity to get to know individuals beyond their role, build trust through regular and open communication, and problem-solve in partnership. As such, increasing potential situations for individuals outside of leadership to form similar relationships will provide similar benefits throughout the system.

Formalized Conflict Resolution Process

A significant barrier that is related to, but distinct from, the relational dynamic of the conflict, is a lack of systematic or organizational mechanisms to ensure accountability for respectful behaviour and to manage conflict. The research showed that within the current environment, to varying degrees, both physicians and administration do not feel safe to disagree or debate, and do not feel supported by broader organizational mechanisms when faced with disrespectful behaviour or conflict.

This barrier may be more difficult to navigate in alignment with broader Island Health mechanisms, and in light of the fact that physicians are not staff and therefore are not under the purview of Island Health mandate and processes. However, it is evident that a mechanism to ensure collective adherence to codes of conduct or ground rules for behaviour would be beneficial to both administrators and physicians. Development of such a mechanism would require a collective process to establish purpose, scope, and process for accountability. Ideally, it would include a multi-level plan which empowers individuals to address and resolve conflicts, as well as a collective structure to support individuals who may not feel equipped to deal with a conflict, or if a conflict involves a larger group.

An administrative-physician compact is an example of such a mechanism which is supported by the literature. A compact refers to a written commitment by administration and physicians outlining reciprocal expectations and responsibilities (particularly regarding behaviour), a shared vision or common purpose, accountability processes, and a process for dispute resolution. Fraser Health Authority and Vancouver Coastal Health Authority have both implemented physician compacts. Also see Appendix M for an example physician-administrator compact from Ottawa Hospital. Committing to a compact would not only improve relations by ensuring a common standard of interaction, but would also increase trust and contribute to a greater sense of safety and support. Having an external person who can assist in this process may also be helpful, however it should be ensured that this person is approved by both parties to avoid perceptions of bias.

5.4 What specific structures and processes can be implemented to improve collaboration within the organizational context of MHSU?

Many of the primary barriers identified in the survey and interviews are related to the underlying administrative-physician relationship and have therefore been previously explored. However, MHSU also faces functional barriers to engagement, which are largely consistent with the common barriers identified in the literature, particularly:

- Time constraints, including ineffective meetings which do not maximize use of limited physician time
- Top-down bureaucratic approaches to change and centralized decision-making
- Inadequate resources to support physician engagement
- Lack of physician leadership, including opportunities for leadership development
- Singular engagement methods which do not use audience-appropriate language and do not draw on group norms

These barriers can be addressed through process changes, particularly through the diversification of engagement methods. While the literature and research data show that increased resourcing and financial incentives for physician involvement would increase collaboration, the current budgetary reality of Island Health limits this possibility. Instead, it would be more effective to ensure that the time physicians give to quality improvement initiatives is optimized and efficient. Engagement methods should be cognisant of the fact that physicians are not paid to read background information and material, and are not compensated equally to attend large quality improvement meetings. Therefore, methods should be succinct, focussed, and brief. Ideally, background information would be already summarized, and feedback would be gathered on a one-to-one or in-person format. Implementing new ways of including physician voice would help to mitigate barriers created by time constraints and differences in professional orientation.

Joint training and leadership development opportunities would also serve a number of purposes in mitigating barriers:

- It would increase knowledge of quality improvement and change management
- It would enhance physician leadership skills throughout the Department
- It would help bridge the gap between professional cultures and perspectives by creating a shared understanding and recognition for the role of different professional backgrounds
- It would provide an opportunity for individuals to establish personal relationships
- It may help create a culture that is less resistant to change

Finally, recognizing and enabling informal physician leadership at multiple levels of the organization will aid in being responsive to the needs of different areas of the system and for sustaining cultural change and trust. Distributive physician leadership includes identifying physician champions, and diffusing authority, accountability, and capability. Interview data also identified informal physician championship as a helpful resource in bridging the gap between administrative and physician processes and ways of thinking. Recognizing that filling physician co-lead positions continues to be a challenge, encouraging formal and informal physician leadership at multiple levels and providing training and development opportunities would be beneficial to bridging that physician-administration rift.

5.5 A note on Island Health fiscal conditions

In developing the recommendations presented, the current fiscal conditions of Island Health were taken into account. The recommendations sought to be responsive to the realities of a restricted budget, with efforts to limit the number of recommendations that are dependent on financial expenditure. Some recommendations do note where financial support would be beneficial in order to provide comprehensive options if financial conditions or priorities change in the future.

6 RECOMMENDATIONS

The recommendations, created using the conceptual framework and knowledge drawn from the literature review, are intended for the MHSU Leadership Council. They are intended to improve the relationship and communication through meaningful dialogue, opportunities to build personal relationship, and a behavioural accountability framework. They should also help bridge differences in professional cultures, clarify roles and responsibilities, and facilitate commitment from both administration and physicians to work more effectively and collaboratively in future quality improvement initiatives. They consider physician time limits as well as the physicians fee-for-service structure, which pays more for clinical work than for quality improvement work.

It should be noted that adopting the following recommendations will require significant commitment of time, energy, and in some cases money. However, establishing effective partnerships between management and physicians has potential for far-reaching and long-term benefits for organizational culture and outcomes.

There are external funding opportunities for physician participation in quality improvement, which could be helpful in implementing the following recommendations. Doctors' of BC's Specialist Services Committee (SSC) offers the Physician Quality Improvement Initiative, which provides training and support to physicians involved in quality improvement, and the Supporting Facility Engagement Initiative which supports engagement between physicians and health authorities.

It should be noted that the use of a trained facilitator is integral to successful dialogue, and is also recommended for building a behavioural accountability framework. This facilitator should be external to MHSU and needs to be approved of by both Administration and physicians. The importance of an opportunity for open dialogue should not be overlooked as it is a fundamental method for improving deeply-rooted conflict and cultural differences, and would provide a valuable foundation to ensure the administrative-physician compact is meaningful.

It is recognized that efforts to improve the relationship are vulnerable to the same issues that this project addresses; physician participation to a large extent is voluntary and engagement may be a challenge. However, this research does indicate a willingness to improve the relationship, as well as acknowledgement that collaboration is in fact necessary for quality improvement. Recommendations are targeted to the service level, in recognition that smaller groups will likely be easier to engage and to facilitate flexibility in *how* physicians are engaged. Again, physician leadership is an effective tool in physician-to-physician engagement and should be utilized in implementing the recommendations.

Recommendations:

1. Offer facilitated dialogue sessions with physicians and key MHSU staff at the service level to address assumptions, professional cultures, and areas of distrust.
 - a. Target and prioritize areas where conflict is greatest or where it will be most beneficial.
 - b. Integrate into team meetings or already dedicated physician time to the greatest extent possible.
 - c. Compensate physicians to the greatest extent possible.
2. With the use of a facilitator, establish a working group to build a Behavioural Accountability Framework to hold all MHSU staff and physicians accountable to a common standard of behaviour.
 - a. Align with Island Health Standards of Conduct and Values and the Canadian Medical Association Code of Ethics.

- b. Empower all individuals to hold each other accountable and as a Leadership Committee act as a reinforcing body.
 - c. Integrate varying layers of accountability (ex. calling inappropriate behaviour, having one-on-one discussions, dissolving meetings where inappropriate behaviour is present, official apologies, and reporting to Island Health or the Royal College of Physicians and Surgeons of Canada).
- 3. Encourage formal and informal opportunities for people to get to know each other beyond their role as administrator or physician to mitigate the perception of incompatible collective identities.
- 4. Apply for funding through the Supporting Facility Engagement Initiative, and invest this funding in activities which will contribute to more sustained improvements to the relationship itself, such as dialogue sessions or physician participation in relevant working groups.
- 5. Offer in-person joint training opportunities for change management, leadership, and dispute resolution.
 - a. Provide to multiple levels of MHSU staff and physicians.
 - b. Compensate physicians to the greatest extent possible; consider using funding from the Physician Quality Improvement Initiative.
- 6. Explicitly acknowledge and celebrate successful instances of collaboration and engagement within MHSU.
- 7. Propose a time-limited working group of physicians and MHSU staff to the Department of Psychiatry to address methods of communication between the MHSU Leadership Council and the Department as collective bodies.
 - a. Explicitly outline roles, responsibilities, and agency to implement change at all levels of organization—communicate this to all service areas.
- 8. Utilize physician leadership and the co-leadership structure to explore preferred physician engagement strategies at the individual service level.
 - a. Utilize and empower Manager and Physician Co-leads to experiment and implement new methods based on feedback.
 - b. Consider brief one-on-one meetings to gather in person feedback on key decision points.
- 9. Encourage informal physician leadership opportunities at multiple levels of the organization; identify champions and diffuse authority and accountability in order to bridge the cultural gap and be more responsive to physician needs.
- 10. Offer leadership and development training to all physicians.
 - a. Consider using funding from the Physician Quality Improvement Initiative.
- 11. Following recommendations 1,2 and 3, develop an Administrative-Physician compact to explicitly articulate the relationship and explicate reciprocal expectations and responsibilities.
 - a. Include a shared vision statement.
 - b. Integrate with the Behavioural Accountability Framework.

This research project has revealed that transforming the relationship and establishing a collaborative partnership within MHSU is not only valued by both physicians and administration, but is also universally identified as necessary for successfully improving the system within the SI Review. Despite the dedicated effort required, and the many barriers which present themselves in the process, establishing effective partnerships within MHSU offers both short- and long-term benefits for the organization, and potentially for broader networks.

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8 APPENDICES

APPENDIX A: Survey Questions

| | | MHSU | DoP | | |
|---|--|--------------------------|--------------------------|--------------------------|--------------------------|
| Please indicate whether you are MHSU staff or a member of the Department of Psychiatry | | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Please indicate to which extent you agree or disagree with the following statements: | | | | | |
| | 1= Strongly Disagree | 2= Disagree | 3= Neutral | 4= Agree | 5= Strongly Agree |
| 1) The current relationship between MHSU and the Department of Psychiatry is problematic | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Trust exists and is maintained in the current relationship between MHSU and the Department of Psychiatry | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) The current relationship between MHSU and the Department of Psychiatry has implications for the broader MHSU organizational culture | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) The current relationship between MHSU and the Department of Psychiatry negatively affects my well-being at work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) At some point, I have felt my traditional professional role has been negatively impacted by the relationship between MHSU and the Department of Psychiatry | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) The current relationship between MHSU and the Department of Psychiatry does not negatively affect general staff satisfaction at work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) The current relationship between MHSU and the Department of Psychiatry does not affect staff and physician turnover rates | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) The current relationship between MHSU and the Department of Psychiatry is a primary barrier to implementing quality improvement initiatives | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) I feel I have sufficient opportunities to voice concerns or opinions regarding quality improvement initiatives | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10) I feel safe voicing my opinions and concerns to colleagues and leadership regarding quality improvement initiatives | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11) I feel my ideas and concerns are considered when making decisions regarding quality improvement initiatives | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12) Collaboration between MHSU and the Department of Psychiatry is necessary for the SI Review and successful future quality improvement initiatives | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13) The following are current barriers to successful collaboration and | <input type="checkbox"/> Differences in administrative and physician professional cultures <input type="checkbox"/> Stereotyping of each other <input type="checkbox"/> Time constraints | | | | |

| | |
|--|---|
| engagement (check all that apply) | <input type="checkbox"/> Desire for autonomy <input type="checkbox"/> Lack of knowledge and skills in quality improvement <input type="checkbox"/> Current communication structures between MHSU and the Department of Psychiatry <input type="checkbox"/> Current methods of including physician voice in quality improvement initiatives |
| If other, please specify | |
| 14) The following would increase collaboration and engagement (check all that apply) | <input type="checkbox"/> Economic incentives and compensation <input type="checkbox"/> Staff and physician training in quality improvement and change management <input type="checkbox"/> Establishing a shared purpose <input type="checkbox"/> Showing data-driven results of quality improvement initiatives |
| If other, please specify | |
| Open-Ended Questions | |
| 15) Within the context of MHSU, define “collaboration” and “engagement” | |
| 16) What is your preferred method for engaging and collaborating? | |
| 17) What do you see as keys to successful collaboration and engagement? | |

APPENDIX B: Survey Implied Consent Form



Investigating Barriers to Collaboration in Island Health's Mental Health and Substance Use

SURVEY PARTICIPANT INFORMATION & CONSENT FORM

PRINCIPAL INVESTIGATOR AND STUDY TEAM:

Principal Investigator Name and Affiliation/Title: Anna Baker BA(H), University of Victoria

Phone Number: 250-419-1545

Email: anna.baker@shaw.ca

Project Supervisor: Dr. Rebecca Warburton, University of Victoria

MHSU Sponsor: Monica Flexhaug, Project Manager

Background and Purpose of the Study

You are invited to participate in a research study. Your participation must be free and voluntary. You are free to withdraw at any time.

The purpose of this research project is to investigate the organizational culture within Island Health's Mental Health and Substance Use, within the context of the South Island Review and quality improvement initiatives. This survey seeks to identify current or potential barriers to collaboration, with a focus on MHSU and Physician relations.

You are being asked to participate in this study because you are either a MHSU Administrative Leader, Manager, or Coordinator, or are a member of the South Island Department of Psychiatry, and thus have valuable expertise regarding the identified issues.

Please be assured that, in alignment with the dispute resolution analytical framework of this project, the responses, conclusion, and participation of individuals will be managed with the aim of harmonizing some of the cultural-relational discord, and never to alienate individuals, stakeholders, respondents, or community-groups.

Location of Research

This survey will be conducted online and can be accessed by both internal and external electronic devices. The survey may be conducted during work hours.

Number of Participants

The survey portion of this research study seeks to recruit approximately 90 participants, with representation from both MHSU staff and Department of Psychiatry physicians.

What is Required if I Participate?

If you decide to participate in this study, you will be asked to complete an online survey consisting of both closed and open-ended questions. The study requires that the survey is completed only one time,

with an estimated time commitment of approximately 10 minutes. No question is mandatory, and each question will have the option to not answer.

What are the Possible Risks or Inconveniences of Participating?

The anticipated risks of this study are minimal, however there is recognition that the topic area may cause some participants emotional discomfort. The primary potential inconvenience of participating in this study is the time commitment required to complete the interview, given the busy schedules of participants.

What are the Possible Benefits of Participating?

The possible benefits of your participation in this study include:

- Improved current and future working relationships within MHSU
- Improved organizational culture and communication structures within MHSU
- More efficient and effective quality improvement initiatives due to improved staff engagement and collaboration
- Improved staff and physician wellbeing within the organization
- General advancement of knowledge in the field of dispute resolution and organization development

Do I Have to Take Part?

Your participation is entirely voluntary. This research project includes Island Health staff and Physicians on contract with Island Health. If you decide not to participate employment status will not be affected in any way. Participation in this study will remain anonymous, you will not be asked to provide personally identifying information during the survey. By consenting, you have not waived any rights to legal recourse connected to research-related harm. If you do decide to participate and then change your mind later, you can withdraw without any consequences or explanation; you may withdraw at any point during the survey by cancelling your submission. This is done by simply closing the browser window. Your survey submission will be erased, meaning no data entered up until the point of withdrawal will be used. However, once you have officially submitted your final survey responses, you will not be able to withdraw.

Will I be Paid for Taking Part?

You will not be provided with any payments or coverage of costs for participating in this study, however the survey may be completed during work time.

Researcher's Relationship with Participants

As the Principle Investigator, I am a former colleague of some participants. Further, this project is sponsored by MHSU through Monica Flexhaug, Project Manager. To help prevent my previous relationship from influencing your decision to participate, the following steps have been taken:

- I am no longer an employee of Island Health
- The study sponsor will not have access to research data
- Any perceived conflict of interest has been identified and openly stated
- My supervisor, an impartial third party, has reviewed all research material which helps minimize undue or avoidable bias

On-Going Consent

If new information becomes available, or if this project takes place over a longer period of time, we will ask you to renew your consent to participate.

Confidentiality & How my Personal Information will be used

If you decide to participate in this survey, every effort will be made to ensure that you and the data you provide remain anonymous to the greatest extent possible. The only identifiable information collected during the survey will be whether you are Island Health staff or a physician. Disclosure of names or position title will not be requested. Raw data collected from the survey will not be shared. The data collected for this research project will be stored in Canada at Island Health, on encrypted devices, for the purpose of this study only. Access to data will be limited to the Principal Investigator only. Please note that a limitation to confidentiality is the small work place pool of study recruitment and participation.

Data Management

Survey data will be maintained within the REDCap survey application for analysis. REDCap is maintained by Island Health, meaning that all survey data is stored within Canada. Only the Principal Investigator will have access to this data, which is password protected. The data will be retained for the duration of the study, approximately 6 months. Results of data analysis will be transferred to personal laptop of the Principal Investigator. This data will be encrypted, and the laptop itself is password protected will access limited strictly to the Principal Investigator.

Future Use of Data

Data will be destroyed at the conclusion of the study, and thus will not be available for future use.

Disposal of Data

Your data from this study will be disposed of in the following manner:

| Data Source | How Destroyed | When Destroyed |
|-----------------|--|---|
| Survey response | Permanently Deleted from the REDCap database | Will be destroyed at the completion of this project |

Sharing of Study Results

A summary of the study results will be provided to you upon request. You will be notified when the study results are finalized, at which point a request can be made. The study results will be presented as a report to a committee including my Island Health client (Monica Flexhaug, 250-370-8260 x18260) and UVic Public Administration faculty as part of my master’s project defense. Once approved, the final report will also be publicly available on the UVic website: <https://dspace.library.uvic.ca:8443/handle/1828/83>

Who Should I Contact if I Need More Information or Help?

The contact information for the Principal Investigator is provided on the first page of this Informed Consent Form. You may also contact the supervisor of this research project, Dr. Rebecca Warburton (rnwarbur@uvic.ca) for further information about this research or the project process more broadly. For questions or concerns about your rights as a research participant, please contact the Island Health Research Ethics Office in Victoria at (250) 519-6726 or email: researchethics@viha.ca.

CONSENT

By beginning the survey, you provide your implied consent. By providing this consent you indicate that:

1. You understand the requirements, risks, and responsibilities of participating in the research project, and;
2. You understand how your information will be accessed, collected and used.
3. You understand that your anonymous data cannot be withdrawn once your survey responses have been officially submitted
4. All of your questions have been fully answered by the researchers.
5. You consent to participate in the research study

APPENDIX C: Interview Questions

1. From your perspective, please describe the nature of the current relationship between MHSU Administration and the South Island Department of Psychiatry.
2. Do you feel that this relationship affects the organizational culture of MHSU more broadly? If so, can you please explain further.
3. Do you feel the current relationship (and resulting organizational culture) impact your wellbeing at work? If so, in what ways?
4. Can you help me better understand the history of the relationship between MHSU and the Department of Psychiatry?
5. My project is overcoming barriers to collaboration and engagement between MHSU and the Department of Psychiatry. What do you feel are the barriers to collaboration and engagement occurring or being successful?
 - a. Is there anything that could be done to improve this?
6. Can you tell me about what collaboration means to you in the context of MHSU?
7. Can you tell me about what engagement means to you in the context of MHSU?
8. Can you describe a negative experience between MHSU and Physicians?
 - a. In your opinion what were the factors which contributed to this?
9. Can you provide me with any examples where you've seen collaboration or engagement happen in a positive way?
 - a. In your opinion what were the factors which contributed to this?
10. What do you see as keys to successful engagement and collaboration?
11. What do you think are ways to make the conversation about collaboration and engagement more successful?
12. What is your preferred method for engaging/collaborating?
13. If there is positive change, describe what the future working relationship between MHSU and the Department of Psychiatry would look like?

APPENDIX D: Interview Informed Consent Form



Investigating Barriers to Collaboration in Island Health's Mental Health and Substance Use

INTERVIEW PARTICIPANT INFORMATION & CONSENT FORM

PRINCIPAL INVESTIGATOR AND STUDY TEAM:

Principal Investigator Name and Affiliation/Title: Anna Baker BA(H), University of Victoria

Phone Number: 250-419-1545

Email: anna.baker@shaw.ca

Project Supervisor: Dr. Rebecca Warburton, University of Victoria

MHSU Sponsor: Monica Flexhaug, Project Manager

Background and Purpose of the Study

You are invited to participate in a research study. Your participation must be free and voluntary. You are free to withdraw at any time.

The purpose of this research project is to investigate the organizational culture within Island Health's Mental Health and Substance Use, within the context of the South Island Review and quality improvement initiatives. This survey seeks to identify current or potential barriers to collaboration, with a focus on MHSU and Physician relations.

You are being asked to participate in this study because you are either a member of MHSU Administrative Leadership, or are a member of the South Island Department of Psychiatry, and thus have valuable expertise regarding the identified issues.

Please be assured that, in alignment with the dispute resolution analytical framework of this project, the responses, conclusion, and participation of individuals will be managed with the aim of harmonizing some of the cultural-relational discord, and never to alienate individuals, stakeholders, respondents, or community-groups.

Location of Research

This research study will be conducted at the Royal Jubilee Hospital, in locations convenient for or preferred by participants. Locations will be pre-determined prior to the interview and will be chosen to protect participants' confidentiality. You may participate in the interview during work hours.

Number of Participants

In total, the interview portion of this research study will consist of ten participants, with equal representation from physicians and MHSU administration. Interviews will be conducted individually.

What is required if I participate?

If you decide to participate in this study, you will be asked to participate in one in-person interview. Interviews will be approximately 1 hour in length, and will be held at a location most convenient for you, which will be established prior to the interview.

What are the Possible Risks or Inconveniences of Participating?

While this study has minimal potential risk, there is recognition that participation may cause emotional discomfort during interviews due to the topic area. Discussing aspects of the current organization culture may give rise to negative feelings or may be a sensitive topic. To reduce risks, the following steps will be taken:

- You may terminate the interview at any point if you feel distressed
- You may choose to not answer any question you do not wish to address

The primary potential inconvenience of participating in this study is the time commitment required to complete the interview, and potential scheduling inconveniences given the busy schedules of participants. You will not be required to travel as the Principle Investigator will be travelling to your preferred location.

What are the Possible Benefits of Participating?

The possible benefits of your participation in this study include:

- Improved current and future working relationships within MHSU
- Improved organizational culture and communication structures within MHSU
- More efficient and effective quality improvement initiatives due to improved staff engagement and collaboration
- Improved staff and physician wellbeing within the organization
- General advancement of knowledge in the field of dispute resolution and organization development

Do I have to take part?

Your participation is entirely voluntary. This research project includes Island Health staff and Physicians on contract with Island Health. If you decide not to participate employment status will not be affected in any way. Recruitment of interview participants will remain private, and expression of interest to participate will remain confidential. Data collected during interviews will be de-identified to maintain confidentiality. By consenting, you have not waived any rights to legal recourse connected to research-related harm.

If you do decide to participate and then change your mind later, you can withdraw without any consequences or explanation. You may withdraw at any point during the interview by simply requesting to do so from the Principal Investigator. At that point any interview data already collected will not be used. You may also withdraw your interview data, after the completion of the interview, up until the point of data analysis. You may do this by contacting the Principal Investigator directly, either via email or phone. If you decide to withdraw from the study, your interview data will be destroyed immediately by the Principal Investigator.

Will I be paid for taking part?

You will not be provided with any payments or coverage of costs for participating in this study, however the interview may be completed during work time.

Researcher's Relationship with Participants

As the Principle Investigator, I am a former colleague of some participants. Further, this project is sponsored by MHSU through Monica Flexhaug, Project Manager. To help prevent my previous relationship from influencing your decision to participate, the following steps have been taken:

- I am no longer an employee of Island Health
- The study sponsor will not have access to research data
- Any perceived conflict of interest has been identified and openly stated
- My supervisor, an impartial third party, has reviewed all research material to ensure it is free of bias

On-Going Consent

If new information becomes available, or if this project takes place over a longer period of time, we will ask you to renew your consent to participate.

Confidentiality & How my Personal Information will be used

Some information will be collected during interviews for the purposes of identification. Information collected will include participant position (either Administration or Physician) as well as the name of the participant. All data recorded will be stored on encrypted devices with access limited to the Principal Investigator only. Once interview data is transcribed participant names will be removed and interviews will receive an identification number. The Principal Investigator will be responsible for de-identifying the transcriptions and will be the only person with access to personal information. At no point will personal information be shared. Please note that a limitation to confidentiality is the small work place pool of study recruitment and participation. Any identifiable information that may result from interview answers or content will be removed from discussion of data analysis and the final report.

Audio Recording of Interview

Interviews will be audio-taped by the Principle Investigator, using a digital voice recording application on the Principal Investigator's cell phone. Audio files will be stored locally on the cell phone memory card and will be encrypted and password protected, as will the device itself. Access to the recorder will be limited to the Principal Investigator. The audio-recording will be transcribed by the Principal Investigator. The recording will be deleted at the completion of this study.

Data Management

Interview data will be stored and maintained by the Principal Investigator, at their residence. Data will be transferred using a password protected laptop and all documents will be encrypted. Any data existing in paper will be maintained by the Principal Investigator. This will be done by ensuring documents remain on the Principal Investigator's person when in public or onsite, and will be held in an opaque folder to ensure visual concealment. All information will be stored at the personal residence of the Principal Investigator, in a locked filing cabinet. Access will be limited to the Principal Investigator exclusively. All data will be retained for the duration of the study, approximately 6 months,

Future Use of Data

Data will be destroyed at the conclusion of the study, and thus will not be available for future use.

Disposal of Data

Your data from this study will be disposed of in the following manner:

| Data Source | How Destroyed | When Destroyed |
|-----------------------|-------------------------|-----------------------|
| Audio recording | Permanently Deleted | After study completed |
| Interview transcripts | Confidentially Shredded | After study completed |
| Interview notes | Confidentially Shredded | After study completed |

Sharing of Study Results

A summary of the study results will be provided to you upon request. You will be notified when the study results are finalized, at which point a request can be made. The study results will be presented as report to a committee including my Island Health client (Monica Flexhaug, 250-370-8260 x18260) and UVic Public Administration faculty as part of my master's project defense. Once approved, the final report will also be publicly available on the UVic website:

<https://dspace.library.uvic.ca:8443/handle/1828/83>

Who Should I Contact if I Need More Information or Help?

The contact information for the Principal Investigator is provided on the first page of this Informed Consent Form. You may also contact the supervisor of this research project, Dr. Rebecca Warburton (rnwarbur@uvic.ca) for further information about this research or the project process more broadly. For questions or concerns about your rights as a research participant, please contact the Island Health Research Ethics Office in Victoria at (250) 519-6726 or email: researchethics@viha.ca. If at any point during this study you require further support, you may also contact the Island Health Employee Assistance Program at 1.866.833.7690 or at workhealthlife.com.

CONSENT

Your signature below indicates that:

- All sections of this Consent form have been explained to your satisfaction
- You understand the requirements, risks, potential and responsibilities of participating in the research project, and;
- You understand how your information will be accessed, collected and used.
- All of your questions have been fully answered by the researchers.
- You consent to participate in this research study

Name of Participant

(print)

Signature

Date

Please retain a copy of this consent for your own records

APPENDIX E: Certificate of Ethical Approval



Board of Record
Island Health
Health Research Ethics Board (HREB)
1952 Bay Street
3rd Floor – Kenning Wing, Memorial Pavilion
Royal Jubilee Hospital
Victoria, BC V8R 1J8

Certificate of Ethical Approval for Harmonized
Minimal Risk Health Study

Also reviewed and approved by:
University of Victoria

Principal Investigator:

Ms. Anna Baker

Primary Appointment:

Island Health

Board of Record

Approval Reference #:

J2017-056

Study Title: **Investigating Barriers to Collaboration in Island Health's Mental Health and Substance Use**

Study Approved: 14 August 2017

Expiry Date: 13 August 2018

Research Team Members: Dr. Rebecca

Warburton Sponsoring Agencies: **N/A**

Documents included in this approval:

Project Proposal, Version 3, Dated, 03 August 2017
Interview Informed Consent, Version 3, Dated, 03 August 2017
Survey Informed Consent, Version 3, Dated, 03 August 2017
Email Recruitment Letter, Version 3, Dated, 07 August 2017
Data Collection Instruments, Version 4, Dated, 09 August 2017
Data Flow Diagram, Version 3, Dated, 03 August 2017
Supervisor Approval Email Version Dated, 06 June 2017

This ethics approval applies to research ethics issues only and does not include provision for any administrative approvals required from individual institutions before research activities can commence.

The Board of Record (as noted above) has reviewed and approved this study in accordance with the requirements of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2, 2014).

The “Board of Record” is the Research Ethics board designated on behalf of the participating REBs involved in a harmonized study to facilitate the ethics review and approval process. In the event that there are any changes or amendments to this approved protocol, please notify the Board of Record.

Board of Record Research Ethics Board Representatives

Name: Ms. Sherri Pooyak, MSW

Name: Ms. Crystal White, MA

Title: Co-Chair, Island Health HREB

Title: Co-Chair, Island Health HREB

Date: 14 August 2017

Date: 14 August 2017

Signature:

Signature:

APPENDIX F: Certificate of Operational Approval



Research and Capacity Building

Memorial Pavilion – Main Floor | Royal Jubilee Hospital | 1952 Bay Street | Victoria, BC V8R 1J8

INSTITUTIONAL APPROVAL TO CONDUCT A RESEARCH PROJECT

Researcher: **Ms. Anna Baker**

Study Title: **Investigating Barriers to Collaboration in Island Health’s Mental Health and Substance Use**

Island Health File Number: **J2017-056**

Institutional Approval Date: 16 August 2017

Certificate of Ethical Approval Date: 14 August 2017

This is to inform you that your research project may now be initiated as of the approval date above and is approved based on the following:

1. The Certificate of Approval dated above issued by the Health Research Ethics Board on behalf of Island Health.
2. All Island Health Operational Review approvals are received by Research and Capacity Building.

The institutional Approval to Conduct a Research Project will remain in effect as long as the Health Research Ethics Board approval is renewed annually and all amendments submitted are approved as required throughout the duration of this project. The Institutional Approval to Conduct a Research Project will expire upon the HREB receipt and acknowledgement of the study closure report.

This Institutional Approval to Conduct Research does not represent approval to use a new intervention or product within Island Health. Please discuss with the appropriate Director/Executive Director regarding making any changes to practice.



Our Values

Courage: to do the right thing – to change, innovate and grow.

Aspire: to the highest degree of quality and safety.

Respect: to value each individual and bring trust to every relationship.

Empathy: to give the kind of care we would want for our loved ones.

Date: 16 August 2017

Signature:

Terri Fleming, Manager Research Compliance and Ethics
on behalf of Cindy Trytten Director, Research and Capacity Building

APPENDIX G: Certificate of Amendment Approval



Board of Record
to Harmonized
Island Health
Health Research Ethics Board (HREB)
1952 Bay Street
3rd Floor – Kenning Wing, Memorial Pavilion
Royal Jubilee Hospital
Victoria, BC V8R 1J8

Ethical Approval for Amendment

Minimal Risk Health Study

Also approved on behalf of:
University of Victoria

Principal Investigator: Primary Appointment: Board of Record Approval Reference #:

ANNA BAKER **UNIVERSITY OF VICTORIA** **J2017-056**

Study Title: **Investigating Barriers to Collaboration in Island Health’s Mental Health and Substance Use**

Amendment Approved: **13 OCT 2017**

Research Team Members: Dr. Rebecca Warburton, University of Victoria

Sponsoring Agencies: n/a

Documents included In this approval:

- Amended Project Proposal v 4 dated 12 Oct 2017

This ethics approval applies to research ethics issues only and does not include provision for any administrative approvals required from individual institutions before research activities can commence.

The Board of Record (as noted above) has reviewed and approved this study in accordance with the requirements of the TriCouncil Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2, 2014).

The “Board of Record” is the Research Ethics board designated on behalf of the participating REBs involved in a harmonized study to facilitate the ethics review and approval process. In the event that

there are any changes or amendments to this approved protocol, please notify the Board of Record.

Board of Record Research Ethics Representative

Name: Terri Fleming

Title: Manager, Research Compliance & Ethics

Signature:

Date: 13 Oct 2017

APPENDIX H: Survey Ordinal Data Analysis Table

| Variable | Admin Mean | MD Mean | p-value |
|--|------------|---------|---------|
| 1. The current Relationship between MHSU and the Department of Psychiatry is problematic | 4.08 | 3.82 | 0.30 |
| 2. Trust exists and is maintained in the current relationship | 3.67 | 3.44 | 0.51 |
| 3. The current relationship has implications for the broader MHSU organizational culture | 4.75 | 4.35 | 0.03* |
| 4. The current relationship negatively affects my well-being at work | 3.08 | 3.23 | 0.71 |
| 5. At some point, I have felt my traditional professional role has been negatively impacted by the relationship | 3.83 | 3.71 | 0.72 |
| 6. The current relationship does not negatively affect general staff satisfaction at work | 3.83 | 3.71 | 0.65 |
| 7. The current relationship does not negatively affect staff and physician turn over rates | 3.27 | 3.71 | 0.26 |
| 8. The current relationship is a primary barrier to implementing quality improvement initiatives | 4.25 | 3.18 | 0.01* |
| 9. I feel I have sufficient opportunities to voice concerns or opinions regarding quality improvement initiatives | 2.75 | 2.76 | 0.97 |
| 10. I feel safe voicing my opinions and concerns to colleagues and leadership regarding quality improvement initiatives | 2.25 | 2.65 | 0.29 |
| 11. I feel my ideas and concerns are considered when making decisions regarding quality improvement initiatives | 2.67 | 3.06 | 0.28 |
| 12. Collaboration between MHSU and the Department of Psychiatry is not necessary for the SI Review and successful future quality improvement initiatives | 1.09 | 1.41 | 0.05* |
| Overall t-test for all variables | | | 0.91 |

*Statistically significant at 95% confidence level

In this survey, some questions have higher scores for indicators that are negative for organizational culture and ability to work collaboratively, and some are reverse-scaled, with higher scores for positive indicators, which provides better answers by participants as no bias is seen in the questions. However, reverse-scaled questions (2, 6, 7, 9-12) must have their scores adjusted (reflecting how far from 3 the answer was) before calculating means and testing for the difference in means. Blue-shaded questions above are reverse-scaled.

APPENDIX I: Survey Checklist Data Analysis Table

| Barriers | Admin n=13 | Admin % | MD n=17 | MD % | p- value |
|---|-----------------------|--------------------|--------------------|-----------------|---------------------|
| Differences in Administrative and Physician professional cultures | 10 | 77% | 14 | 82% | 0.74 |
| Stereotyping of each other | 9 | 69% | 12 | 71% | 0.91 |
| Time constraints | 10 | 77% | 14 | 82% | 0.74 |
| Desire for autonomy | 9 | 69% | 9 | 53% | 0.38 |
| Lack of knowledge and skills in quality improvement | 4 | 31% | 10 | 59% | 0.13 |
| Current communication structures between MHSU and the Department of Psychiatry | 5 | 38% | 12 | 71% | 0.08 |
| Current methods of including physician voice in quality improvement initiatives | 2 | 15% | 10 | 59% | 0.02 |

| Facilitators | Admin n=13 | Admin % | MD n=17 | MD % | p- value |
|---|-----------------------|--------------------|--------------------|-----------------|---------------------|
| Economic incentives and compensation | 5 | 38% | 13 | 76% | 0.04 |
| Staff and physician training in quality improvement and change management | 7 | 54% | 11 | 65% | 0.55 |
| Establishing a shared purpose | 12 | 92% | 11 | 65% | 0.09 |
| Showing data-driven results of quality improvement initiatives | 10 | 77% | 14 | 82% | 0.74 |

APPENDIX J: Characteristics of Dialogue vs. Debate

| Debate | Dialogue |
|---|---|
| Assuming that there is a right answer and you have it | Assuming that many people have pieces of the answer and that together they can craft a solution |
| Combative: participants attempt to prove the other side wrong | Collaborative: participants work together toward common understanding |
| About winning | About exploring common ground |
| Listening to find flaws and make counterarguments | Listening to understand, find meaning and agreement |
| Defending assumptions as truth | Revealing assumptions for re-evaluation |
| Critiquing the other side's position | Re-examining all positions |
| Defending one's own views against those of others | Admitting that others' thinking can improve on one's own |
| Searching for flaws and weaknesses in other positions | Searching for strengths and value in others' positions |
| Seeking a conclusion or vote that ratifies your position | Discovering new options, not seeking closure |

Yankelovich, 1999, pp. 39-40

APPENDIX K: Strategies of Dialogue

| | |
|--------------------|---|
| Strategy 1 | Err on the side of including people who disagree |
| Strategy 2 | Initiate dialogue through a gesture of empathy |
| Strategy 3 | Check for the presence of all three core requirements of dialogue—equality, empathic listening, and surfacing assumptions nonjudgmentally—and learn how to introduce the missing ones |
| Strategy 4 | Minimize the level of distrust before pursuing practical objectives |
| Strategy 5 | Keep dialogue and decision making compartmentalized |
| Strategy 6 | Focus on common interests, not divisive ones |
| Strategy 7 | Use specific cases to raise general issues |
| Strategy 8 | Bring forth your own assumptions before speculating on those of others |
| Strategy 9 | Clarify assumptions that lead to subculture distortions |
| Strategy 10 | Where applicable, identify mistrust as the real source of misunderstandings |
| Strategy 11 | Expose old scripts to a reality check |
| Strategy 12 | Focus on conflicts between value systems, not people |
| Strategy 13 | Be sure trust exists before addressing transference distortions |
| Strategy 14 | When appropriate, express the emotions that accompany strongly held values |
| Strategy 15 | Encourage relationships in order to humanize transactions |

Yankelovich, 1999, pp. 127-128

APPENDIX L: Negative Intergroup Behaviour Definitions and Attitudinal Principles of Good Communication


Negative intergroup behaviour definitions:

- **Cognitive biases** which result in and from stereotypical assumptions (Hewstone & Giles, 1986, p.15).
- **Attribution errors involving biases.** These include assigning responsibility for errors to out-group members, remembering in-group and out-group member behaviour differently, and developing expectations about individuals based on group category (Detweiler, 1986, pp. 71-72).
- **Deindividuation and depersonalization of out-group members,** in which individuals do not see individual personality traits, but rather view all members of an out-group as largely homogenous (Gudykunst, 1986, p. 165).

Mayer (2000) provides seven ideal attitudinal principles, which he argues form the basis for successful communication and conflict resolution (p. 122-123):

- *Caring about what others are saying-* genuine care to understand what that other person is saying will be communicated, and vice-versa.
- *There is always new information to learn from a communication-* real communication cannot occur if people are composing a response to what they think the other person is saying.
- *Good communication requires focused energy-* focused attention on an exchange usually makes the other person feel respected, even in the midst of communication. However, communicating clearly takes energy and work.
- *Effective communication requires a joint effort between speaker and listener-* effective communication is interactive and iterative, and people need to directly or indirectly verify whether they have really understood each other.
- *Communicating is different from persuading, evaluating, and problem solving-* effective communication is less likely if the focus is on convincing others you are “right” or on evaluating the merits of what others have said. The focus should be on trying to understand what each other is saying.
- *Tolerance of people’s difficulty in communicating is essential-* it is important to be respectful of others who are trying to communicate, with recognition that everyone mixes up communicating, persuading, and problem solving at times.
- *The best communication occurs when people are genuine and natural-* communication is most effective when people are being authentic, speaking from the heart, and connecting with others on the basis of human personalities, which by definition are flawed.

APPENDIX M: Example Administrator/Physician Compact

|  | THE OTTAWA HOSPITAL / PHYSICIAN ENGAGEMENT AGREEMENT | |
|--|---|--|
| The Hospital's Commitment to Physicians | Values of The Ottawa Hospital | Physicians' Commitment to The Hospital |
| <ul style="list-style-type: none"> • Foster a culture of excellence in quality of care within an academic environment. • Strive to develop a culture infused with, and informed by, our organization's four values. • Support this commitment to quality by choosing measures that are relevant, context sensitive, meaningful and objective. • Cultivate a culture of trust. To that end, evaluations of processes, systems and people must be timely, candid and constructive. | Commitment to Quality | <ul style="list-style-type: none"> • Champion the development and adoption of organizational processes, practices and policies that drive excellence in quality of care within an academic environment. • Provide quality patient care. Measure progress. • Actively work with the hospital. Acknowledge your key role in improving individual and hospital care processes to boost quality and safety. |
| <ul style="list-style-type: none"> • Create an environment that contributes to physical and emotional health. • Provide care in a manner consistent with patient- and family-centred principles. • Promote physician and staff health and well-being. | Compassion | <ul style="list-style-type: none"> • Recognize patients as the primary focus of our collective efforts and advocate on their behalf. • Protect patient privacy and dignity. • Communicate with patients and families in a clear, timely, supportive, engaged and empathetic manner. |
| <ul style="list-style-type: none"> • Make decisions and allocate resources in a consultative manner: listen to stakeholders, be transparent and assume accountability for those decisions. • Share information and communicate directly and proactively in an honest, consistent and meaningful way. • Ensure that organizational processes and clinical systems are effective; that they recognize and respect the relationship of physicians with the hospital and patients, and align with the hospital's core values. • Recognize and celebrate the accomplishments of physicians and staff. • Demonstrate clear, effective and transparent leadership. | Working Together | <ul style="list-style-type: none"> • Engage with others, actively listen to them, communicate respectfully, and consider their ideas. • Participate in decision-making. Practice in accordance with group decisions. • Use resources in an appropriate way and be accountable for utilization. • Work within and respect organizational processes and clinical systems. • Treat co-workers as you would like to be treated. |
| <ul style="list-style-type: none"> • Treat everyone at The Ottawa Hospital with fairness, equity and respect. • Value and respect diversity. | Respect for the Individual | <ul style="list-style-type: none"> • Treat everyone at The Ottawa Hospital with fairness, equity and respect. • Value and respect diversity. |
| <hr/> Dr. Jack Kitts, TOH President & CEO | <hr/> Physician Name | <hr/> Physician Signature |
| | <hr/> Dept/Division Head Signature | <hr/> Date |