Intentional Partnering: How nurse and physician managers in formalized dyads work together to address clinical management issues in a hospital setting

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DEDICATION

For Lionel - my life partner.

Your love, patience and tolerance have carried me through this journey.

You are a partner like no other.

ABSTRACT

Background: In today's healthcare organizations, the pace of technological change, increasing complexity, competitive demands and risks involved in decision making have made it difficult for one individual to lead alone. Collaborative management structures are critical to transforming healthcare delivery and a co-leadership model offers one such approach. Nurses and physicians are uniquely positioned to share the executive roles of co-leadership; however, little is known about how this management dyad operates in the healthcare setting. Most of what is known about the nurse-physician relationship has been based on research at the clinical unit level from the nurses' perspective.

Objective: This grounded theory study seeks to explain how nurse and physician managers in formalized "partnerships" work together to address clinical management issues.

Methods/Procedures: A nurse-physician management structure (Partnered Management Model) was adopted throughout an urban Canadian university affiliated teaching hospital in 2008 where nurse and physician managers in each division or program were expected to formally "partner" with each other to address clinical management issues. Dyads were purposefully sampled in the Department of Surgery in 2013 on the recommendation of key stakeholders who believed the department effectively illustrated nurse-physician "partnerships". This was followed by theoretical sampling to elaborate on properties of emerging concepts and categories. A total of 36 interviews with 21 participants (12 nurses, 9 physicians) were audio-recorded and transcribed verbatim. The total time spent in observation was 142 hours (110 hours at senior management level and 32 hours at clinical management level) with field notes recorded for 90 observed events. Peer debriefing, informant/participant feedback and an audit trail of all methodological

decisions ensured the trustworthiness of the data. Constant comparison, open and focused coding, theoretical sensitivity and memos were used in the data analysis.

Findings: A substantive theory on *intentional partnering* was generated. Nurses' and physicians' professional agendas, which included their interests and purposes for working with each other, served as the starting point of *intentional partnering*. The theory explains how nurse and physician managers align their professional agendas to reap the benefits of partnering through the processes of accepting mutual necessity, daring to risk together and constructing a shared responsibility. Some partners may take the lead or contribute differently in each of the processes. Essential conditions such as being credible, earning trust and safeguarding respect built a foundation for partnering and communicating effectively. Deliberate strategies from senior leadership provided momentum in the *intentional partnering* process.

Conclusions: The theory elucidates the strategizing that underlies the processes as well as the characteristics that influence how the nurse/physician management relationship develops and evolves. The findings may inform the process of developing effective partnerships between nurses and physicians as they take on co-management responsibilities in an evolving healthcare system. The findings may also be applied to health professional management education.

Keywords: nurse-physician, co-leadership; management dyad, collaboration, grounded theory, strategy, professional agenda, health system

RÉSUMÉ

Contexte : Les structures de gestion en collaboration sont essentielles à la transformation de la prestation des soins de santé et le modèle de leadership de collaboration offre une telle approche. Les infirmières et les médecins sont particulièrement bien placés pour partager un rôle de direction dans le cadre d'une collaboration. Toutefois, on en sait très peu sur le fonctionnement de cette collaboration dans un établissement de soins de santé. La majeure partie des connaissances sur la relation infirmière-médecin est fondée sur des recherches à l'échelon de l'unité clinique et selon le point de vue des infirmières seulement.

Objectif: Cette étude de la théorie ancrée vise à expliquer comment les infirmières et médecins gestionnaires collaborent dans un partenariat officiel pour s'attaquer aux problèmes de gestion clinique.

Méthode: Une structure de gestion infirmière-médecin a été adoptée en 2008 dans l'ensemble d'un hôpital d'enseignement affilié à une université canadienne, située dans un centre urbain. Les infirmières et médecins gestionnaires de chaque service ou programme devaient travailler officiellement en partenariat pour traiter des questions de gestion clinique. En 2013, des partenariats infirmières-médecins du département de chirurgie ont été choisis pour composer un échantillon aux fins de l'étude, suivant la recommandation d'intervenants importants qui étaient d'avis que ce département illustrait bien la collaboration. Un échantillonnage théorique a ensuite été réalisé pour étudier les caractéristiques des concepts émergents et des catégories. Au total, 36 entrevues comptant 21 participants (12 infirmières et 9 médecins) ont été enregistrées en version audio puis transcrites textuellement. Les participants ont été observés durant 142 heures (110 heures au niveau de la haute direction et 32 heures au niveau de la gestion clinique). Des notes ont été prises au sujet de 90 événements qui ont été suivis. La récapitulation entre collègues, le

retour d'information des participants et autres personnes concernées et une vérification de toutes les décisions méthodologiques, ont assuré la fiabilité des données. Des comparaisons constantes, un codage ouvert et ciblé, une sensibilité théorique et des notes ont servi à l'analyse des données.

Résultats : Une théorie sur le *partenariat intentionnel* a été élaborée. Les agendas professionnels des infirmières et médecins gestionnaires qui comprennent leurs intérêts et objectifs liés à leur collaboration servent de point de départ au *partenariat intentionnel*. La théorie explique comment les infirmières et médecins gestionnaires adaptent leurs agendas professionnels pour tirer avantage du partenariat en suivant un processus qui consiste à accepter la nécessité de la collaboration, à oser prendre des risques conjointement et à créer une responsabilité commune. Certains partenaires peuvent assumer un rôle de direction ou contribuer de manière différente à chaque étape du processus. Établir sa crédibilité, gagner la confiance de l'autre puis conserver son respect représentent les conditions essentielles du partenariat et le fondement de la collaboration et d'une communication efficace. Les stratégies délibérées des dirigeants principaux donnent une impulsion au processus de *partenariat intentionnel*.

Conclusion : La théorie présente des stratégies qui sous-tendent les processus ainsi que les caractéristiques qui influent sur la manière dont s'établit et évolue la relation entre infirmière et médecin gestionnaires. Les résultats peuvent être appliqués dans les secteurs de la santé et de l'éducation.

PREFACE

This thesis is the original work of the candidate, Christina Clausen (CC). As such, CC was engaged in the conceptualization and the conduct of all aspects of this research inquiry, including the study design, the recruitment of participants, the collection of data, the transcribing of interviews, the analysis and interpretation of results and the writing of the thesis. Dr. Melanie Lavoie-Tremblay and Dr. Margaret Purden, as co-supervisors, provided essential conceptual and methodological support throughout the conduct of the research study as well as CC's research training.

CC met with both co-supervisors regularly, and they supported each step of the development of the study protocol, reviewed the main products of data collection, offered guidance with the analytic process and reviewed drafts of the chapters and the final dissertation. All committee members, Dr. Lise Lamothe, Dr. Hélène Ezer and Ms. Lynne McVey met with CC a number of times throughout the research study to discuss the design of the study and the initial interpretations of the data and to provide comments and/or feedback on the chapters. Dr. Lise Lamothe provided expertise in healthcare management. Dr. Hélène Ezer offered expertise in the area of interprofessional collaboration. Ms. Lynne McVey provided clinical management expertise as a Director of Nursing and Chief Executive Officer of two different institutions during the time this study was undertaken. In addition, she acted as the initial decision maker of CC's FERASI fellowship and therefore took part in the identification of the research topic of interest. Additional methodological expertise was sought from Dr. Rita Schreiber at the University of Victoria, BC, Dr. Judith Holton, previous editor of the *Grounded Theory Review* and Dr. Barney Glaser, one of the originators of the Grounded Theory (GT) approach. CC

engaged in a number of discussions regarding GT and presented aspects of her work with these scholars.

The work presented is an original contribution to the field of healthcare management and nursing administration. There are not many empirical studies on the nature of nurse and physician co-leader or co-manager relationships, what issues they face in practice, how they go about addressing these issues and how their relationship evolves. Previous work on the nurse-physician management dyad is primarily descriptive and based on rhetorical and personal opinions rather than on empirical findings. This study presents an original and substantive grounded theory that explains a *process* of how nurse and physician managers in formalized dyads work together to address clinical management issues and align professional agendas to reap the benefits of partnering. Additionally, findings from this study suggest that there is an important role for senior nurse managers to play in initiating and supporting this process. Cultivating interprofessional management experiences is a key strategy to support physician engagement and leadership in healthcare organizations.

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CHAPTER ONE: INTRODUCTION

The Canadian healthcare system faces a number of complex challenges, such as staff shortages, pressures for cost containment, complex care environments and rapid change, while continuing to strive for high quality and safe patient care. For example, in the last decade, medication safety and preventing surgical site infections have gained prominence in the patient safety agenda as these two issues exemplify complications arising from healthcare management, rather than the natural course of the patient's disease. These complications can have devastating outcomes for patients, including death, disability and longer hospital stays (DeLissovoy, Fraeman, Hutchins, Murphy, Song, & Vaughn, 2009; Ross Baker et al., 2004).

Many healthcare administrators are struggling to find ways to implement new and innovative approaches to respond to these conditions. There is an urgent need to redesign the healthcare system in order to improve patient outcomes, reduce errors, decrease costs, and increase staff engagement and satisfaction (Committee on the Robert Wood Johnson Foundation, Institute of Medicine, 2011). Changing the approach to healthcare management and leadership has been identified as a key factor to facilitate change and transform care delivery (Canadian Health Leadership Network, 2014; Canadian Nurses Association, 2009; Committee on the Robert Wood Johnson Foundation, Institute of Medicine, 2011; Reinertsen, Bisognano & Pugh, Institute of Healthcare Improvement 2008). The authors of the recent document "Closing the Gap: A Canadian Health Leadership Action Plan" state that the Canadian health system performance is affected by long standing economic challenges and is failing to provide quality health services. Leadership in health care "*is an enabler for healthcare system reform"* (Canadian Health Leadership Network, 2014, p. 3). The authors strongly advocate a Pan Canadian approach to the development of leadership in the healthcare sector.

Specifically, the development of collaborative management structures and working relationships at every level within healthcare organizations has been acknowledged as critical to achieving a transformation. The transformation begins by promoting effective collaboration among senior leaders (Porter O'Grady, 2011; Reinertsen, Bisognano & Pugh, Institute of Health Care Improvement, 2008). This style of management has been referred to as "collaborative leadership"; however, little is known about what it actually looks like in practice or how it originates and develops in the healthcare setting (Browing, Torain & Enright Patterson, Center for Creative Leadership, 2011; Canadian Health Leadership Network, 2014; Committee on the Wood Johnson Foundation, Institute of Medicine, 2011).

Despite the lack of clear definitions and empirical evidence concerning collaborative leadership, a number of healthcare systems in Canada and the world are instituting co-leadership and co-management models, often using these two terms interchangeably (Denis, Gibeau, Langely, Pomey, & Van Schendel, 2012). One of the main objectives in implementing this type of structure is to improve performance, accountability, quality, and effectiveness of care (Hahn & Criger, 2011). Although each model implemented is structured somewhat differently, they function under the assumption that the benefits of working in a management dyad outweigh the challenges. Scholars have provided arguments to both support and refute the advantages of co-leadership (Alvarez & Svejenova, 2005; Denis, Langley, & Sergi, 2012; Locke, 2003; Locke, Conger, & Pearce, 2005; O'Toole, Galbraith, & Lawler, 2002).

A recent review of the various forms of "leadership in the plural" within the field of strategic management indicates that there is more to learn about how dual management relationships form, evolve, and function (Denis, Langley, & Sergi, 2012). The authors conclude that future research must focus on the dynamics and tensions in dual leadership arrangements, as

well as on the nature of the context in which they function (Denis, Langley, & Rouleau, 2010). In literature pertaining to the private sector, authors note that personal characteristics may be important to the functioning of the dyad. Indeed, there are a number of examples of co-Chief Executive Officer (CEO) relationships that have failed due to personal differences and a similar number of successful co-CEO dyads in which differences have led to complementary working relationships (Sally, 2002), suggesting that personal characteristics may only be part of the equation. A number of co-leadership initiatives illustrate that dual leadership is a distinct form of collective leadership that warrants specific research attention (Heenan & Bennis, 1999; Hunter, Cushenbery, Fairchild & Boatman, 2012). What needs further investigation are the structures, norms and behaviors that support these co-leader or co-manager pairs.

In the healthcare literature, a recent publication issued by The Joint Commission of Healthcare Accreditation (Berman, 2012) identified the importance of developing physician and nurse leaders who can work in collaboration to improve the quality and safety of the healthcare system. This is an essential collaboration as nurses and physicians represent a large proportion of professional staff involved in clinical and organizational decision making and are also engaged in work that is complementary and inextricably linked in addressing patient-care issues. Therefore, it is not surprising that the Joint Commission report identifies these two professions to be uniquely positioned to share the executive roles in a co-leadership arrangement.

The importance of nurses as co-leaders has also been noted by the Committee on the Robert Wood Johnson Foundation, Institute of Medicine's report, *The Future of Nursing: Leading Change, Advancing Health* (2011), which is considered to be the most significant report on nursing and the future of healthcare reform to be published in decades. The authors highlight the critical role of nurses in transforming the healthcare system given their close proximity to

patients, their scientific understanding of care processes, and their capacity to lead change. The report states that the nursing profession needs to assume key leadership positions in policy making and the politics of healthcare delivery, and that nurses must become full partners with physicians and other healthcare professionals. The authors contend that being a full partner "transcends all levels of the nursing profession and requires leadership skills and competencies that must be applied in collaboration with other health professionals" (p. 8). As leadership scholar Porter O'Grady (2011) states in response to this report, "Nurse leaders are charged with facilitating action to devise and implement the appropriate change strategies necessary to increase quality, access and value in a patient-centered care environment" (p.33).

Engaging physicians in management has also been identified as critical in transforming healthcare systems (Denis et al., 2013; Dickson, 2012; Kaissi, 2012; Snell, Briscoe, & Dickson, 2011). As health policy and management expert Ross Baker (2012) states, "no substantial change in clinical care is possible without the full involvement of physicians" (p. 10). The role of physician executives in healthcare organizations contributes to quality improvement in patient care, strategic planning and governance, cost control, information systems, communication and networking (Goodall, 2010; Schneller, Greenwald, Richardson, & Ott, 1997). Day (2007) argues, "the more doctors [in management] the better, as so much expenditure is done at the level of doctor and patient" (p. 230).

Much of what is known about the nurse-physician relationship derives from research at the clinical unit level. In these work environments, effective communication and collaboration between nurses and physicians have been associated with positive patient outcomes (Baggs, Ryan, Phelps, Richeson, & Johnson, 1992; Higgins, 1999; Leidtka & Whitten, 1998; Taschanen & Kalisch, 2009), positive provider outcomes (Aiken, 2001; Baggs & Ryan, 1990; Baggs et al.,

1992, Baggs, Schmitt, Eldredge, Oakes, & Hutson, 1997; Miccolo & Spanier, 1993) and healthier work environments (O'Brien-Pallas et al., 2004; Schmalenberg et al., 2005, Schmalenberg & Kramer, 2009). Little is known, however, about the characteristics and working relations of nurse and physician managers working together.

Some co-management models were identified and described in the literature that are based on the nurse and the physician as co-leaders in the management structure. (Benhaberou-Brun, 2011; Kim, et al., 2014; Patton & Pawar, 2012; Reid Ponte, 2004), but there is very little empirical literature pertaining to nurse-physician co-leadership (Jennings, Disch, & Senn, 2008). Most existing studies examine individual roles, characteristics and behaviors of nurse or physician managers/leaders and emphasize the need for developing and advancing their knowledge, skills and abilities so that they can adapt to the changing and complex healthcare environment (Duffield & Franks, 2001; Garg, van Niekerk, & Campbell, 2011; Kleinman, 2003; Lin, Wu, & White, 2005; Warren & Carnall, 2011). Other authors suggest the need for understanding the role of leadership in patient outcomes (Wong & Cummings, 2007). Less empirical work exists on the nature of co-leader or co-manager relationships, how they function in practice and the roles of nurses and physicians in a co-leadership arrangement.

This study addresses some of these gaps; and it contributes to understanding how nurses and physicians work together in formalized management dyads, what issues they face in practice, how they go about addressing and resolving these issues, and how their relationship evolves over time. The data are reflected in a substantive theory that elucidates the day-to-day functioning of the nurse-physician management dyad in addressing priority issues within the hospital, the factors influencing the relationship and the characteristics that determine how the nurse and physician management relationship evolves. In addition, the developed theory may be used to

guide and support the implementation of nurse-physician management models in clinical practice.

CHAPTER TWO: LITERATURE REVIEW

2.1. Approach to the literature search strategy and associated challenges

Understanding how nurse-physician management dyads function is challenging. Much of the literature that focuses on the functioning of nurses and physicians is embedded in the clinical practice unit and in close proximity to the patient. Previous work on the nurse-physician management dyad is primarily descriptive and based on rhetoric and personal opinions rather than on empirical findings. Given these limitations, the literature search strategy (see Appendix A) in addition to the healthcare databases, included co-leader or co-manager relationships within the social psychology, sociology, education and management literature. However, these disciplines use a variety of terms interchangeably to describe dyadic management. These include co-management (Senger, 1971), dual leadership (Etzioni, 1965; Fjellvaer, 2010; Reid & Karambayya, 2009), co-leadership (Sally, 2002; Vine, Holmes, Marra, Pfeifer, & Jackson, 2008), and leadership couple (Gronn, 1999), to name a few. Furthermore, although a distinction has been made between leadership and management, with management activities described as controlling, coordinating, and directing (Mintzberg, 1973; 2009) and leadership activities described as involving vision, cooperation, networking, teamwork, creativity, inspiration, and the creation of change (Alvesson & Sveningsson, 2003), these distinctions are largely absent in the literature. For the purposes of this study, individuals in formal management positions were assumed to carry out both leadership and management functions within the organization and to have some authority and influence over other members.

Another area of inconsistent terminology is related to the recent work on leadership within the fields of organizational behavior and strategic management. The individual as leader has shifted to pluralistic leadership defined as "the combined influence of multiple leaders in

specific organizational situations" (Denis, Langley, & Sergi, 2012, p. 1). Terms such as collective, team, shared, distributed, and relational are used to describe multiple forms of leadership but may be based on different epistemological and methodological assumptions, contributing to the ambiguity of the concept (Sergi, Denis, & Langley, 2012; Yammarino, Salas, Serban, Shirreffs, & Schuffler, 2012). Denis, Langley, and Sergi (2012) attempted to address the terminology issue within strategic management by identifying four streams of plural leadership. These streams are: a) sharing leadership within teams (members of the group leading each other); b) pooling leadership at the top of organizations (dyads, triads, joint organizational leaders); c) spreading leadership across levels over time (dispersion of leadership roles among a variety of people across organizations over time) and d) producing leadership through interaction (leadership emerging from relationships). Following this framework, "pooling leadership at the top" appears to be the most consistent with the co-leader and co-management models described in the healthcare literature. Thorpe, Gold and Lawler (2011) note that these plural leadership structures have been either formally created by organizations or have spontaneously emerged in the workplace. Regardless of why or how the leadership model has formed, the structure can take on various configurations (Gronn, 2009).

In order to situate the phenomenon of the nurse-physician management dyad, this literature review is organized into five sections. In section one, the concept of 'dyad' is described as well as the essential features that make it qualitatively distinct from a team or small group. This section provides the background for defining the principle unit of analysis for the study, namely, the nurse-physician management dyad. In section two, aspects of the nurse-physician relationship described in the healthcare literature are outlined. The focus of this section is on the characteristics and influencing factors of the nurse-physician dyad, in particular,

their common modes of interaction and the organizational factors within the healthcare environment that may influence the functioning of the dyad. In section three, co-leader interactions are reviewed in order to provide the background for the nurse-physician management dyad. Common factors that support the success of management dyads are described. In section four, studies that focus on management dyads in both public and private sector organizations are reviewed highlighting the process of role sharing. In addition, this section includes the healthcare management literature on the management roles and characteristics of nurses and physicians. In section five, empirical studies that specifically address the nurse-physician management dyad are examined.

2.2. Dyads: Definitions and characteristics

Friendships, marriages, business/work partnerships and parent-child relationships are examples of dyadic relationships in our lives. While each of these dyads or pairs may have distinct qualities they all represent close, personal relationships. However, it is less clear whether dyads operate under the same principles that guide group processes involving three or more members. Scholars have presented the following four distinctions between dyads and groups: a) individuals often feel different and stronger emotions in dyads than in groups; b) dyads can form and dissolve more quickly than groups; c) some group phenomena, such as coalition formation, cannot occur in dyads; and d) research on dyads has developed independently from research on groups, with different theories and methods being developed and applied (Moreland, 2010; Williams, 2010). Although dyads may incorporate some group process phenomena, the proposed study presumes dyads are qualitatively different from groups or teams, relying upon the distinctions above.

One of the most important definitions of the dyad is found in the seminal work of Becker and Useem (1942) that was based on a sociological analysis of the dyad. They offer the following definition: "Two persons may be classified as a dyad only when intimate, face to face relations between them have persisted over a length of time sufficient for the establishment of a discernable pattern of interacting personalities" (Becker & Useem, 1942, p.13). They refer to this interchange as *patterned mutual action*. On the basis of this definition, three preconditions appear necessary. First, there must be a sufficient period of time for the dyadic relationship to manifest itself. Second, there must be mutuality in the relationship whereby each person's actions and attributes are influenced by the other's actions, views, and experiences. Third, the individuals must be engaged at a close, personal level of face-to-face exchange (Thompson & Walker, 1982). Therefore, a distinction is to be made between a dyad and two individuals who enter into a relationship for a specific purpose that is limited by time. The time-limited relationship involves an interaction that is more circumscribed. Dyadic research has therefore focused on the *patterned mutual action* and attributes of two persons, referred to as the interpersonal relationship. Furthermore, the eminent German sociologist, Georg Simmel (1950) noted that dyads represent structural arrangements different from individuals, triads or larger constellations by virtue of greater unity, co-responsibility, interdependence and preservation of the individuality of their members.

The concept of *patterned mutual action* also appears in the early work of Hinde (1976, 1995), although it is not labeled as such. They suggest that a relationship involves a series of interactions in time between two individuals known to each other. "Because the individuals are known to each other, the nature and course of each interaction is influenced by the history of past

interactions between individuals concerned, and perhaps by their expectations for interactions in the future" (Hinde, 1976, p.5).

A key challenge to dyadic research has been to differentiate between individual and relational dimensions of the dyad and to identify whose construction of the dyad or relationship is being studied (Thompson & Walker, 1982). An example of this is found in the family and close personal relationship literature. Jaccard, Brinberg, and Dittus (1989) studied dyadic decision making among married couples. They pointed out that an individual-level analysis of dyadic decision making would examine the perceptions, preferences, and orientations that each individual brings to the interaction. A dyadic-level analysis examines the process by which these individual perspectives are expressed, understood and acted on by the dyad to reach a decision. In other words, dyadic research is not only concerned with what each individual brings to the relationship but also the nature of the interaction and its unique features/patterns. Individuals bring their values, opinions, attitudes, behaviors and needs to the relationship, but the dyad can possess properties such as norms, rules and power dynamics that also shape the interaction.

Thompson and Walker (1982) maintain that these dyadic properties arise from the values and views of two people and cannot be inferred from information about or from only one member. In addition, dyadic properties must be studied in the context of the relationship and capture the interactive, relational components, such as trust and conflict, that cannot be captured by an individual-level analysis. This is particularly important to consider when reviewing the extensive body of research addressing the nurse-physician relationship.

On the basis of the preceding discussion, the nurse-physician relationship can be characterized as a dyad. Nurses and physicians are the principle care providers in addressing the needs of patients and their families and often establish close working relationships that involve a

series of interactions over time and with frequent face to face contact. Most of the research in this area, however, has focused on the perspective of nurses, even though nurses and physicians appear to perceive their relationship quite differently (Corser, 1998). The process whereby effective nurse-physician relationships develop remains, however, somewhat obscure. The socio-historical context of this kind of relationship as well as some empirical studies that focus on ways nurses and physicians interact can provide a place to start and offer a valuable perspective on the properties of the relationship that may inform our developing understanding of the nurse-physician management dyad.

2.3. Characteristics and influencing factors of the nurse-physician dyad

2.3.1. Social-historical context. A classic model for understanding nurse-physician interactions was proposed by Stein (1967), who reported that nurses' relationships with physicians were based on a 'game-playing' model where nurses gave recommendations regarding care without appearing to do so too directly or to disagree with the physician. In revisiting the doctor-nurse game in 1990, Stein noted that the 'game' had changed. Nurses used more overt strategies, such as negotiation, to engage with physicians in the decision-making process. These changing dynamics of the nurse-physician relationship seemingly increased nurses' influence on patient care decisions made by physicians. The classic 'doctor-nurse game' model no longer seemed to provide a suitable basis for interpreting this evolving relationship (Svensson, 1996).

Some authors propose that factors constraining the work relations of nurses and physicians are due to the sex stereotypes and rituals that have established, maintained and justified hierarchical relations between these professional groups (Campbell-Heider & Pollack, 1987). Other barriers within the relationship include role misunderstanding and differing role

expectations (Cassanova, 2007) and discrepancies in education and status (Fagin, 1992), as well as real and perceived differentials in power (Porter, 1991). Researchers often relate the power asymmetry to traditional stereotypes - the physician possessing more power derived from his/her medical expertise and the nurse being attributed more interpersonal competence - or by the traditional hierarchy of authority prescribed in these two disciplines (Corser, 2000).

Moreover, the medical profession has traditionally emphasized autonomy, independence and a directive role. In contrast, nursing has valued interdependence, teamwork and dialogue. Fagin (1992) notes that conflict can arise between the two professions partly because of contrasting values and focus. In addition, each discipline works within different professional regulations and standards, as nurses have historically been employees of healthcare institutions and physicians have acted as independent contractors. Some authors suggest that even today, nurses and physicians may not fully appreciate how their routine interpersonal exchanges may still be influenced by their socio-historical legacies (Corser, 2000).

Despite these issues, researchers continue to examine strategies to foster nurse-physician relationships because effective work relations are seen as integral to improved patient and provider outcomes and a healthy workplace (Crawford, Omery & Seago, 2012; McInnes, Peters, Bonney, & Halcomb, 2015; Kapelli, 1995; Pullon, 2008; Zwarenstein & Bryant, 2005). Most of this research centers on interprofessional communication, which has dominated the patient safety literature. Studies report an increase in medical errors and in-patient mortality when deficiencies in communication between nurses and physicians exist (Kohn, Corrigan, & Donaldson, 2000; Page, 2004).

2.3.2. Modes of interactions. Collaborative nurse-physician relationships have been associated with improvements in patient satisfaction (Baggs & Ryan, 1990; Leidtka & Whitten,

1998), patient transfer and discharge planning decisions (Baggs et al., 1992; Higgins, 1999; Naylor, 1990), age-adjusted patient death and adverse event rates (Baggs et al., 1992; Knaus, Draper, Douglas, Wagner, & Zimmerman, 1986); decreases in risk-adjusted length of stay (Taschanen & Kalisch, 2009) as well as healthcare provider satisfaction, such as decreased job stress, increased retention and enhanced work productivity (Aiken, 2001; Baggs & Ryan, 1990; Baggs et al., 1992; Miccolo & Spanier, 1993). Scholars focusing on outcomes of nurse-physician collaboration often approach it in terms of how communication and coordination within the relationship is perceived and its impact on joint decision making and problem solving around patient care issues (Baggs, et al., 1990, 1992; Boyle & Kochinda, 2004). However, a lack of conceptual clarity and inconsistent definitions of collaboration have made this phenomenon difficult to study (Corser, 1998; Dougherty & Larson, 2005; Henneman, Lee, & Cohen, 1995).

To gain greater conceptual clarity, Corser (1998) conducted an extensive review of the medical and nursing literature and developed a conceptual model that described the specific factors and interactions associated with the nurse-physician relationship. It was the only model uncovered in the literature search that specifically addressed nurse-physician interactions, and it suggests that collaborative nurse-physician interaction consists of the following: respect for each other's professional roles, competencies and contribution to patient care, as well as respect for joint goal setting, decision making and power symmetry relative to one another. In addition, it highlights pertinent organization/professional influences such as traditions of professional socialization and education, the complexity of the care environment and institutional policies and protocols. Individual communication and behavior tendencies, traditional gender/role norms and

personal attitudes of nurses and physicians are also described as some of the personal/interpersonal influences on their interactions.

The Corser model illustrates the multiple factors at play, including the context of the nurse-physician relationship that may influence interactions. It suggests that nurses and physicians may have different perspectives of collaborative and non-collaborative interactions which need to be considered when examining this phenomenon from a dyadic standpoint. Yet the model does not consider the actual nature and dynamics of the relationship, such as how the relationship is managed by the two professions.

The nature and dynamics of nurse-physician relationships have been explored by various empirical studies, typically focusing on disagreement/conflict or effective communication. Seminal work by Prescott and Bowen (1985) used self-report questionnaires and semi-structured interviews to examine the basis of interprofessional disagreement. Two hundred and sixty-four staff nurses and one hundred and eighty physicians in fifteen general hospitals were asked to describe an example of a situation in which the physician and a nurse disagreed about an aspect of patient care and to describe how the disagreement was handled. They reported that the dominant mode of interaction in disagreements between the two professions was that of competition in which each individual attempts to satisfy his or her own concern. Little mutual give and take by the participants and little active participation by both parties was evident. The second mode of interaction was accommodation, which was characterized as one individual conceding to the wishes of the other. Nurses demonstrated this behavior more often and particularly when their authority was challenged. The authors caution that such behaviors are closely related to those characterized in the "doctor-nurse" game and that although signs of

egalitarian relationships, such as addressing each other on a first name basis, may be evident in the 'modern' relationship, patterns of physician dominance and nurse deference may still prevail.

Although the majority of the physicians and nurses in this study described their relationships as mostly positive, descriptions of negative relationships differed. Physicians described a lack of diplomacy, clinical competence, and helpfulness as key elements of negative relationships, whereas nurses emphasized a lack of respect. An essential feature of positive relationships endorsed by both nurses and physicians was establishing familiarity in terms of the amount and longevity of contact. Nurses noted that working closely with physicians helped them know how best to work together. For physicians, however, their expectations of the nurse's role varied and working closely with a nurse provided an opportunity to know the nurse's areas of competence. Moreover, the findings suggest that conflict within the relationship is not necessarily undesirable. Physicians saw disagreements as a necessary and healthy part of their interaction. Both groups acknowledged their responsibility to 'manage' the other for the patient's well-being.

More recent work by Gotlieb Conn, Kenaszchuck, Dainty, Zwarenstein & Reeves (2014) used a sequential mixed methods approach and surveyed nurses (both direct care and managers) and physicians in medicine wards of five hospitals. The outcome measurement scale was an adaptation of the Nurse's Opinion Questionnaire (Adam's, Bond & Arber, 1995). This adapted scale used a 3-factor structure to measure dimensions of nurse-physician relationships in an inpatient care setting: communication, accommodation and isolation. Survey data was completed on-line and returned from fifty-one physicians and one-hundred and ninety nurses. They used shadowing and interviews to explore the quality of nurse-physician collaboration. Their quantitative findings indicated that nurses perceived physicians as less accommodating

than physicians perceived nurses, and nurses felt more isolated from physicians than physicians did from nurses. Qualitative data illuminated physician authority as a contributing factor to isolation. Physicians' collaborative efforts were perceived by nurses as poor in units where physicians exhibited attitudes of authority and upheld "traditional" ideas about the role of the nurse and her standing in the professional hierarchy. This created hostility and isolation.

Leever et al. (2010) explored conflict management between nurses and physicians and proposed that motives such as clarification, avoidance of escalation, improvement of collaboration and care, modification of an existing communication structure and creation of learning opportunities may also be at play when engaging in conflict. How the conflict is worked through and managed may have more lasting repercussions than the occurrence of conflict alone. While effective communication is clearly acknowledged as an essential feature of the nurse-physician relationship, mutual trust, respect and power are also commonly described as foundational to successful collaborative relationships. However, little is known about how each of these factors operates within the relationship.

Pullon (2008) examined the nature of the nurse-physician relationship using in-depth interviews with nine nurses and nine doctors working in primary care settings by inquiring about each profession's perception of the work and role of the other. Their qualitative findings suggested that trust was regarded as something that developed only within a context of understanding and respecting professional competence. Professional competence, once demonstrated and understood, led to professional respect. Over time, mutual respect can be developed and earned between individuals, which can lead to the development of interprofessional trust. Pullon (2008) points out that trust between people working together is not a fixed or a static entity but ebbs and flows over time, is situation specific and is influenced

by prior and current experience. Furthermore, she contends that different types of trust, such as "calculus-based" and "identification-based" trust, are evident in successful professional relationships. "Calculus-based" trust can build up over time if people are predictable, reliable and consistent in their behavior. "Identification-based" trust can develop when people share values and where they understand each other's intentions so that they can 'act for each other', often without the need for specific instructions. She contends that both of these types of trust are evident within the nurse-physician relationship. Yet we still know very little about how trust is established, the implications for the relationship when trust is broken or if and how trust may be repaired.

In addition, a number of studies conducted by Schmalenberg and Kramer (2005, 2009) within magnet hospital settings, known for their high quality nurse-physician relationships, found that multiple types of relationships can exist between nurses and physicians. According to these authors, five different relationship types can be characterized by how power is shared. Nurse-physician relationships described as 1) collegial or "excellent" emphasized equality and how equal but different power and knowledge contribute to the interdisciplinary team; 2) collaborative or "good" relationships were based on mutual trust and respect but did not have equal power; 3) "courteous" relationships were exemplified by the physicians' willingness to discuss, explain and teach, but power was unequal. Overall, the outcome of being in the first of these three types of relationships was seen as beneficial. The last two types had a power differential and feelings of either suppression or frustration, hostility and resignation were expressed, and neither was seen as completely beneficial. Although this work contributes to the understanding of factors that promote strong nurse-physician collaboration, these typologies do

not explain how power is manifested within the relationship or describe how an egalitarian relationship is achieved.

2.3.3. Organizational factors. Although many studies within the healthcare literature highlight organizational factors as influencing nurse-physician interactions, the direct effects of these factors on nurse-physician interactions have received little study. A theoretical and empirical review of the literature on interprofessional collaboration among allied healthcare professionals conducted by D'Amour and colleagues (2005) noted that in complex healthcare systems, a better understanding of organizational determinants, such as the structure, philosophy, administrative support, team resources and mechanisms for co-ordination and communication are needed in order to shape the context to support collaboration. The majority of the studies selected for the review focused on the nurse-physician clinician dyad, which largely comprises the focus of the interprofessional healthcare literature. In addition, Schmalenberg and Kramer (2005) interviewed 141 physicians, managers and staff nurses from 44 clinical units in five magnet hospital settings in order to identify structures that enable highly collaborative nurse-physician relationships and found that specific organizational factors supported the relationships. These included a culture where concern for the patient is first; strategies and clear policies for conflict resolution; and regular, interdisciplinary collaborative patient rounds. However, the literature is silent on how organizational factors influence the nurse-physician management dyad.

In summary, despite the considerable work being done to describe collaboration and communication between nurses and physicians, the two disciplines are often characterized by hierarchy, an imbalance of power, and misconceptions. Studies of magnet hospitals have identified good nurse and physician relationships as an essential feature in recruiting and retaining nurses. It is unclear, however, whether characteristics of the nurse-physician clinician

dyad can be generalized to the nurse-physician manager dyad, where the context is different. In the latter, both professionals may act as key stakeholders in terms of developing strategies and setting organizational or departmental agendas. Their interactions may play out quite differently according to their objectives. Issues of hierarchy, power and influence, and role expectations may manifest differently within a management relationship. In addition, it is unclear whether the gender shift of men entering nursing and women entering medicine has changed the nurse-physician manager relationship (Brandi, 2000). In order to gain further insight into management dyads, the literature concerning the characteristics and functioning of the co-leader or co-manager dyad was reviewed.

2.4. The co-leader relationship

In today's organizations, whether business, government or non-profit, the pace of technological change, increased complexity, competitive demands and risks involved in decision making have made it difficult for one individual to lead alone. Contemporary approaches favor collective or plural forms of leadership. Although previous studies within the field of leadership have focused mainly on the attributes, traits, styles and behaviors of individual leaders (Yammarino et al., 2012), scholars have begun to argue that dyadic leadership is in fact best suited to meeting present-day challenges and warrants further study (Hunter, Cushenbery & Fairchild & Boatman 2012).

According to O'Toole and colleagues (2002), the benefits of working in a dyad include shared risk and responsibility in decision making, support and reinforcement on issues, as well as greater opportunity for group members to get guidance and discuss issues with one of the leaders. However, according to Locke (2003), a co-leader dyad is not viable as it can result in ambiguity when there is no single voice. Nevertheless, the management literature is replete with

descriptions of co-led companies and reasons why the model works in some cases and not in others (Alvarez, Svejenova, & Vives, 2007; Hennan & Bennis, 1999; O'Toole, Galbraith, & Lawler, 2002).

O'Toole (2002) and colleagues note that the success of dual management depends on how effectively the individuals involved communicate, handle crises, allocate and reallocate tasks and decision making and develop common positions on key issues. Successful co-leader relationships are often described as "symbiotic" in the field of management with the dyad working in tandem, each picking up different parts of a problem. Zismer and Brueggeman (2010), note that the success of the dyad is tied to each individual within the dyad. These authors ask how distinct and separate responsibilities and accountabilities are identified, divided and managed. A history of working within a dyad is important as it promotes the skills and/or the desire to work in a similar relationship in the future, illustrating a feedback effect that occurs in successful working relationships. One of the key factors emphasized in the management literature that supports the success of dyads relates to how roles are shared (Alvarez and Svejenova, 2005; Alvarez, Svejenova, & Vives, 2007).

2.4.1. Role sharing

Hodgson, Levinson, and Zaleznik (1965) provide one of the first theoretical perspectives addressing the formation of executive roles of a top leadership team in a psychiatric hospital. Based on clinical observations and interviews, this single case study focused on the roles of three leaders who shared the top position. The authors' analysis suggests that executives' roles in the organization tend to become specialized around the performance of certain tasks and the expression of certain emotions. They note that several specialized roles are differentiated from one another in the executive group, yet the specializations of the various members complement

and balance one another to form a relatively integrated whole. Although their analysis was based on observations of a triad, their perspective has influenced dyadic research. For example, Gronn's (1999) single case description of the successful collaboration between two individuals who share the role of principal in a school draws on the concepts of specialization, differentiation and complementarity of role tasks that originated in the work of Hodgson et al. to explain how an effective work unit is formed.

Gronn (1999) used archival data including extensive correspondence between the leaders to elucidate role patterns within the dyad. He notes that despite a formal agreement to share the principal position, one of the partners always took the initiative while the other remained passive. Gronn suggests that this pattern is consistent with the dynamic nature of role taking, role making, and role "routinisation" described by Graen (1976). The role-taking phase involved each member discovering the relevant talents and motivations of the other over a period of time. By the time roles were formally established (role "routinisation"), "each individual had a very sound understanding of the other's strengths and weaknesses, their potential for the exercise of discretion, their capacity to solve problems and the limit of each other's endurance under pressure" (Gronn, 1999, p. 55). Furthermore, Gronn notes that in circumstances in which the two leaders experienced role overlap, they were able to manage this without difficulty through daily interaction and frequent communication.

In the private business sector, a work by Alvarez and Svejenova (2005) examined the roles and interpersonal relationships of various models of shared executive management with dyads and triads. Although no clear methodology is presented, findings drawn from fieldwork supplemented by archival data not only align with the process of role sharing but, in addition, point to the importance of having joint responsibility and a clear motivation for working

together. They describe a "professional duo" relationship that consists of either a simple professional relationship or a multilayered relationship wherein both friendship and professional collaboration can determine the nature of the bond between individual members.

In a way similar to Gronn's description, Alvarez and Svejenova (2005) contend that for a dyad to become a professional duo, a history of increasing task-related exchanges over an extended period of time is required to improve awareness of respective competencies, styles and reliabilities. Moreover, they contend that, "it is essential that members of the dyad perform jointly and are held jointly responsible for a set of activities"; but it is not clear what these responsibilities are or how they are shared (Alvarez and Svejenova, 2005, p.117). The authors suggest that in addition to complementarity, *commonality* is a necessary element that brings the partners together and provides a set of shared ground rules that helps smooth differences that can surface later in the relationship.

The studies reviewed in this section suggests that co-leaders engage in both task-and relation-orientated work and have specialized yet complementary functions. A clear reason or motivation to work together brings the individuals together. Furthermore, the literature acknowledges that roles within a dyad emerge, evolve and need to be responsive to new ways of working. Roles need to be dynamic and flexible to allow for the influence of personal experience and interaction. There is little empirical literature that refers to the process of role sharing in the nurse-physician management relationship. However, the concept of role sharing may have relevance to this dyad. Role sharing suggests a process of mutual influence occurring between members of the dyad that is shaped by frequent interactions over time and under varying circumstances; this is likely to be the case for nurse and physician managers who are working together.

On the other hand, studies in the field of healthcare management literature do address the individual role, characteristics and behaviors of nurse or physician managers/leaders and emphasize the need for developing and advancing the knowledge, skills and abilities of managers (Duffield & Franks, 2001; Garg, van Niekerk, & Campbell, 2011; Warren & Carnall, 2011). These aspects are included in the competency-based frameworks that each discipline has developed as standards for management practice (The Medical Leadership Competency Framework, Academy of Medical Royal Colleges and the National Health Services Institute for Innovation and Improvement, 2010; The AONE Nurse Executive Competencies, American Organization of Nurse Executives, 2011). Each of these frameworks includes aspects of managerial activities and roles such as communicating, planning, decision making, managing human resources, negotiating, managing conflict, training and developing which have also been outlined in the general management literature (Kotter, 1982; Luthans & Lockwood, 1984; Mintzberg, 1973). There are two key points to be noted from the healthcare management literature. First, the cited competency frameworks highlight 'working with others' or 'managing relationships' as a key domain; however, the process of how this is accomplished has not been described. Second, this literature brings out the pivotal role of the nurse manager within the organization. The nurse manager links management with employees, facilitates and assures quality of care and is responsible for translating strategic goals and objectives into practice. The nurse manager is key in the development and retention of staff as well as the overall productivity and performance of the unit (Lin,Wu, & White, 2005; Mintzberg, 1994; Oroviogoicoechea, 1996). In addition, findings from a systematic review on the relationship between nursing leadership and patient outcomes conducted by Wong and Cummings (2007) noted that nurse leaders play a key role in managing the context, staffing and financial resources required to

deliver effective care. These authors suggest that effective nursing leadership is essential to safer patient-care environments.

Having reviewed the concept of the dyad and its essential features, the characteristics, modes of interactions and influencing factors of the nurse-physician dyad and co-leader interactions, the last section focuses on what is known about nurse-physician managers working together.

2.5. The nurse-physician management dyad

Descriptions of the nurse-physician management dyad in the literature are often tied to clinical areas, such as intensive care units, emergency rooms and other specialty areas where there is still close proximity to the patient (Hughes, 2008). Other authors note that informal physician-nurse collaborative practices have likely been in existence in many hospitals; however, formalizing the dyad partnership may be an important step in fostering collaborative efforts to improve quality of care (Kim, et al., 2014). Yet, only a few studies were located in the literature that address this management relationship empirically.

A recent study by Culver Clark and Greenwald (2013) interviewed ten nursing unit directors and eight physician medical directors in formalized dyads of magnet-designated trauma centers of six intensive and six progressive adult medical surgical units. Their qualitative descriptive data indicated that nurses and physicians each had limited knowledge of the practices, responsibilities and values of the other and that they often differed in beliefs about possible solutions and barriers to progress. Effective interprofessional collaboration was characterized by explicit common goals that develop through regularly scheduled communications regarding progress. In the absence of this, the dyads tended to interact according to classic clinical roles, focus on individual patient care issues and address their roles

as unit directors independently of their partner. Participants also indicated that organizational structures and support in terms of setting expectations and allocating resources for interprofessional activities had the potential to positively influence collaboration. These strategies were seen as essential to changing the nature of the interactions among these professionals.

Among the few studies that address the nurse-physician management dyad, many are concerned with physician under-involvement in administration and consider joint leadership as a way to increase physician participation (Disch & Ingbar, 2001; Hughes, 2008, Tjosvold & MacPherson, 1996). Some authors suggest that physicians may be indifferent to engaging in interprofessional relationships, as it is counterintuitive to their professional values of autonomy, independence and entrepreneurialism (Hughes, 2008). As Glouberman and Mintzberg (2001) note, "although physicians may seem to be obvious candidates for management of hospitals, physicians are trained to take decisions individually and decisively, whereas managers have to ponder ambiguous issues collectively" (p. 82).

Disch and Ingbar (2001), considered the importance of role negotiation of physicians and nurses working in a management relationship in order to determine responsibilities of each actor. In their description, they note that in order to develop this relationship, particular strategies need to be employed, such as establishing clarity in role expectations; developing a shared vision; negotiating what involvement and participation will look like; consulting with others when working out difficult issues; committing to regular times to exchange, inform, plan, and evaluate the progress and effectiveness of the partnership; using time to get to know one another; developing better skills in constructive controversy; providing support to each other; and sometimes just allowing each other to express their feelings. Moreover, they identify contextual

factors that may influence the working of this relationship. These include a hierarchical hospital structure in which the influence of nurses and physicians is balanced as well as a collaborative interprofessional approach that is valued within the organizational culture.

An empirical study by Tjosvold and MacPherson (1996) used Deutsch's theory of cooperative and competitive goal interdependence (1973) to examine how physicians and nursing administrators work together and identify what contributes to participation and successful collaboration. However, the authors did not provide a definition of 'successful collaboration'. Deutsch's theory proposes that the dynamics and outcomes of interaction can be analyzed in terms of how people perceive their goals are related. Tjosvold and MacPherson (1996) suggested that Deutsch's theory would be useful to understanding the dynamics of physician and nurses working together as they presumed a critical barrier to effective involvement between the two professions was due to traditional hostility based on the feelings of competitiveness. They used Deutsch's theory of cooperative and competitive goal interdependence (1973) to guide the analysis of how these dyads solved problems.

A critical incident method was used to develop an interview schedule along with specific questions about the incident to gain descriptive information from participants' own experiences. Respondents rated on a 7-point Likert-type scale, the extent that they and the others had cooperative, competitive and independent goals. The participant's also rated on a 7-point Likert-type scale the extent that they expected themselves and the other would work effectively. The authors identified factors associated with successful collaboration and participation of thirteen physician leaders and thirteen nursing administrators from a major regional hospital in Greater Vancouver, British Columbia.

Results of this study indicated that successful collaboration between nurses and physicians involves constructive controversy, which is characterized as an interaction involving cooperative goals that is likely to facilitate open and productive discussions. They note that collaborative leadership requires a cooperative rather than a competitive agenda, as well as acknowledgement of how each member sees his or her role and responsibilities within the relationship. For example, physicians in the study perceived greater cooperation with nurses when physicians had responsibility for certain managerial functions such as hospital strategic decisions, management of physician credentialing and peer review, cost/quality policies and partnership arrangements between the medical staff and hospital organization. These findings suggest that perhaps a substantive part of a nurse-physician management relationship may be defined in terms of acknowledging what should be or can be shared within a management dyad. Reid Ponte (2004) supports this notion and argues in her description of a nurse-physician co-leadership management structure that nurse-physician co-leaders must have a clear understanding of where their discipline-specific lines of accountability and scope of decision making reside in the organization.

In summary, little is known regarding the collaborative process among co-leaders in general, and even less work has included nurse and physician managers. This management relationship does not appear to be addressed empirically at the macro level of management but is considered to be a naturally emerging relationship that occurs more informally in the healthcare context and where characteristics of the relationship are largely visible at the clinical unit level. An integration of management theory and healthcare literature is needed to do justice to the nurse-physician management dyad.

2.6. Summary, study objectives and research questions

The co-leader or co-manager arrangement is appealing to organizations in both the public and private sectors. Healthcare organizations have implemented co-leader or co-manager structures in Canada and abroad. Fundamental to this management structure is the concept of the dyad in which the obligation to work together manifests itself within the pair.

However, this management arrangement may not be a panacea for the problems in health care. Although there is increasing interest in developing co-leadership to address various challenges in health care, gaps remain in how collaboration between leaders develops, evolves or operates in healthcare settings. Studies are needed that address the evolving dynamics and tensions that are part of co-leaders' day-to-day functioning. Indeed, management scholars contend that few studies have focused on the concrete activities of managers that occur on a daily basis, especially for leaders who operate in the higher echelons of organizations (Hambrick, 2007; Nicolini, 2012).

The extant research on nurse-physician relationships supports the notion that the two professions are crucial to ensuring the quality of care on the basis of patient and provider outcomes and improved work environments. Both professions are well positioned to engage in a co-leader or co-management dyad and have the potential to effect change within the system (Hughes, 2008). Characteristics such as power, trust and respect are intrinsic to the functioning of the relationship, but it is unclear how each may operate within the relationship or contribute to how the relationship develops. In addition, as the organizational context of practice continues to change and evolve and more nurses and physicians enter management and/or leadership positions, new forms of collaboration between these professionals are likely to emerge.

Unfortunately, there remains a gap in our understanding of the nature and patterns of interactions within the nurse-physician management dyad. Corser's model (1998) described naturally occurring nurse-physician relationships in practice seventeen years ago. While this conceptual model has provided important information on the salient variables to consider in nurse-physician interactions, it may not reflect current practice and does not integrate the emerging perspectives from management theory. From the literature, the main challenges identified within nurse-physician management dyads may relate to how the relationship develops, how trust is established and maintained, and how roles are defined, negotiated and communicated between each partner.

Given the current state of knowledge on the nurse-physician management relationship, I set out to investigate the process of how nurse and physician managers work together within a formalized dyad. My goal was to elucidate the characteristics and explain how they function when working together within a dyad as well as to identify the factors that may facilitate or constrain the functioning of these dyads. This knowledge may guide future research initiatives studying the impact of nurse-physician management dyads on management outcomes. In addition, the findings may inform other dyads in the organization of the process that delineates the nurse-physician manager relationship as well as other settings where initiatives of co-managing are being considered or implemented.

To investigate this process, grounded theory (GT) methodology was chosen, as will be described in the next chapter. It is appropriate for a phenomenon not previously studied, where major gaps exist in our understanding and where a new perspective might be beneficial (Schreiber & Stern, 2001). In keeping with grounded theory (GT) methodology, the research question was broad and exploratory: *"How do nurse and physician managers in formalized*

dyads work together to address clinical management issues?" The sub-questions were "*What strategies do they use in managing their relationship within their workplace context? What are the successes and challenges they experience in their work together? What influences their ability to work together?"*

CHAPTER THREE: METHODOLOGY

In this chapter, I describe the rationale for choosing grounded theory (GT), its development and the various approaches that have ensued. I then describe how I situated myself in approaching GT, my own epistemological and ontological stance and the methods I employed. Although there are various conventions for organizing a methodology chapter, I describe the study as it evolved. I provide specific details on the setting, participant sampling and recruitment as well as an overview of data collection and analysis. In addition, I describe some challenges that I faced by sharing some of my memos and how the issues were addressed.

3.1. Rationale for choosing grounded theory

GT is an appropriate methodology for exploring areas where there has been little to no previous research and areas where there are few adequate theories to explain behavior (Schreiber & Stern 2001). Developed in the healthcare setting by sociologists Barney Glaser and Anselm Strauss in the 1960s, GT provides "a systematic approach to generate a theory that illuminates human behavior as a social process among participants in their interactional context" (Aldiabat & Le Navenec 2011, p. 1068). This methodology represents the collaboration of two intellectual lineages. Glaser studied quantitative methods and middle range theories while working at Columbia University, and Strauss studied symbolic interactionism and pragmatism at the Chicago School of Social Psychology with George Herbert Mead as well as doing ethnographic field research (Charmaz, 2014). Each partner acted "as a lens that refracted diverse and profound traditions (both theoretical and methodological) towards the focal point of GTM" (Bryant & Charmaz, 2007, p. 5).

Their seminal work, Discovery of Grounded Theory (1967) was acknowledged as positioning an approach that supported theory-building rather than theory-testing, which had dominated the 20th century research landscape (Walsh, et al., 2015). Glaser and Strauss wanted

to demonstrate the explanatory power of inductive research with the creation of their classical grounded theory that could withstand positivistic scrutiny. Some scholars contend that this infused certain positivist ontological and epistemological principles into their approach (Birks, Chapman, & Francis, 2008). Other scholars note that because the initial text provided little reference to "how to", scholars cited it as a methodological justification for their research studies but with ample room to create their own procedures and interpretations of the approach (Locke, 1996).

Various applications of the method have been cited in the literature (Annells, 1996; Chenitz & Swanson, 1986; Charmaz, 2006; Milliken & Schreiber, 2001; Wuest, 1995). Charmaz (2006), a student of Glaser and Strauss, is now credited with a constructivist adaptation of grounded theory methodology (GTM) that acknowledges the influences of positivism and pragmatism and seeks to develop the latter. Charmaz states, "consistent with pragmatism, constructivist grounded theory acknowledges multiple perspectives and multiple forms of knowledge" (Charmaz, 2011, p. 374).

Charmaz (2006) maintains that within a constructivist paradigm, the ontological perspective assumes that there are multiple, social realities existing simultaneously rather than only one "real" reality as postulated by the positivist paradigm. Methodologically, this suggests that data are constructed through an on-going interaction between researcher and participant. Charmaz's constructivist approach encourages researchers to enter the world they are studying and learn from the 'inside'. The analysis reflects both the participants' and the researcher's way of thinking. The researcher's interpretive understanding, rather than the researcher's explanation of how a participant creates his or her understanding and meaning of reality is the result of the analysis. According to Charmaz (2006), the researcher takes a reflexive stance and studies how,

and sometimes why, participants construct meanings and actions in specific situations. Although there are variations that are arguably influenced by specific ontological and epistemological origins, the choice of this methodology is directly related to the purpose and intent of the present research project.

The originators of GT and the scholars who have continued to use and develop GT share the same intent to "elicit fresh understandings about patterned relationships" between people and their social world (Suddaby, 2006, p. 636). As previously mentioned, GT is well suited for answering questions related to social processes, in this case the process of how nurse and physician managers in formalized dyads work together to address clinical management issues. It is also well suited to move beyond description to theorizing. The key purpose of this study is to theorize the complex processes involved in "working together in formalized dyads" in order to inform other dyads in an organization of the process involved in a nurse and physician manager relationship as well as in other settings where co-management initiatives are being considered or implemented. In addition, the resulting theory illuminates the contribution of nurses and physicians in a management dyad that may be applied to the education of managers in the health professions. GT has worked to assist me in developing a substantive theory on *intentional partnering*, a complex process that represents purposeful interactions between nurse and physician managers as well as defines the essential conditions that initiate and sustain their relationship.

Upon entering the world of GT, I was left with numerous citations and approaches. During my course work, I was introduced to three principle sources for GT: *Discovery* (1967) by Glaser and Strauss, *Basics of Grounded Qualitative Research* (1991) by Corbin and Strauss and *Constructing Grounded Theory* (2006) by Charmaz. When initiating this study, I leaned

towards Charmaz's work as it resonated with my sensibilities as a nurse researcher who had worked in a clinical management position prior to beginning my PhD. The positivist undertones of Glaser's classic GT did not seem to align with my own ontological and epistemological position, as it appeared to be an objectivist approach to social research which seemed untenable to me. I was not able to accept that the researcher is distanced and neutral. I also felt that the rigid data analysis structures in the version of Strauss and Corbin (1998) were tempting to follow for a novice researcher, but I agreed with Glaser's claim that they would force and prescribe the data, strangling opportunities for seeing the "possibilities of the data".

What struck me in my readings of Glaser's independent work (1992, 2009), which responded to Strauss and Corbin's version and later to Charmaz's version, was his declaration that their GT versions were no longer GT but "full forced, conceptual description" (Glaser, 1992, p. 5) also referred to as "descriptive qualitative data analysis (QDA)". I was left with two significant questions: What were the differences between these variations and a "true" classic GT? Where and how would I situate myself in this complex GT world? As I began to work with GT, I sought a clearer understanding of its original purpose and tenets. The next section highlights the epistemological and ontological assumptions that distinguish Charmaz's approach from Glaser's. These assumptions can be most clearly identified by how each scholar articulates his or her approach to the basic social concern, the position of the researcher in relation to the participant, and the role of symbolic interaction. Finally, what I conclude with in this section is my own epistemological and ontological stance that has guided me throughout the study.

3.2. Navigating through the grounded theory experience

The goal of GT methodology for Glaser is to uncover the main concern of individuals and how these individuals attempt to resolve or process this concern. The researcher studies a problem that exists for the participant and not for the researcher. He states:

> Grounded theorists study a problem that exists for the participants in the area not what is supposed to exist or what a professional says is important. "Whose relevance" drives the focus of a research project? GT requires that it is the relevance of the people in the substantive area under study. It is their main concern and their continual process of it that is the focus of grounded theory.… The importance of the main concern of the people in the substantive area cannot be underestimated. Continually resolving it is the prime mover of their behavior. A theory of how it is processed will help participants tremendously by giving them conceptual power (Glaser, 1998, p. 116).

Within GT, the term 'concern' refers to what preoccupies participants, what takes their attention and what motivates the behavior of individuals in a substantive area. For Glaser, the concern is not known or speculated about in advance. Instead, the main concern is the focus of the research and emerges as the research progresses. For Charmaz (2006), however, what constitutes a main concern depends on one's point of view. She states:

> When Glaser argues grounded theory is a 'theory of resolving a main concern' that can be theoretically coded in many ways, he offers an excellent use of grounded theory, but not the only one…. Constructions matter. Who defines this main concern? With which criteria? Whose definitions stick? Note that addressing such questions treats the main concern as problematic, not as given, and brings power and control into the analysis (Charmaz, 2006, p. 180).

A constructivist GT is ontologically relativist and epistemologically subjectivist. It "reshapes the interaction between the researcher and participant in the research process and in doing so brings to the fore the notion of the researcher as author" (Mills, Bonner and Francis, 2006, p. 6). According to Charmaz, it requires the researcher to reflect on and be cognizant of potential power imbalances and to have specific plans in place to equalize the relationship as much as possible. Charmaz (2011) states that the constructivist approach

> loosens grounded theory from its positivist, objectivist roots and brings the researcher's roles and actions into view.… Constructivist grounded theory views knowledge as located in time, space and situation and takes into account the researcher's construction of emergent concepts (p. 365).

However, both scholars appear to agree that the researcher's perspectives and theoretical sensitivity are treated as a point of departure that can be challenged, interrogated and expanded during the research. Where Glaser would suggest that the researcher's perspective, previous experience, reflections and interpretation represent another incident of data to be compared, Charmaz situates the researcher as part of the research process and as a co-constructor of the data, providing perhaps more 'voice' to the researcher's narrative and interpretation, in contradiction to the original tenets of GT which works specifically to uncover the participant's experience.

Given Charmaz's acknowledgement of multiple perspectives and sources of knowledge, it is not surprising that she subscribes to the pragmatist underpinnings of GT and symbolic interactionism (SI). Some scholars note that SI has informed GT from its origins and cannot be separated from it (Shreiber & Stern, 2001). For me, SI offered a theoretical perspective to

understand the behavior of nurse and physician managers and the meanings they give to their experience in working together in a hospital setting.

According to the tenets of SI, human beings actively interpret each other's gestures in social interaction and act on the basis of these interpretations. Blumer (1969) refers to this process as "joint action". Interpretations of a situation are therefore influenced by a person's social interactions with others and the socio-cultural environment in which they exist. This determines what the phenomenon is and how the researcher looks at it. Individuals base their actions on their interpretation of meanings; therefore, it is essential for the researcher to discover the actor's meanings in order to understand and explain the behavior. As Schreiber and Stern (2001) contend, to understand human conduct requires the study of a person's overt and covert behavior, which is directly addressed through GT and its SI origins.

Glaser (1998) on the other hand acknowledges the influence that Strauss and SI brought to their work together and states:

> Through Anselm, I started learning the social construction of realities by symbolic interaction making meanings through indications to self and others. I learned that man was a meaning making animal. Thus there was, it seemed to me no need to force meaning on a participant, but rather a need to listen to his genuine meanings, to grasp his perspectives, to study his concerns and to study his motivational drivers (p. 32).

Yet, for Glaser, this does not make GT symbolic interactionism, as some have suggested; rather, Glaser simply acknowledges his introduction to working with a new kind of data, a new epistemological perspective (Holton, 2011). Similarly, Glaser's approach to defining 'process' also reveals his perspective on how other versions of GT force the data. For Glaser, Strauss's version of GT forces process by bringing process into the analysis as a preconceived essential

feature. Yet for Glaser process is one theoretical code among many if it is relevant to the theory as it emerges.

I concur with Charmaz (2009) that all versions of GTM are inductive, demand a rigorous adherence to constant comparative relationship between data collection and analysis and value the construction of practical theoretical analyses that may be of use in informing policy and practice. Charmaz states that with Glaser's classical GTM, the researcher stands outside the phenomenon as opposed to entering it and attempting to see it from the inside, as the constructivist approach advocates. My concern, however, was not to step too far inside the phenomenon, for doing so might obscure the priority of understanding the participant's concern. In my mind, the participant was the principal author, rather than the researcher as author. Yet I went into the study with the lens of understanding the nature of interactions, which cannot be disassociated from its SI underpinnings.

In addition, aside from my own philosophical stance, my research area and study context represented challenges in applying classic GT. The research topic, while relevant to the setting, was not necessarily relevant to all participants. When initiating this study in 2010, the senior leaders of the setting asked whether I could look at how nurse and physician managers make decisions together. After conducting some preliminary interviews and observations, the participants appeared perplexed when questioned about how they made decisions together. Participants responded politely to the questions; but the basic social concern had not been captured, as the focus of the research did not seem to center on their experience/reality (Glaser, 1992). In fact, from a classic grounded theory approach, the main concern of participants may or may not be relevant to nurse -physician management, let alone decision making (personal communication with B.G. Glaser, July 30, 2014). Nevertheless, the topic was raised by key

stakeholders in the setting who were also participants. I resolved this dissonance by broadening my research focus to explore individual experiences and perceptions of how nurse and physician managers work together to address clinical management issues.

Although I pursued a goal consistent with a classic GT approach, such as identifying the basic social concern, and focused on what participants were working on, I was also influencing and being influenced by the research process. I assumed that there were common fundamental behavior patterns shared by humans. As Milliken and Schrieber (2001) contend, "patterned behavior and shared meaning allow for the possibility to predict interaction giving stability to social interaction" (p. 178). For that reason, I aligned my approach with Glaser's but was unable to dissociate it from the principles and assumptions of pragmatism and symbolic interactionism. I used reflexivity as a key strategy to account for the relationship between the researcher and the research study. Moreover, I assumed the thesis of ontological realism that suggests that a real world exists independently of our perceptions, theories and constructions; but, at the same time, I accepted an epistemological constructivism according to which our knowledge of the phenomena is derived from a framework built out of our own perspectives and standpoint. According to Levers, (2013) this stance is consistent with Charmaz's constructivist approach to grounded theory. From this stance, I endeavored to make everyone's vantage points explicit, including those of participants, peers, mentors, supervisors and my own. In addition, I have drawn from several GT sources, namely, Glaser, 1978, Charmaz 2006, 2014, Schreiber and Stern, 2001, Strauss and Corbin, 1998, rather than one version.

3.3 Sensitizing concepts

Existing empirical knowledge and experience is not ignored in a GT approach according to various scholars (Charmaz, 2006; Corbin & Strauss, 2008; Schreiber & Stern, 2001; Suddaby, 2006). According to Charmaz (2006), sensitizing concepts offer starting points for building analysis and can include the researcher's worldview, disciplinary assumptions, theoretical inclinations, and research interests that will influence his or her observations and the categories developed. Schreiber and Stern (2001), on the other hand, note that sensitizing concepts refer to the idea or understanding that is salient in the researcher's mind about the phenomenon of study. This understanding may come from research, clinical practice or popular literature. The goal for the grounded theorist is to be explicit about his or her pre-existing notions, biases and assumptions and to use GT techniques to work beyond them in the analysis (Schreiber & Stern, 2001). For example, my review of the literature identified a number of representative concepts and influencing factors of nurse-physician manager interactions found in Table 1 and which may exemplify some of the starting points used in building the analysis.

Table 1. Example of sensitizing concepts from the literature

Sensitizing concept	Description
Individual/Personal	Values, opinions, attitude, need, motivation, expectations, history, perceptions, style
Relational	Norms and "rules" of the relationship, respect, power, trust, communication, conflict management
Profession	Values, philosophy, theoretical orientation, structure, hierarchy
Organization	Structure, philosophy, culture, support, goals and possible outcomes of Partnered Management Model (PMM)
System	Social factors: gender, social status, political and economic reality
Managing/leading	Decision making, negotiating, allocating, influencing, planning

Moreover, my own healthcare background as a nurse manager working closely with physicians, my disciplinary training guided by the McGill Model of Nursing and my previous research experience on interprofessional collaboration also contributed to my pre-existing notions of the phenomenon. As a grounded theorist, I reminded myself that what I was observing was a function of both who I am and what I may be hoping or expecting to see, and I therefore applied reflective strategies to interrogate the validity of my pre-existing notions.

3.4. Setting and research context

The study was conducted at a tertiary care, university affiliated teaching hospital in an urban center in Montreal. The institution consists of 637 beds, 1650 nurses, 700 physicians, approximately 24 000 admissions/year and over 12 000 surgical patients. It serves a broad cross-section of culturally and ethnically diverse populations. Because it is a referral center, large numbers of patients are also referred from across Quebec and other Canadian provinces. Approximately half of the hospitalized patients come from the region around the hospital, 30 per cent from elsewhere in Montreal and 20 per cent from outside Montreal.

A nurse-physician management structure was adopted throughout the institution in 2008 and is known as the *Partnered Management Model* (PMM). This model identifies nurse-physician partners at all levels of the institution but has been implemented more formally in senior management. The PMM was implemented as an organizational model for clinical decision making whereby nurse-physician partners work together to achieve positive health outcomes. The goal of this organizational model is to 1) promote patient-centered care; 2) develop a culture of mutual respect, openness and shared accountability; 3) define roles and responsibilities of team members; and 4) recognize and reward each partner's unique contribution to patient-centered care (personal communication, Director of Nursing, 9.9.2010).

All senior nurse-physician management dyads from every hospital division (i.e., critical care, oncology, obstetrics, surgery etc.) have formal 'partners'. They are known to each other as 'partners' and are expected to address specific clinical management issues together. In addition, almost all steering committees are led by an Associate Director for Nursing and a Physician Department Chief. Some of the dyads emerged naturally, while others were appointed; but all dyads were formalized by senior organizational leaders. It is important to note that at the time at which this study was undertaken, senior nurse managers at the study site reported directly to the Director of Nursing (DoN). Each nurse manager was expected to address the nursing agenda. The Nursing Department manages and is responsible for its own budget. The DoN works with the Director of Professional Services (DPS), who is a physician, in the management of clinical programs. In addition, physicians reported to their Chief of Service who reported to the DPS for administrative issues. A Medical Executive Committee reported to the Board. The Chief Executive Officer (CEO) did not have a formalized 'partner' per se but worked closely with the DoN on a number of management matters. Moreover, physicians in the Canadian context are contracted through the government system on a fee-for-service basis, and nurses are contracted as employees of the hospital.

3.5. Study participants

A formal nurse-physician management dyad was operationally defined as a nurse and physician who have a formal management position within the organization. This position can be either at the senior management or clinical management level. The nurse and physician have been appointed to work together to manage and lead a program, department, or division of care; and they are known to each other. Participants were included in the study if they were members of a formalized nurse-physician dyad working with their partners on a management issue, such

as program initiatives, budget and resource allocation, professional and practice issues. Participants were excluded from the study if they were not in a formal nurse-physician management dyad or did not have a formal management position. Socio-demographic information, such as gender, age, years of management experience, educational background in management or leadership, amount of time working in the current dyad, and previous experience working in a dyad, was collected to describe the sample participants.

3.6. Sampling of study participants

Initial sampling was purposefully done in the Department of Surgery on the recommendation of key stakeholders who believed the department effectively illustrated nurse-physician 'partnerships'. This was followed by theoretical sampling (Coyne, 1997; Cutcliffe, 2000). This department provided variations of dyads (newly formed and established) since it was one of the first to implement the PMM. The sample is representative of participants who have some experience that is relevant to the research question. I focused on dyads that both consented to participate and whose working habits gave me the opportunity to observe them interacting to address clinical management issues. The sample included twenty-one participants (twelve nurse managers and nine physician managers), with the majority of participants in the Department of Surgery. See Appendix B 1 & 2 for summaries of the study participants and management dyads.

In some instances only one member of the dyad consented to participate. In such cases, only interview data were collected. The sample represents eleven dyads in total: seven dyads observed and interviewed (managers may have more than one partner), two dyads interviewed but not observed, two individual members of dyads interviewed only. Four individuals were interviewed in order to learn about the context of the PMM. Total time spent on observation was

142 hours (110 hours at the senior management level and 32 hours at the clinical management level); field notes were recorded for ninety observed events and the majority of the individual interviews. A total of 36 interviews were audio-recorded and transcribed verbatim.

Theoretical sampling was essential in concluding the analysis and refining the theory. Memo writing was used to direct theoretical sampling of the study. It was used to flag categories requiring more data and potential gaps in the developing theory. For example, theoretical sampling allowed me to return to selected participants to ensure that I had constructed full and robust categories that would lead me to clarify relationships between categories (Charmaz, 2006, p. 103). This procedure will be discussed later in the chapter.

3.7. The recruitment process

Ethics approval for this study was obtained on September 3, 2013, and can be found in Appendix C. Presenting and generating interest in the study was an important step in the recruitment process as well as was highlighting the ways confidentiality would be protected. Written consent was obtained from participants to collect observational data and/or conduct interviews. The following section describes the recruitment process as it occurred in the setting.

I first introduced my study to senior managers in the Department of Surgery on August, 28, 2013, at one of their planned weekly meetings. This was arranged through the Associate Director of Nursing. After obtaining consent, I began observing senior managers on September 9, 2013, by shadowing and attending planned weekly meetings. This enabled me to familiarize myself with individuals, management issues and the context as well as to sensitize individuals to my research intentions and topic of interest.

Two presentations were then given in the Department in order to begin my recruitment process with clinical nurse-physician manager dyads. On October 8, 2013, I first presented my

study to the Nursing Surgical Committee, which consisted of all nurse managers in the Department of Surgery. I presented the purpose of the study and explained my role as a participant observer and where they could anticipate seeing me.

At the end of the presentation, I distributed a study information sheet as illustrated in Appendix D that included all of the details of the study that had been reviewed in the presentation. On a separate sheet, I asked the following two questions: 1) Do you meet (formally or informally) with your partner to address clinical management issues? Yes or no. 2) May I contact you to discuss your possible participation in the study? Yes or no. These questions allowed me to identify my initial sample and the possibility of focusing on dyads that interact in face-to-face meetings. It also initiated the consent process. Individuals present at the committee were asked to complete these questions and write their name and surgical program on the sheet and place it in a sealed envelope that I provided. This ensured that only I knew who had agreed to participate in the study. Each name was then replaced with a non-identifying pseudonym by which they were referred to on recorded observations. For those members who were not at the presentation, the study information sheet was sent to them via email, and I contacted them directly to ask the first question and explore their interest in participating.

All of the members of the committee agreed to be contacted; however, two clinical nurse managers asked me whether they would be eligible to participate, one being a nurse practitioner and the other being a nurse manager who was unclear about whom to identify as her physician partner. Given the nature of the nurse-practitioner's position, she was excluded from the study; however, the other nurse manager was included as she did have a "formal" partner but did not feel they had established a "partnership". This dyad became a comparison case.

The second presentation was given October 21, 2013, to the Surgical Committee, which consisted of all Surgical Department physician chiefs and was chaired by the Chief of Surgery. The same presentation was given except that physicians gave a nod in order to show their consent to be contacted. This modification was suggested by the Chief of Surgery and was verified with the Ethics Committee prior to the presentation.

Response and reactions to my presentation at this venue indicated more ambiguity around the "partnered management model". Only the Associate Director of Nursing for Surgery attended these monthly meetings, although for certain issues nurse managers were encouraged to come. After I presented the study, the Associate DoN for Surgery named the nursing partners of some of the surgical chiefs in order to clarify the nurse-physician management partnerships. There was certainly skepticism in the room about what my project would actually entail or who would be eligible or would want to participate. However, there were nods from these individuals. Following the meeting, I proceeded to identify dyads in which both the nurse and physician partner expressed an interest in participating in the study, and I started by emailing the members of these dyads.

I organized individual meetings to review the details of the study with them again; my interest in observing their interactions, which would be captured more easily in their specific management dyad meetings; and my interest in having an individual interview and/or a shadowing session. Both nurses and physicians from four of the clinical management dyads agreed to participate, and I obtained written consent for observations and interviews. In the 5th dyad, the physician did not respond to my invitation to participate, and only interview data were collected from the nurse manager. Reasons for not participating were not provided. A 6th dyad was recruited later in the study once the nurse manager was available to participate. I also

gathered details on when and how these management dyads were interacting in order to organize my data collection process and pace my data collection, knowing that I would need time for field notes, transcription of interviews and memo writing. Appendix E describes the study timeline. Participant recruitment had ended by September 2014, and data collection was complete by March 2015. The following sections describe in detail my strategies of data collection and analysis. I attempt to illustrate similarities to and differences from Glaser's and Charmaz's approaches where I see them.

3.8. Data collection

Glaser proposes that "all is data", meaning "everything that is going on in the research scene, whatever the source, whether interview, observations, documents" (Holton & Glaser, 2012 p. 235). Glaser defines the data as "what it is" and the researcher collects, codes and analyses exactly what s/he has to constantly compare to generate a category and properties that vary it (Holton & Glaser, 2012). Charmaz (2006) notes that there will likely be a great deal of variety in the quality and relevance of this information. The nature of the research should direct the data collection process with certain research questions lending themselves to certain data collection methods. However, both Glaser and Charmaz caution that grounded theorists should not force preconceived ideas and theories directly upon their data but rather "follow leads that are defined in the data, or design another way of collecting data to pursue one's initial interest" (Charmaz, 2006, p. 17). This was an important consideration in the planning and implementation of data collection for this study. The context of the participants and the nature of the research question strongly influenced when and how data were collected.

When conducting some preliminary interviews prior to starting formal data collection, I became more aware of the sensitivity that could arise from this research topic. While some

participants were far more at ease and articulate in speaking about their relationships, other participants either had difficulty or did not feel comfortable doing so. In other instances, participants appeared to feel compelled to tell me what they thought I wanted to hear, a term Glaser (1998) refers to as "properline" data. Several approaches were used in this research to ensure that rich data captured how nurse and physician managers worked together. These included participant observation (scheduled meetings, shadowing, informal conversations), semi-structured interviews and review of administrative documents where possible. Each data source provided a different perspective in viewing and understanding the phenomenon and allowed me to achieve theoretical saturation of the key conceptual categories developed during constant comparative analysis.

3.8.1. Participant observation. Observation is an ongoing dynamic activity that complements interviews by providing data about processes (Muhall, 2003). Observations capture the social setting in which individuals function by taking into account the work context. I conducted unstructured observations in the setting in order to be open to what was occurring in the interaction. Observational methods allowed me to ascertain whether what people said they did was congruent with what they actually did; however, it is important to note that both accounts were valid in their own right and represent different perspectives (Atkinson & Coffey, 2001).

I defined my participant observer role as an individual who conducts intermittent observation with interviewing and whose role is known to those in the setting (Gold, 1958). I asked participants where they would like me to sit during the meeting and whether they were comfortable if I took notes. I discreetly jotted descriptions of discussions, phrases, actions of participants, a description of the setting, circumstances of the event, and the position of the

participants at the actual time of data collection. These descriptions were quite detailed as I found myself capturing and recording most of the interactions verbatim. These hand-written notes were then transcribed highlighting focal points and adding more details of the interaction for the final and permanent record of the event. This was completed as soon as possible or within 24 hours of the event (Chiseri-Strater & Sunstein, 1997). Field notes included both descriptive and interpretive data and were bound by the time in the field. I added as much detail as I could remember and focused on individual and collective actions, significant processes occurring in the setting, what the participants defined as interesting and/or problematic, as well as participants' use of particular language or expressions. At the end of a field note, I jotted down the possible themes and added relevant personal reflections, such as my perceptions of my behavior in the interaction and how it might have influenced the data.

As I coded the field notes, I also created a list of tentative concepts I was observing and other issues that I clarified either in brief situational questioning or conversations during an observational event. This allowed me to gain a stronger understanding of the meaning of interactions (Schatzman & Strauss, 1973). I also asked questions such as "How did this [situation] strike you? How do you see this situation moving forward?" These informal conversations occurred during periods of observation and were documented verbatim in the field notes.

Some clinical nurse managers indicated that in certain circumstances they did not have formal dyad meetings but would interact with their partner when they were rounding on their unit. In these circumstances, I shadowed the clinical nurse manager at the time the physician was expected to do rounds. I shadowed the nurse manager for a set period of time (0.5-4 hours)

negotiated in advance. However, shadowing attempts were less successful, as the interaction with the physician did not occur or occurred outside of the set shadowing period.

The use of participant observation was invaluable in gaining rich data on how nurse and physician managers work together. Changes in senior management positions were occurring during the time of data collection and resulted in last minute changes to meeting schedules. I had to remain flexible in this period of transition and mindful of participants' concerns about confidentiality. During certain agenda topics, I would be asked to leave the meeting. However, participants had noted my presence in the setting, which diluted "properline" data from occurring. Knowing that I had attended the same meeting, seeing me in the hallway, or throughout the setting, participants perhaps assumed that I was in tune with their context and their issues. In one particular instance, when I struggled to organize a date and time for a particular physician interview, I adopted a nurse participant's strategy to just "pop into" the physician's clinic during the physician's clinic hours. After three months of trying to organize this interview through this physician's assistant unsuccessfully, I was able to conduct the interview at the end of that clinic day. While these data collection strategies and sources provided rich data, I created, over time, deeper participant relationships and had to be mindful of maintaining an analytic distance and my role as a researcher.

In one particular instance, the senior nurse manager I was shadowing assumed that I could attend one of the senior management meetings with her. While it was tempting to tag along, I felt strongly that she should ask the chair of the meeting (a physician manager who was also a participant in the study) if I might observe. He responded that although he did not mind me observing in other contexts, this meeting was strictly confidential and that I could not attend. This incident provided important 'data' that I recorded. However, being mindful of my role as a

researcher in this case may have ensured integrity of the participant-researcher relationship. This is discussed later in the chapter in the section addressing rigor and reflexivity.

3.8.2. Interviews. I conducted intensive interviews designed to encourage the participant to do most of the talking (Charmaz, 2014). The interviews usually happened after a few observations of the dyad occurred. I arranged an interview at a time and place convenient to the participant. The interview lasted 30 to 60 minutes and members of the dyad were interviewed separately. Most interviews were conducted in the participant's office. Many of the nurse managers at the end of the interview described the experience as "therapeutic", serving as a "debrief". Their interviews would easily extend beyond the set time. Obtaining data from nurse managers happened also quite informally, such as walking to a meeting, rounding on their units or dropping by their offices. Obtaining data from physicians, however, was more successful when a formal appointment had been made with their assistants, a clear objective of the interview was provided and the time allotted for the interview was respected. Physicians preferred a maximum of 30 minutes for the interview.

Whereas Glaser favored less structure in gathering data in an interview format, Charmaz raises no objections to utilizing an open-ended interview guide. A very broad, open-ended question along the subject areas was used with all participants, as illustrated in Appendix F. However, GT as an emergent design is dynamic and continuous, and thus the semi-structured interview guide changed over time. As Charmaz (2014) notes, when a particular theme, idea or process is deemed important according to the frequency with which it occurs, the emotional response of participants or the researcher's interpretation, further information should be sought to examine it. Minor modifications began after the first three interviews were completed, such as adding additional questions to explore recurring concepts in the data. Additional questions were

made to the guide from this point right up until the final interview was conducted; however, the initial broad question was kept the same for all of the initial participant interviews.

I used interviews to gain a comprehensive understanding of how dyads function and to clarify, validate and explore further what I was observing as well as to target emerging categories and elaborate on their specific properties. As the interview proceeded, I also requested details to learn about the participant's experiences and reflections that involved real time and retrospective accounts. I explored, probed and asked further questions that illuminated the topics that appeared important to the participants. For example, during an interview with one of the participants, I explored his meaning of accountability with the following questions: "You mentioned that if you were going to accomplish anything, one had to push responsibility for doing things and the accountability for doing things out to the members of the department, that is, nurses and surgeons. Can you describe a situation where you feel the nurse and physician involved demonstrated accountability**?** Are there ways or strategies that promote accountability? What do you do when accountability does not appear to be forthcoming?" I commonly asked for additional examples to illustrate their descriptions. Subsequent interviews for the purpose of theoretical sampling were conducted with eight participants; and they focused on the concepts, categories, and patterns in the data. In the later stage of theoretical sampling, the evolving theoretical model was shared with participants as a vehicle to clarify and elaborate on particular concepts. This occurred with participants individually as well as in one dyad. All interviews were audio-recorded and transcribed verbatim by me. Characteristics of speech such as intonations, pauses and pace were recorded in the transcripts, as they can be important for interpretations (Bailey, 2008).

Intensive interviewing takes practice to execute well. I made a focused effort to improve my interviewing technique by listening to interview recordings many times and taking note of where participants were cut off or where leading questions were used. I made notes to identify where improvements could be made for the next interview and to refine my interviewing skills.

3.8.3. Relevant documents. To the extent possible, I included relevant texts and documents, such as meeting minutes and agendas, annual reports, and/or presentations. These documents served to describe the context of the PMM, the clinical management issues and the individuals involved. Meeting agendas were particularly helpful. The Associate Director of Nursing's daily agenda was also a useful tool in helping me navigate within the environment. Her assistant provided me with updated copies of her agenda every day. These daily agendas allowed me not only to target specific meetings and interactions but to learn how the department functioned as a whole. Her daily agenda provided data on the clinical priorities for the department and how these priorities were shaped or were changed according to various events and situations.

3.9. Data analysis

GT data collection and analysis are not linear. They involve an iterative process of collecting, coding, comparing, memoing, sorting and writing. These processes blur and intertwine, making analysis a challenge to describe with precision. Figure 1 represents a schematic representation of the data analysis process for this study.

I began analysis after the first few sets of observational field notes on senior managers were recorded and the second interview was completed. Analysis continued throughout data collection but also continued even while early drafts of the findings were being written. GT

analysis is an interpretive process beginning with careful reading and open coding, which is described below.

3.9.1. Coding. Corbin and Strauss (2008) emphasize the importance of early coding to inform subsequent data collection. Despite some of the epistemological differences in the GTM approaches that have been previously highlighted, coding procedures are similar though with slight variations in nomenclature. Coding involves different phases. In the first level (Schreiber & Stern, 2001), open (Glaser, 1978) or initial coding (Charmaz, 2006, 2014), initial codes suggest what each line indicates, often using gerunds and the participant's own words (Charmaz, 2006, 2014). This initial phase involves reading transcripts and field notes to identify chunks of data relevant to the research question. The second phase is focused coding.

According to Charmaz (2006), once a strong analytic direction has been established through initial coding, focused coding can begin to synthesize and explain larger segments of data. Using the most significant and/or frequent codes from phase one, I selected certain codes that had overriding significance. Charmaz (2006) notes that codes are selected according to which make the most analytical sense in order to categorize the data. Some of these focused codes became provisional categories that I then used to re-code the data. Comparing data to these codes helped to refine them. I continued to compare new data to those ideas that had emerged through this process. I then attempted to define the properties of the category, the conditions under which it operates, the conditions under which it changes and its relation to other categories (Charmaz, 2006, p. 186).

It is important to reiterate that this is not a linear process. Coding is an emergent process; and as one code is constructed to fit one incident or statement, it may elucidate another requiring the researcher to return to the original data to re-code. Subsequent data collection was guided by

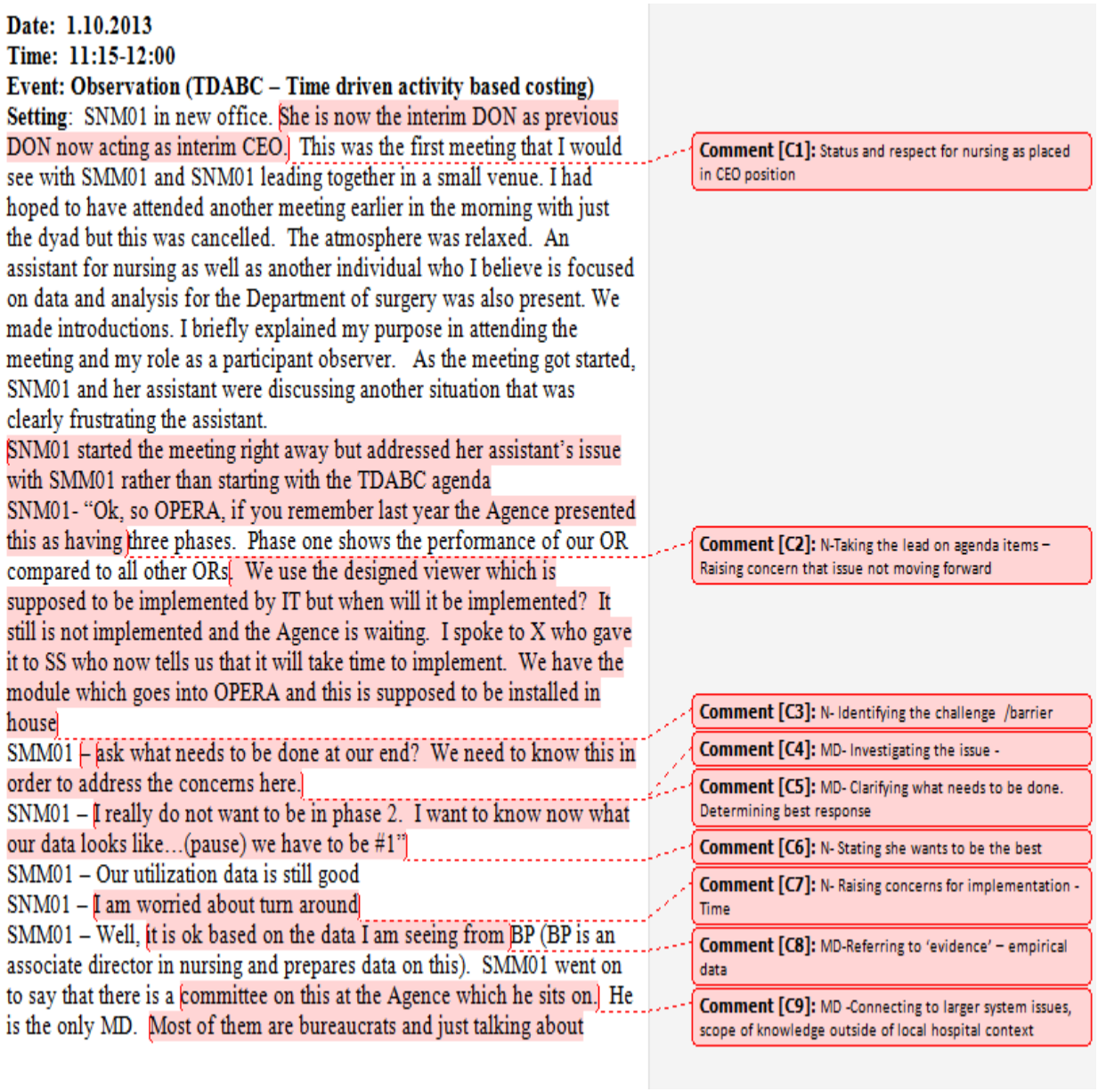
the focused codes. I also used axial coding whereby data were brought back into context and codes were reassembled in new ways in order to construct a coherent explanation of the processes under study.

The final step in the GT process is theoretical coding, which occurred once the concepts had achieved saturation. At this point, I shifted my attention to explore the fit of potential theoretical codes that specified the possible relationships between categories. Glaser (1978) notes that grounded theories must not only be conceptually rich but must have a theoretical model that relates the categories. Charmaz (2006) notes that these codes are integrative and "help tell an analytic story that has coherence" (p. 63).

Field notes and interview transcripts were analyzed in the same manner. I began with open coding, printed out field notes on paper and coded them chronologically. As I recorded my handwritten field notes into electronic documents, I began coding simultaneously in the margins. The initial codes became the building blocks of the emerging theory. They included any valuable or pertinent information that conveyed meaning. For every instance, I used a code that responded to the questions: "What is happening here? What processes are at issue here—how can I define it? How do participants act while involved in this process? What are the consequences of the process?" (Charmaz, 2014). The goal of open coding is to break down the data into manageable segments and identify the relevant data, which are the quotes or observations directly related to the research questions and emerging theory. Figure 2 shows a segment of a field note to demonstrate open line-by-line coding.

Figure 2.

An example of descriptive field note with open coding



After the first set of field notes and interviews was coded, I moved recorded field notes and transcriptions into N-Vivo software to determine how I could use software in the analysis process. Subsequent early coding was done using N-Vivo; however, after coding four interview transcripts over 300 codes were identified. The initial list of codes remained descriptive in

nature. At this point, I felt that using N-Vivo, while it was helpful as an organizing tool, prematurely fossilized the codes and did not allow me to be open to the meaning of the data. I used Word documents in table formats, as well as pen and paper to start diagramming and clustering codes.

The data and the open codes were analyzed by making constant comparisons. Constant comparison is a central process to GT involving comparing coded data with other data and concepts to uncover patterns in the data. It is a key intellectual strategy articulated by Glaser and Strauss (1967) to discover theory in the data. It involves testing tentative ideas and concepts against existing and ongoing data. Tentative categories were identified and then used to re-code the data. Table 2 illustrates some of the focused codes generated from open coding.

Table 2.

Examples of open and focused codes

Open Code	Focused Code/Tentative Category	Description
• Living up to duties or obligation in terms of job title • Being part of building the big picture. • Being innovative • Being recognized and being valued • Achieving the ideal practice for patients • Advocating for the team • Sharing concerns for protecting resources • Gaining influence by partnering • Being part of the game, learning the game • Looking to others for mentoring	Motivations to work together	Reasons why nurse and physician partners want to work together. Relates to personal, practical, political and patient-centered reasons
• Finding a common topic or relating to their interest, grabbing attention	Appealing to agendas	Strategies for engaging the other to work together? What sets the tone? What

Open Code	Focused Code/Tentative Category	Description
• Using humor and sharing personal stories—effort in getting to know the other person • Personalizing their potential contribution • Being flexible—speaking informally, going into their setting • Validating their concerns, their challenges and trying to understand their reality • Giving a way out when suggesting something new to try • Depersonalizing the issue—Supporting rationale with evidence		draws the other person in?
• Using formal tools or methods that implicate both nursing and medical practice • Belonging to the same professional organizations • Ensuring frequent, regular interactions, i.e. being available and accessible, being in each other's work space	Establishing and working within a communication infrastructure	Facilitating factors for building effective communication

Table 2. This table illustrates how the researcher selects codes that are more frequent and meaningful and are then organized to form a focused code. The focused code becomes the nucleus of the developing theory (Charmaz, 2014).

3.9.2. Memo-writing. Memos helped me to clarify what was happening in the field. Memo-writing prompted me to analyze the data and codes in order to discover ideas about them (Charmaz, 2006). These written records of my thinking during the process of undertaking this GT study provided a way to capture and preserve conceptual analysis (Montgomery & Bailey, 2007). I wrote memos concurrently with data collection and analysis, interrupting the analysis process at any point to record my ideas so they were not lost.

Glaser (1998) contends that memos have no preconceived structure and can vary from being a "jot" of a few words all the way to parts of the theory. I categorized memos as theoretical, methodological or personal. To stimulate theoretical memoing, I wrote memos on some of the focused codes/tentative categories. Early theoretical memos were mainly descriptive but documented my early theorizing and questioning of the data. Figure 3, represents an initial theoretical memo which illustrates my reflections on an emerging pattern and/or concepts.

Figure 3

An example of an initial theoretical memo

Title: Reasons to work together
Date: 17.6.2014

There seems to be a tension around working together. This has become more apparent as I continue to interview and observe nurse participants. They have a need to work with physician because there are so many medical issues related to patient care but do they have other added benefits CNM01 B wonders if it was really him (CMM01) to be a manager? "You can see that he is really at his best in the clinic, having his secretary and treating patients. I am not sure he wants to be managing people." So she needed him in some respects but for managing, he was not particularly helpful. Did he need her? I am not sure if optimal partnerships can occur without this recognition for the other, this need for the other's expertise. If you do not feel you need the partner, it seems like it is not prioritized, not valued. In the optimal partnerships, feeling the need and value of the partner came out very strongly. Perhaps CMM01 had apathy in managing his surgeons or issues because he did not see it as his role and therefore did not prioritize his partnership. But he spoke so highly about the importance of managing with nurses. Interestingly, he referred to his nurse partner as the Associate Director of Nursing and not so much the post-surgical head nurse CNM01. This may have to do with working within hierarchy and physicians aligning themselves with those who have greatest influence or have a higher "status".

Memos recorded research decisions, guided theoretical sampling related to codes and categories and followed up interviews with participants to enhance understanding of the categories and their properties (Charmaz, 2006). As memos became more advanced, they helped to identify, clarify and examine properties and variations of categories. Charmaz notes that the content of more advanced memos describes how the category emerges and changes; identifies

the beliefs and assumptions that underlie the category; describes the phenomenon from various vantage points; compares the data, codes, and categories; provides evidence to support the definition of the category and analytic claims about it; and identifies gaps in the analysis. Figure 4 is an example of a more advanced theoretical memo entitled "Aligning professional agendas", which illustrates some of these aspects.

Figure 4

An example of an advanced memo

Title: Aligning professional agendas -
Date: 25. 3. 2014

Participants are speaking about 'agendas' in significant ways. Consider the following interview excerpts:

"Yes, the nurses, at least the nurses are trying and we have a common agenda. I have a long history going way back when we did the first care map for this hospital and that was a huge learning experience for me because I realized because I don't think we had any clue of what we were setting out to do, I don't think and yet it was me along with the HN and few others and started to brainstorm, change practice and really look at best practice and did something." (Individual interview with clinical medical manager)

"… everyone coming in with their own little interests and they want to defend it strongly and they are very opinionated about their own things." (Individual interview with clinical nurse manager)

The concept of an "agenda" outside of its physical definition is defined as "matters that need to be attended to" or "things to be done". The term 'agenda' is often considered as having a negative connotation. For example, an individual with an ulterior motive may have a hidden agenda or purpose, implying a lack of transparency or being based on selfish motives. While every perspective can certainly carry with it an explicit and implicit purpose or agenda, it does not have to be negative. When I consider the word in terms of our nursing and medical professional contexts, what appears to be evident amongst the participant data is an overriding agenda for providing high quality patient care which has been agreed upon in some certain way and in some certain process. Within this overriding agenda of care are different agendas based on professions, what they feel responsible for and accountable to. What becomes more and more evident in the interactions between nurse and physician managers is that their discourse appears to reflect common yet particular 'matters of attention'. Nursing commonly refers to the implications that decisions and actions have on the patient care experience and the local context where the operational details of providing that care were executed. Physician discourse appears to surround issues related to efficiency and implications to the broader context and system. This

is not to say that these matters are exclusive to one profession but that our disciplinary knowledge and training may represent specific core values which are reflected in how we use language and present our priorities.

When thinking more closely about the significance of these different agendas, I wonder whether there is an effort in aligning them as a way to bridge or connect these professional differences? What is this effort for each profession? In order to put something in alignment, there needs to be an ideal position. While there are professional agendas, there are also management or corporate agendas but there is the overriding caring agenda, what everyone is there for and what many of the participant's actions are attributed to. If every perspective carries with it an agenda of what is important, then what are individuals prepared to bargain on or give up? Where is there some room for openness?

Interestingly, I am not seeing issues of power imbalance per se in the interactions of these two disciplines but seeing mutual respect, particularly at the senior management level. There is an obvious imbalance in relation to professional structures with physicians having decision making authority and nurses strategizing to be part of the decision making process. What are these strategies based on, e.g. nursing controlling their own resources? Do nurses hold a position of influence for physicians? Physicians have a position of influence at the organizational level. How are they aligning these differences? Does one profession require putting in more effort in the process? How are they developing their relationship then? Seems like there is a recognition of needing the other to move their professional agenda forward. Credibility also seems important to develop the relationship as well as clarifying and understanding the different perceptions of professional frameworks.

I shared advanced memos with supervisors and committee members to bring them closer to my thinking and analysis. At this stage, memo-writing was invaluable as it helped me to locate and then conceptualize the main pattern in the data that eventually became the core category. Once I identified the core category, I selected the concepts related to it and then wrote a memo on how they related to it and to each other. This allowed me to elaborate the dimensions of the core category.

3.9.3. Theoretical sorting, diagramming, and integrating. With a robust bank of memos, I sorted them according to each category and examined the data for patterns and relationships among the categories. I did this in a variety of ways. I used diagramming frequently which provided visual representations of the categories and their relationships. This enabled me to ask questions about the data and how categories related to each other, and to identify gaps in my understanding which triggered theoretical sampling. The goal of this process

was to help me think more conceptually and uncover the meaning attached to what participants were experiencing. These diagrams were dated and filed.

A second method that I used was color-coded post-it notes. On a wall, I placed the tentative core category at the center. I used the colored post-it notes in different ways. Codes from nursing data and physician data were color coded. I then placed the codes under larger categories allowing the different colors to reveal patterns. The visual display of a color pattern alone began to shift my line of questioning around the data. I began to memo on what nurse and physician managers change as a result of working in a "partnership". Memos illustrated characteristics of how nurses and physicians functioned independently and not in "partnership", revealing properties and dimensions of "professional agendas". I also began to look at each dyad as an individual case. I compiled all of the data for each dyad (observational field notes and interview transcriptions) and re-coded the data in the margins by focusing on two principle questions: What is the main concern being faced by participants i.e., what is attracting their attention? and what accounts for participants resolving this concern? (Glaser, 1978, 2004). I wrote memos on these revised codes, which usually resulted in more diagrams. After completing this same technique for each dyad, I then wrote memos on which codes were similar and which different across the dyads and why. I identified codes that could be clustered into a larger category and memo'ed on how these codes represented the category. The process revealed how concepts were working their way into the theory through this constant comparison process. This technique generated numerous diagrams for each dyad. Using different strategies allowed me to re-examine the data and ask myself how the codes represented the category and how they represented the experience. A collection of memos was produced to explain why nurse and physician managers work together.

3.9.4. Identifying the core category. The core category is that pattern of behavior which is most related to all the other categories and their properties in the theory and explains how the participants are resolving their main concern. The core category is the largest of the categories and often integrates a number of smaller categories.

At this point in time, I had identified certain concepts but was overwhelmed with memos, diagrams, codes etc. I was exhausted with the coding process and felt like I was hitting a wall in my analysis. I felt there were a number of patterns in the data that inevitably could be theories on their own. I had attended Glaser's institute in the early stages of my course work when first learning about GT and felt that returning for a second time at this juncture with some of my codes and categories would help me over this hurdle. Dr. Glaser agreed to meet with me personally to talk about my work. I sent him a short summary of where I thought I was in the process along with concepts emerging from the data.

In our two mornings together, he offered numerous examples of GTs. He knew the challenges for novice grounded theorists like myself and was trying to help me to move past describing concepts to think more abstractly. I realized that in my analysis and thinking, I had become preoccupied with common concerns among the nurse managers and common concerns among the physician managers, but I had not focused on a shared concern for the dyad. I needed to go beyond what was preoccupying each individual in the partnership to what jointly preoccupied the individuals in the partnership. Secondly, it was clear that I had enough data for several studies. I had been going for "full coverage" with my analysis and had not limited it to a key concern. As Glaser cautioned, "You are doing too much and not enough" (personal communication, B.G. Glaser, July 30, 2014). He encouraged me to take one of the patterns in the data and see where it would take me. Even if it was not the core category, the exercise would

push me to examine its dimensions and properties and to think conceptually. The other patterns could be left for another grounded theory. I went home with this new learning in mind and decided to memo on what I had come to terms with in my data. My codes identified a number of deliberate strategies and actions that both nurse and physician managers took when working together. There were also a number of codes identifying their individual professional interests that they wanted to achieve, but there were also interests related to bringing nurse and physician managers together.

In my preparation to meet Dr. Glaser, I had identified the concept of accepting mutual necessity which was dyadic in nature but had not realized that it was one of the processes participants experienced in order to align their agendas and achieve their interests. I decided to take his advice and try to "pattern out" the concept of accepting mutual necessity. I wrote my first 'official' draft with this as the core category and submitted it. The feedback suggested that there was a larger pattern in the data that included accepting mutual necessity as one of the categories. Support from my thesis supervisors was essential at this stage. We decided to explore 'intentional partnering' as the core category. I took data excerpts of concepts that I thought related to this core and sent them to each of the supervisors. We coded the data independently. Then we came together and shared our individual codes. Charmaz (2006) would probably describe our approach as "an opportunity for seeing possibilities, establishing connections and asking questions" (p. 135). I had labeled the basic social concern as nurse and physician managers aligning their professional agendas and placed the core category of intentional partnering at the center of the blackboard. As we worked through the data together, my supervisors redirected my thinking back to one of the original neutral questions, "What is this data a study of?" Our exchange helped me to focus on the "partner work" and the strategizing

involved in intentional partnering. We identified two more categories at this time: daring to risk reflecting the emotional undercurrents that partners navigate in their work together, and constructing a shared responsibility which reflects how partners ensure the partnership remains viable in order to achieve their end. I then went back to memo on the categories related to this core. Were they all about strategizing? Why or why not? This memo-writing helped me to let go of some of the codes that were not earning their way into the theory. After more writing and revisions, we conducted the same process a second time, asking more questions around certain concepts as well as proposing a theoretical code that appeared to be integrating the concepts. As Glaser notes, the theoretical code is what "weaves the fractured story back together again" (Glaser, 1978, p. 72). For Charmaz, the process of identifying the theoretical code takes the analysis that has been developed and moves it towards theory.

In this case, I focused theory development around answering the research question, "How do nurse and physician managers in formalized dyads work together to address clinical management issues?" "Strategizing" was evident in nurse and physician managers' work together, which illustrated how participants were resolving the main concern to align professional agendas. The data had been collected over sufficient time and captured adequate variation in the partnerships so that the core category reflected something of a linear process of the participants' experience. I identified a basic social process to integrate the categories and their properties that is outlined in the findings chapter.

3.10. Theoretical sampling and saturation

As the core category and subcategories were identified, theoretical sampling became more specific. This involved seeking specific data to fill in the properties of the categories of the emerging theory (Charmaz, 2006). I asked myself questions such as "What were the theoretical

findings that made me want to keep sampling?" This related to both breadth and depth of concepts. I reviewed how my coding was evolving. Once I had organized categories, gaps showed up in the content of the analysis and this also directed theoretical sampling. While looking at the data, I asked questions on what "surprised me" and memo'ed on this to ensure the theory was grounded and not a synthesis of ideas incorporated from the literature.

Theoretical sampling included additional interviews with participants (senior and clinical nurse and physician managers) as well as returning to the data already collected. I conducted additional interviews with participants who had specific relevance to those categories. For example, many nurse manager participants in their first interviews spoke about establishing credibility with their partner. I went back to these participants to gain a deeper understanding of this concept and to physician manager participants to ensure a deeper understanding of the properties associated with establishing credibility.

In the final stages of theoretical sampling, I used a diagram of the emerging theory with participants as a conversation tool. For example, after I had presented the diagram to one participant, she stated, "This really puts words on what I am feeling and doing. It is so helpful." She then went on to use the tool to indicate where some partnerships had gone "wrong". This allowed me to gather more data on comparison cases as well as identify more critical concepts in the intentional partnering process.

Another participant elaborated on the concept of reaping benefits. Originally, I had labeled one of the benefits as creating synergy and optimizing the patient experience. This participant clarified how the process of intentional partnering went beyond this to include innovation. He stated:

> Synergy is important but should also include innovation. It is not only synergy, but you are creating something new. You are defining something new. Synergy is making more of the things that exist. Innovation is about creating something new that did not exist before. That is the difference.... It is not just about optimizing the patient experience, it is not even about improving the patient experience, but rather expanding the human experience, giving them a different experience, a more human experience. People function in communities, it is a need we have; that is why isolation does not work… It is like two cells, they have to interact. (Clinical medical manager, 9.3. 2015)

This concept became labeled *creating synergy and innovating.* Theoretical sampling at this point in time allowed me to present more descriptive labels (in some cases) to participants who were then able to extract meaning out of their own lived experience. Theoretical sampling was critical to theoretical saturation.

Disagreements are evident among scholars about the meaning of saturation (Morse, 1995; Bowen, 2008). Dey (1999) prefers the term "theoretical sufficiency" in which the grounded theorist has categories *suggested* by the data rather than establishing categories saturated by the data. This allows for analytic possibilities rather than prematurely foreclosing them. As Charmaz (2006) notes, GT saturation is not the same as witnessing repetition of the same events or stories, as many qualitative researchers would think, but rather refers to "nothing new happening" or "finding the same patterns" (p. 113). A number of critical points during concurrent data collection and analysis indicated that I was identifying a significant and recurring pattern in the data.

After four months of collecting and analyzing observational and interview data, I had identified the basic social concern as participants wanting to align their professional agendas

while protecting their professional silos. At this point in time, a new CEO had been appointed to the hospital. One of his initial activities was to anonymously survey all senior managers concerning their priorities for the hospital. What did they want him to change? What did they want him to keep the same? I attended the meeting at which he summarized and presented the survey results to his senior managers. The survey results supported the direction of my analysis, indicating that individuals desire to "break their silos" and maintain the nurse and physician partnership model that had been formalized in the setting. These survey results indicated that participants were wrestling with this preoccupation and were hoping for new leadership to bring changes.

By the spring of 2014, I had been invited to work with the senior nurse managers on a presentation that they were giving to the Order of Nurses of Quebec. The objective of their presentation was to look at how nurse-physician governance influenced quality improvement, specifically the strategies nursing was employing and the activities they used to develop the partnership. This allowed me to listen to them detail their understanding of when the partnership was actually working and what they felt were the key ingredients. Through this process, a number of the categories that had been identified in the data were confirmed. They spoke at length about the use of influence and how when the priority is outside the nursing domain it requires more calculated strategies to determine how resources get used. As I continued to take field notes and memo on these meetings, what became more evident was how deliberate both nurses and physicians were in their actions when working together. The core category of intentional partnering was being identified.

The use of observational data also facilitated arriving at sufficiency for particular categories. For example, I had noted in my observational and interview field notes that

participant behaviors changed when sensitive topics arose in their interactions together or if I asked a sensitive question in the interview. The intonation and tone of the participant's voice often changed as though he or she was "daring to risk" something by responding to these issues. I could then isolate such incidents in the data more readily, compare them and discover the various properties of the category until no new information was identified.

In addition, when questioning the theoretical sufficiency of my data, I went back to my first exploratory interviews and observations that occurred in another department of the hospital unrelated to Surgery to see whether similar concepts and categories were evident in these data. Not only were a number the concepts and categories validated in this process, but these data provided further variation and depth to my understanding of the properties of the study concepts.

Analysis ends when the theory is abstract and accounts for all of the data, answers the research question, and the basic social process is clear. In the final stage of analysis I reviewed the data and field notes again with the basic social process of intentional partnering and its related categories in mind. I asked questions such as Is this participant talking about this category? Are the data related to the study questions or has the participant started talking about something different? Does the theory fit? Does it work? The timing and use of literature for analysis in grounded theory, although disputed amongst scholars, is important at this juncture. I identified and read key and also new publications regarding some of the emerging categories. For example a report issued by the National Institute for Health Research entitled, How do they manage? A qualitative study of the realities of middle and front line management work in healthcare (Buchanan et al., 2013) helped me to identify and label the properties of professional rewards as they were characterized in the literature. However, in comparing this to the study

data, participants' effort was in *striving towards mutual rewards*, part of a dyadic process that allowed partners to identify and work from common professional values.

One of the most challenging aspects of theorizing was depicting a theory in a model that adequately accounted for the complexities as well as the processes that occurred in the past, over time and in the moment of working together. Diagramming, writing, asking questions of the data, and presenting categories to supervisors, key informants and disinterested peers resulted in refining the theory in a rigorous way. This became evident when I compared early diagrams and notes with later versions.

3.11. Methodological rigor

In this section, I demonstrate that this grounded theory meets traditional criteria for rigor as outlined by Lincoln and Guba (1985), namely, credibility, dependability, transferability and confirmability. I then apply criteria more specific to a GT approach by using Glaser's criteria of fit, work, grab and modifiability in order to adopt criteria particular to the approach. In addition, I discuss particular strategies that enhanced reflexivity in order to make my influence on the research more explicit.

3.11.1. Credibility. Credibility is enhanced as a result of my fellowship and residency period within the setting. I invested time in learning the culture of the organization and conducted a number of interviews and observational sessions in another division of the hospital in order to become familiar with the phenomenon of interest. However, given my background as a healthcare professional and having worked in the setting, I risked introducing biases based on my own values and views (Charmaz, 2006). A number of strategies were used to address this issue. Peer debriefing enabled me to share working hypotheses and reflections with peers who were experts in GT in order to explore aspects of the inquiry that might otherwise "remain

implicit in the researcher's mind" (Lincoln & Guba, 1985, p. 309). The peer debrief also provided opportunities to develop next steps. Investigator variation was a strategy whereby representatives from nursing and management were part of the analysis team. Use of different types of data sources enhanced credibility. A form of member checking was used when participants provided input on emerging interpretations. I sought participant viewpoints and undertook additional interviews to have preliminary categories verified by the participants. This step involved refining the interview questions on the basis of early results.

3.11.2. Dependability. To enhance dependability, I maintained an audit trail to facilitate evaluation of the consistency of the research process (Chiovitti & Piran, 2003). This was achieved by maintaining: 1) a master log recording each step of the research process and 2) field notes, memos and other documentation related to the study.

3.11.3. Transferability. I provided adequate information to describe the research context, parameters of the research study, and alignment of the derived theory with the data (Charmaz, 2006; Chiovetti & Piran, 2003; Lincoln & Guba, 1985). Thick description[1] was used in observational field notes in order to provide rich details so that transferability judgments were possible. Criteria for good notes are that they are not only detailed and contextually complete, but are fairly self-explanatory and remain useful even after a considerable period of time (Martin & Turner, 1986). I shared field notes and memos with supervisors and committee members. Only over time would I be able to determine if these notes remain self-explanatory and useful or if further analysis of the data should be considered.

[1] Thick description, a term originally used by Clifford Geertz, presents details, context, emotions and webs of social relationships that join one individual with another. Denzin (1989) describes it as more than a record of what a person is doing, but rather the voices, feelings, actions and meanings of interacting individuals.

3.11.4. Confirmability. Confirmability refers to the extent to which the data and interpretation are grounded in events and represent the information provided by participants rather than the inquirer's personal constructions (Lincoln & Guba, 1985). I used *in vivo* codes as category names where possible to bring the participant's voice to the theoretical development of the research findings (Chiovitti & Piran, 2003). Confirmability was supported through the audit trail so that independent readers could draw conclusions about the veracity of the interpretation. In addition, Hall and Callery (2001) include the notion of reflexivity to enhance the rigor of GT. They define reflexivity as critically examining one's effect as a researcher on the research process and the construction of data. I made reflexive memos in order to document personal feelings, impressions, values, and insights about my role and behavior in the research process.

3.11.5. Fit, work, grab, modifiability. Glaser and Strauss (1967) contend that the theory with categories and hypotheses must "fit" or be "readily applicable to data". In addition, a theory must "work" or "be meaningfully relevant to and be able to explain the behavior under study" (p. 3). Central to ensuring this fit and work in GT are the strategies used for "collecting, coding, analysing, and presenting data" (Glaser & Strauss, 1967, p. 224). These procedures have been described in detail above. Purposive sampling, line-by-line coding and theoretical sampling ensured the concepts fit the data.

Critically important to rigor in GT is constant comparative analysis. I examined the data for cases that contradicted the emerging categories and relationships and compared differences among partners working together as well as differences among dyads. This was explored further when I was theoretically sampling with a tentative model that was used to generate discussion with participants. The model appeared to let participants speak more readily about challenges in partnering and where they saw partnering getting stuck. It is also consistent with the view that

there are common patterns and processes, but that variation neither negates the pattern nor does the pattern negate the variation. Both are important to our understanding of human social processes and behavior (Glaser, 1998).

Ultimately, the reader and practitioners will have to determine the usefulness (work), resonance (grab) and, over time, the modifiability in subsequent studies. Charmaz (2006) refers to fit and relevance as key criteria for rigor. Relevance is enhanced by providing an "analytic framework that interprets what is happening and makes relationships between implicit processes visible" (Charmaz, 2006, p. 54). I will discuss the relevance of the theory to nursing administration in the final chapter; however, bringing the "analytical framework" back to key informants as a way to illustrate categories and relationships provides additional support that in fact the theory has relevance. An informant feedback session (February 19, 2015) demonstrated this point. The categories "resonated" for this informant and allowed her to identify her experience in a meaningful way. This prompted further reflection and questioning around her own partner relationships.

Thinking theoretically and theoretical sensitivity are essential to rigor in grounded theory (Glaser, 1978). Schreiber, (2001) describes theoretical sensitivity as the "ability of the researcher to think inductively and move from particular (data) to the general or abstract, that is, to build theory from observations of specifics" (p. 60). I spent many hours coding, re-coding, reviewing the coding and memoing on coding in order to define relationships. Through writing initial drafts of the findings and getting feedback from supervisors, thesis committee members and mentors on these drafts, I scrutinized the developing theory for cognitive leaps and unsubstantiated patterns. Having an expert methodologist in classical GT was particularly important in this process as she questioned coding and categories. Not only was she an expert in classic GT which helped me to

delineate differences between classic GT and other variations I had been reviewing, but she was a non-healthcare professional in the field of management, particularly interested in leadership and complex organizations. After submitting to her one of my first attempts at writing up the theory, she questioned whether I had gotten to the underlying meaning of what the participants were saying, or if I was trapped by my own professional preconception of what successful collaboration should look like. Was I making sense of the situation by prescribing what needed to happen according to my own training and experience or how it should work 'in theory'? She encouraged me to stay with the data— what was really going on—to push past what people were saying in order to find out what they really thought, felt and did. This type of questioning helped me to identify that some of the partnerships seemed to be able to align their professional agendas. They had figured out a way of functioning well together, but certainly not all of them had. What was different and why? I needed to add this range of responses/behaviors; otherwise, my theory would remain idealistic rather than truly grounded. I looked for the codes that shifted and changed on the basis of these variations but that were consistent across the dyads. I think it was at this point that the concept of mutual necessity began to take shape.

Having this type of questioning pushed me to be honest about the data, as there is great opportunity to misrepresent what is grounded when it is not. As Glaser (1998) states, "the researcher may be forcing while under pressure to know beforehand or to say what is expected" (p. 3).

3.12. Ethical considerations

This proposal was submitted for ethical review to the study site's research ethics committee. A copy of the approved consent forms can be found in Appendix G. While there were minimal risks for the participants, there were two main ethical issues within the study

relating to confidentiality and anonymity of the participants as well as the observational approach. I provide the strategies used to ensure that ethical standards were met. It is important to note that this study did not involve actions that directly involved patients.

3.12.1. Confidentiality and anonymity. Given that this is one department with known management dyads in Surgery, some data could reveal the participant's identity. This was addressed in the consent process by ensuring participants that every step would be taken to protect confidentiality although I would not be able to guarantee complete anonymity if they consented to shadowing. I aggregated the data when presenting findings (i.e., presenting categories and subcategories of specific disciplines). This was consistent with a GT approach. Participants were invited to review the data and final analyses prior to local presentations, particularly if specific quotes were used. In addition, each participant was assigned a pseudonym to be used on all documents known only to the researcher. Only the supervisor/committee members/GT expert involved in data analysis had access to raw transcripts and field notes.

3.12.2. Observational approach. According to the Tri-council Policy Statement: Ethical Conduct for Research Involving Humans (CIHR, 2010), observational approaches in qualitative inquiry should pay close attention to possible infringements of privacy that may relate to the following factors: 1) the nature of the activities observed, 2) the environment in which the activities are to be observed, 3) the expectation of privacy that prospective participants might have, 4) the means of recording, 5) whether research records or published reports involve identification of the participants, and 6) any means by which those participants may give permission to be identified (p. 142). As a participant observer, I did not conceal my identity. I introduced myself and my general interest in focusing on interactions of nurse and physician managers at meetings rather than the management issue at hand and stated that I was not

evaluating them or their work Written consent was obtained prior to interviews and for shadowing sessions. I disclosed to participants during the consent process that observational data would be used in the analysis. The following statement was presented in the information study sheet:

> Throughout the data collection stage I will observe and note phenomena related to nurse-MD dynamics including verbal/nonverbal communication, contextual events, or interactions that shed further light on the research questions. This can complement the data collected from individual interviews. (F. Carnevale, personal communication, June, 5, 2012)

In shadowing instances, where the nurse or physician manager being shadowed was interacting with someone who had not given consent to participate in the study, I asked them for consent as per Appendix H prior to or after the interaction when such a request was unobtrusive. In addition, participants were encouraged to contact me if they did not want to take part in the observations, and they were told that they could withdraw at any time. I emphasized that their participation was voluntary. Should they consent to participate, they could request that certain observations, statements, conversations, in whole or in part, be deleted from the record of observations. In a few instances, during meetings, participants asked me not to document the issue or their response, but this was rare.

One drawback noted by researchers in terms of observational data is the influence of the Hawthorne effect, the tendency of individuals to change their behavior due to the attention they are receiving from researchers. Some scholars suggest that this is overemphasized and that once the initial stages of entering the field are past, most professionals are too busy to maintain behavior that is radically different from normal (Mulhall, 2003). My experience in the setting

captures both aspects. Having spent time in the field with participants during my residency period may have offset my "novelty" factor. However, from a constructivist perspective, I did assume that my presence would have an impact on the setting and how participants acted. Therefore, during the interview process or in informal conversations, I frequently asked participants if they felt that things functioned differently when I was not at the meeting and prompted them to provide an example. On all occasions, participants indicated that things were not different; however, my field notes from initial observations reveal how one participant felt "distracted" at times and was not sure where I should sit during meetings. She said, "When you are sitting with us, I feel like I need to explain the background of all of the issues so that you understand it well." I responded to this reaction by reassuring the participant that I would follow up with her by asking questions and that I would gain a deeper understanding over time. I realized that my location in the meeting depended on the objective of the meeting and who was present. For the remaining meetings, I would casually ask her where she would like me to sit prior to the start of the meeting.

3.13. Conclusion

In this chapter I have provided the rationale for my choice of using GT and described differences in variations of GT as well as how I collected and analyzed the data. I included in this description some of my challenges and how I addressed them. I have also situated myself as a researcher in the study. In the next chapter, I present the theory of *intentional partnering*. I first provide an overview of the theory and then illustrate the most relevant concepts in more detail. In writing the next chapter, I have also tried to keep in mind Glaser's advice: "write as one talks, not as one writes" (Glaser, 1978, p.135), "think theory, write substance" (Glaser, 1998, p.199) and try to relate concept to concept (Glaser, 1998).

CHAPTER FOUR: FINDINGS

The GT approach involves identifying the basic social concern that preoccupies participants and the core category that has to do with how they are resolving or managing the concern. In this particular study, the core category, called *intentional partnering*, describes how nurse and physician managers align their professional agendas while wrestling with the competing interest to guard aspects of their own professional agendas. Their work through partnering intentionally can be seen as helping to resolve this problem so that they can reap the benefits of partnering. A substantive GT on *intentional partnering* is presented from the data analysis.

The chapter is presented in two parts. Part one provides a description of the backdrop to the study, the social context, the participants and their basic social concern and is therefore written in the past tense**.** The concept of "professional agendas" is detailed and is the starting point to the theory. Part two explains the theory of *intentional partnering* and its key concepts.

PART ONE

4.1 The social context

4.1.1 The "partnering" environment. The institution where the study took place adopted a nurse-physician management structure known as the Partnered Management Model (PMM) throughout the hospital in 2008. It was supported by the Director of Nursing and the Chief Executive Officer on the basis of feedback from a project in one department. Senior nurse and physician managers described the model functioning informally prior to this time. One senior manager stated, "[partnership] was working here philosophically and had been implemented in a sporadic and inconsistent way but it wasn't part of the gestalt or culture and had not been accepted by everyone." One way senior organizational leaders formalized the

model was by delivering the message of "nurse-physician partnership" internally to staff members in professional forums and externally to institutions and government audiences. Despite the fact that these messages occurred more consistently and formally in the initial stages of this study and these individuals have since left the organization, the PMM continues to be operating in management practice. For example, the monthly senior management meetings where senior nurse-physician managers of each division meet formally continue. Management initiatives continue to be co-led by appointed senior nurse and physician managers.

Almost all of the data were collected in the Department of Surgery. This department was nominated as an exemplar by key stakeholders for operationalizing nurse-physician dyads throughout the department. During the time of data collection, this department was preparing for an eventual move to a new pavilion in the fall of 2015. Department meetings co-chaired by the Associate Director of Nursing for Surgery, the Chief of Surgery and the Chief of Anesthesia were being held regularly as well as subcommittee meetings led mainly by nurse managers and their physician partners.

4.1.2. The "partners". At the outset of this study, two key informants (the Associate Director of Nursing for Surgery and the Director of Nursing at the time) identified nurse-physician dyads who fit the study inclusion criteria and were considered to be exemplars of partnership. Although the partnerships had been arranged by senior executive managers, it was possible to compare partnerships that had emerged more naturally with those that had been imposed. In some instances, the nurse and physician manager had been working together prior to the "formalization" of partnerships. Variations among the management partners were evident: some formalized partners being established or long term (greater than five years of working together); newly formed (one year to five years working together), with or without a previous

history of working together; having had coaching by senior leaders or not; having had a range of management experience (one year to twenty-five years). Partners began working with one another largely for the purposes of addressing quality improvement initiatives, accreditation processes and practice change. At the time of data collection, partners were working together on various clinical issues such as budget allocation, new practice initiatives and human resource and communication issues.

From observations and formal interviews, it became clear that individuals had more than one partner and paired up with different partners for different issues. Surgeons, in particular, usually identified nurse partners affiliated with their main clinical focus, namely the Operating Room or the clinic. In some interviews, physician participants did not refer to their "appointed" nurse partner but to the Associate Director of Nursing for Surgery. Moreover, during the time of data collection, formal management positions changed, which permitted me to explore newly formed partnerships as well.

4.2. The basic social concern: *Partnering as a means of realizing professional agendas*

The first section will address individuals' professional agendas and how they differ according to management level and professional affiliation. The second section describes how participants struggled with a 'double bind' situation wherein the benefits of working together clashed with a competing interest to protect or guard aspects of their own professional agendas. The central preoccupation of participants was to reconcile this tension and partner as a means to realize their professional agendas.

4.2.1 Conceptualizing professional agendas. Nurse and physician managers often used the term "agenda" to refer to the implicit and/or explicit objectives, motives or interests arising in their work together. Two physicians (P) described this in a surgical management meeting. P1

said, “Everyone has a different agenda and we have to recognize this.” P2 said, “Yet despite we all have different individual agendas, we all have a common one” (Surgical committee, 3.17.2014). A clinical nurse manager describes the concept of an agenda as “everyone coming in with their own interests that they want to defend strongly and are very opinionated about.” (Clinical nurse manager, 5.3.2014).

Agendas therefore are multi-faceted, have different degrees of individual investment and are shaped by professional concerns and priorities. For example, nurses’ descriptions of priorities often focused on the everyday functioning of their unit, the challenges of bed flow management, quality, safety, budget constraints, and the direct implications on patient care. Their priorities had to do with carrying out decisions. Priorities for physicians, on the other hand, seemed to relate to larger system issues such as their involvement with a new practice change that would have an impact on the functioning of the department as a whole and on access to patients and to resources. Yet both professions had different expectations and perceptions of the management role and different experiences of power.

Nurse managers, as employees of the hospital, were clear about their responsibilities to the organization and had more developed skills in executing decisions. Physician managers, on the other hand, independently contracted on a fee-for-service basis, appeared to have a more ambiguous allegiance to the organization with a higher “stake” in the performance of the operating room. Surgeons demonstrated a desire to innovate and grow services but were often thwarted by bureaucratic and economic constraints and/or feeling excluded from the decision making process. Their initial expectations of their nurse partner appeared to be based on past experiences and an understanding of the nurse’s role as being at the bedside. Nurses expected

physicians to take leadership roles in managing issues pertaining to physician disruptive behaviors and/or poor surgical technique/medical practice.

Nurse and physician managers experienced power differently. Physicians had the authority to make decisions when needed but recognized that they not did not have the time, the skills, the structure or, perhaps, even the interest to make decisions in the practice setting. As one clinical physician manager noted:

> It does not mean we don't have a say because when push comes to shove, they (the administration) will come to me and say, "you have to make a decision", or "you have to tell us," but we are not given the necessary tools to do so. (Clinical medical manager, 6.12.201)

Nurses on the other hand, had the power to operationalize decisions. They knew the system and had the resources and a clear hierarchy to execute decisions but required the physician's approval/support for decisions to be made. Although nurse and physician managers were expected to work in close partnership, they approached partnering from these different perspectives. The multiple layers of professional agendas were most evident when observing interactions or their work together.

Both observation and interview data indicated that each member enters the relationship with a set of practical, political, patient-centered and personal interests when working with their counterpart. For example, nurse and physician managers work together for practical interests to fulfill job/role responsibilities. In some instances, their profession needs to be represented in the issue. Nurse and physician managers work together for political interests in order to learn the hidden details of an issue and/or gain influence in the decision-making process. In other instances, they work together on patient-centered interests, bringing their professional knowledge

and expertise to a situation to move a patient issue forward. Finally, nurse and physician managers work together with personal interests in mind in order to achieve a particular personal goal, such as promoting professional status, gaining prestige, or income. Nevertheless, each member enters the relationship with a combination of interests, as is reflected in the data. Various interests come into play, depending on the level of management, proximity to direct patient care and the nature of the issue. In addition, professional structures or affiliations can shape the extent of how much members invest and how they contribute in the partnership.

4.2.1.1. Proximity to patient care. Although both disciplines at both levels of management maintained the "patient-centered" approach as an expected standard of care, nurses used the patient concern strategically at times to engage physicians. A clinical nurse manager describes the approach she takes to engage a key physician stakeholder:

> If he wants to buy in or not, is his decision but there are some key points that you need, to catch their attention like length of stay, like improving patient outcomes. There is not a good physician who will not be sensitive to that.… I think anybody who tried to build a project for outcomes and improve patient satisfaction and experience will buy in and will want to collaborate on that project, so I think that was my strategy and I tried to pinpoint this in my presentation. (Clinical nurse manager, 5.3.2014)

At the clinical level of management, the patient focus was compelling for nurse and physician managers. As this nurse manager stated, "physicians at this level are always close to their practice." Yet sharing the direct care for a patient together represented a guiding principle for those partnerships that were cohesively aligned. Patient-centered care represented a core philosophy that provided opportunities for partnerships to grow. A clinical nurse manager notes:

> We do have an impact on each other on a personal growth level too.… I think we shape each other's approach interacting with patients. I do think we transform each other.… There is a built-in continuity in connection with the patient but we also see each other all of the time. It takes a while to kind of gel. We know each other so well that we can actually imagine what the other person will say; that is a great thing.… The patient is always at the center, they really are. We talk about difficult patients, when a patient dies and it affects all of us. We get together around a patient. It just becomes that way you work together and how you approach all your projects. (Clinical nurse manager, 10.4.2014)

Sharing the direct care for a patient together was the guiding principle of aligning the relationship. Physicians alike noted that keeping the patient at the center of the discussion was critical: "Once you do that, it immediately implicates more than just yourself" (Senior medical manager, 25.9.2013).

Nevertheless, given that the proximity of patient care was one level further removed at the senior management level, senior nurse managers were strategic about when and how they raised the patient issue as a way of aligning agendas and keeping momentum in the management partnership. After asking one senior nurse manager what she thought she did most often when working with physician partners and what preoccupied her the most when working with her partner, she stated, "Speaking up for the patient, and I am trying to present it in a way that is appealing enough for them to listen; but yeah, that is 90% of the job" (Senior nurse manager, 19.2.2014).

Senior nurse managers learned details of patient stories from their clinical nurse counterparts and strategically brought the focus back to the patient in order to align and arrive at

a common agenda. Nurses did this by constantly including a patient story as an item on meeting agendas and in conversations. After I raised this observation with one senior nurse manager she stated, "Surgeons' love, their passion or *raison d'être* is to perform surgery, not so much to accompany the patient through their whole health experience. So we have to bring that back to the table" (Senior nurse manager, 7.10.2013).

While the concern about patients was most compelling for the clinical managers, the budget was an equally compelling issue for senior managers. Senior managers were further removed from the patient experience than clinical managers and were directly responsible for meeting the fiscal and budgetary demands of the institution. These characteristics resulted in more complex political agendas.

4.2.1.2. Economic nature of the issue. The issues that had an economic focus appeared to affect the relationship differently, causing more guarding and protection of individual agendas. One participant noted:

> When you are discussing things just around budget there is an immediate tension because it is about losing something, or resources.… You don't have that when you work on quality or at the bedside with a physician. It is always about improvement. Of course, costs are considered when we might want to implement something new and can do a business case, but when discussing the budget it creates tension automatically." (Clinical nurse manager, 19.8.2014)

A senior physician manager found that tensions in the relationship were more evident when their approach to achieving a budgetary goal was different. He stated:

> I fight and I fight because I know this is the right direction and can any person tell me it is not the right direction?... They (Nursing) are seeing it from a silo. Nursing has

> overtime that they want to cut for budgetary purposes, so they want to cut nursing overtime, and so this is what happens when you silo it, but we are a team!… It is affecting my relationship with (my partner) because instead of her being a partner, I am fighting her and it is a new thing generated by the crisis of the budget. (Executive medical manager, 6.5.2014)

While the sense of urgency may have caused the partners to work more frequently and consistently together, the nature of the issue in terms of protecting agendas and the fear of loss, pushed the relationship apart.

4.2.1.3. Professional affiliation and structures. Individuals from the different professions may also take a lead in acting on some of these interests and/or will contribute differently according to where and in what they are invested. One nurse manager noted that her investment in an idea was based on the effort involved to execute it and consequences for the unit or the patient. She said:

> I need to be convinced in order to execute a project like this.… I know that my physician partner feels like sometimes there are delays in getting things done and that things are not happening; but you know when you are responsible for a budget, you need to be sure it is worthwhile. (Clinical nurse manager, 20.4.2014)

Yet, other participants identified how professional structures played a part in shaping the way they contribute. For example, one physician noted:

> Our model is that we don't get paid by the hospital. Theoretically, we are private entrepreneurs, using the hospital, providing a lot of services to the hospital for free in other words. We take calls at night, we take calls on the weekends, we run around doing all of the stuff that needs to be done whether we like it or not, and that is the price we

> pay.… The nurses have been brilliant in how they have set themselves up. There is a hierarchy… a director of nursing and then directors of each division and you have head nurses and team leaders and they are constantly meeting and discussing. I am the chief of the department but I still practice. A senior nurse manager does not have six patients today on a ward, checking their temperatures and changing their dressings; but I am doing that and more than that and then I am supposed to be directing [pause of frustration]… we (physicians) have sort of worked ourselves into a corner or out of a corner. (Clinical medical manager, 6.12.2013)

The professional structure of medicine encourages independence and autonomy rather than collaboration. However, what this participant also highlights is how differences in professional remuneration contracted within the government system (i.e. nurses as government employees and physicians contracted on a fee-for-service basis) may shape their interests in which projects and activities they invest and in what they bring to the partnership.

In summary, while professional agendas are multifaceted and are largely shaped by professional concerns, interests can be addressed differently on the basis of professional affiliation and level of management. At the clinical level of management, interest in working together relates primarily to patient and practical interests, whereas at the senior level, it is primarily about managing resources and finance. In this instance, the political components play a more pivotal role. Personal interests are always playing out in conjunction with these other interests at both levels. This is consistent in terms of what each management level is dealing with in their daily functioning. It illustrates what each level is likely strategizing around.

Embedded within professional agendas is how each member addresses his or her interests when working together. Not everything is shared. Some aspects of their respective agendas will

be raised while other issues will not be. What is shared often happens gradually with agendas surfacing over time. Thus, professional agendas are not always explicit or overt. Moreover, the term "partner" seems to presuppose a particular dynamic in the relationship which may or may not exist. Nurse and physician partners would often pursue a common goal, but tensions arose in the relationship when priorities or objectives were incongruent or competing.

While the observational data revealed moments of frustration, uncertainty and ambiguity in the nurse-physician working relationship, the observational and interview data also indicated that physician and nurse managers valued their work with one another. They articulated the importance of that collaboration in their interviews. Despite the skepticism around the term "partnership", there was an effort by these participants to work together to address the work to be done. Despite their own professional agendas, several nurse-physician managers recognized reasons to partner that motivated them to "come to the table". These data illustrate the underlying tensions that participants experienced as they struggled to reconcile professional allegiance with the duty to work interprofessionally.

4.2.2. Partnering as a means of realizing professional agendas. Participants were faced with the current reality of healthcare organizations, which are constantly searching and putting pressure on physicians and nurses to do more with fewer resources while adding value to patients and their families. Although collaboration is a standard of practice for healthcare professionals today, differences in the professional agendas appeared at times to be a source of contention, and interests in working together varied. Many participants wrestled with a "double bind" situation in which the benefits of working together clashed with a competing interest to protect or guard aspects of one's own professional agenda. This double bind situation in some cases appeared to cause unclear expectations, different motivations to partner, ambiguity and

even apathy. However, both physicians and nurses indicated that working with the other allowed them to optimize their agendas with clear benefits resulting from "partnering". As one senior nurse manager stated, "They (physicians) need us because we are the operationalization of the whole organization…. That is why we need each other, we are interdependent (Executive nurse manager, 25.4.2014).

Partnering was a means of realizing their professional agendas, and it preoccupied their working together. Individual members wondered how partnering would help them to achieve their goal but acted on their various interest(s) to come to the table, even though they did not really know where it would take them. The data suggests that there is a process of how some nurse and physician managers resolved this concern and reaped the benefits of partnering. These partners were engaged, committed and in highly sustainable relationships. What does this process look like, and what does it entail? What were the contributing factors?

In part one, professional agendas and the basic social concern were described. Part two presents the substantive theory of *intentional partnering*, which explains how these partners aligned their professional agendas when they came to the table to work together. An overview of the theory is provided first and is followed by a more detailed illustration of each of the key concepts.

PART TWO

4.3. Overview of the theory of *Intentional Partnering*

The theory of intentional partnering begins with individuals' concerns and interests that arise from their professional agendas. These interests are multifaceted and often too complex to tackle alone. Thus individuals come to the table to explore how their interests may be addressed through "partnering". Partners bring a range of interests differentiated by the degree of passion

and personal investment they evoke. In formalized partnerships, individuals may be more or less clear about why they are working with that particular person. Despite these hurdles, individuals foresee benefits and expect them to outweigh the costs of working together. Partners may then decide to try out a joint venture, although they may be uncertain where it will take them. As one clinical medical manager stated, "I had nothing to lose!" (Clinical medical manager, 24.4.2015).

Intentional partnering involves three key processes: accepting mutual necessity, daring to risk (together) and constructing a shared responsibility. Each process involves strategizing and deliberate actions. For example, each partner recognizes that his or her partner is coming to the table with his or her own set of interests. They position themselves in relation to each other while each partner deliberates and perhaps even decides what they are willing to accept, what they are willing to risk and what they need to put into place to ensure that benefits are achieved. These actions are purposeful and represent what is occurring in the interactions but are also based on the effort of both members in the partnership. Partnering is not inferred from the perspective of one member but is understood by observing the exchanges that play out in the dyad. Through the processes of accepting mutual necessity, daring to risk (together) and constructing a shared responsibility partners align their professional agendas. Accepting mutual necessity launches intentional partnering when both individuals recognize that they cannot achieve their goals independently and acknowledge that they need each other in partnership. It involves adopting a different perspective that may challenge one's professional preconceptions. By letting go of preconceptions, nurse and physician managers are able to accept and buy into each other's position of influence in the organization. This ability levels the playing field in the relationship and motivates the partners to get in tune with each other's big picture. Although these "big picture" perspectives are different, partners accept that they need to appreciate each

other's perspective and integrate it into their own vision. Being "in sync" allows partners to capitalize on each other's expertise and move issues forward.

Accepting mutual necessity mobilizes the other processes that are needed to support the partners as they contend with the emotional investment of working with one another. Specifically, the partners must learn when and how to address the sensitive issues that are likely to surface in their close working relationship. Taking risks together means addressing the 'elephant in the room' and being prepared and able to weather the storm when uncertainty or instability in the partnership occurs. Compromising and expressing humility are often involved. The process of daring to risk (together) allows one partner to get to know how the other operates, particularly in challenging circumstances in which they are at odds with each other's values, opinions or approach. Partners must experiment with the relationship without knowing for certain if taking the risk will be successful. Learning how to address the 'sensitive' issues allows partners to re-form and move onward in their relationship and construct an ongoing shared responsibility.

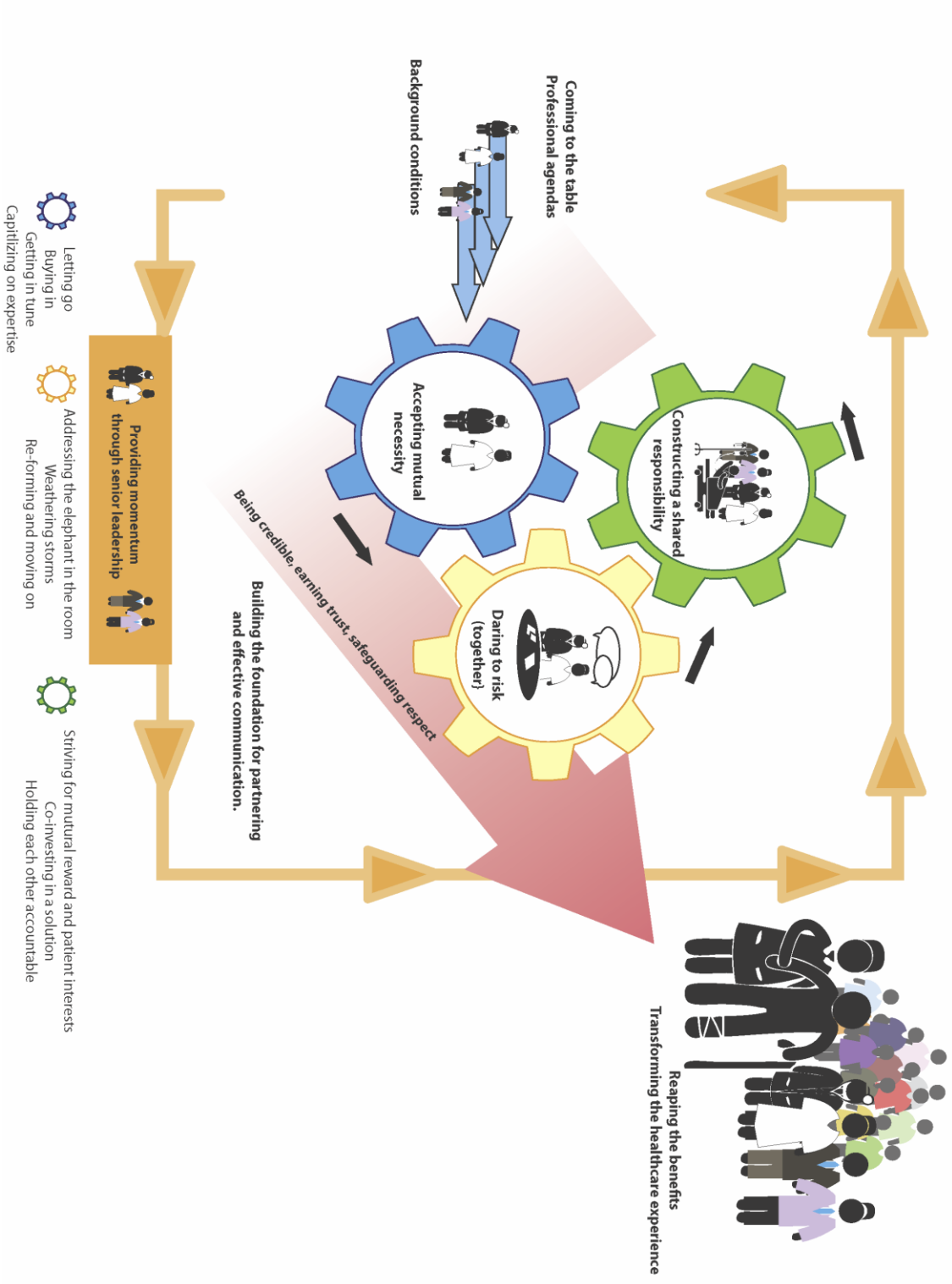
Nurse and physician partners construct this kind of shared responsibility to sustain the relationship. They do so by ensuring that individual needs are addressed so that each partner feels that there are benefits to working together. In striving for mutual rewards, partners need to identify and share common values. In the healthcare context this means having a mutual understanding of patients' interests, co-investing in finding solutions and holding each other accountable. The ability to share responsibility and to step in to manage different aspects of a clinical issue sustains the relationship. All of these three processes—accepting mutual necessity, daring to risk (together) and constructing a shared responsibility—are integral to intentional partnering.

Certain essential conditions initiate and sustain intentional partnering by building a foundation for partnering and effective communication. These conditions include being credible, earning trust and safeguarding respect. Being credible can act as an entry point for intentional partnering and may attract individuals to the table at the outset. Earning trust requires partners to demonstrate that they are willing to take each other's interests into account and give the other the benefit of the doubt. Safeguarding respect becomes evident in how individuals convey a point and how they listen to the other's perspective. These conditions derive from individual actions and face-to-face communication and are essential for partnerships to mature.

In addition, deliberate strategies stem from senior leadership. Senior leaders sponsor the nurse-physician relationship both in terms of the idea of a management model and by supporting and promoting particular dyads. Senior leaders purposefully "match" the nurse and physician they feel will work well together. They role model partnered management by attending to issues together and provide direct coaching to the partners when needed. This creates momentum in the intentional partnering process. These strategies are not inherent to intentional partnering but represent external influences that facilitate intentional partnering to stay in motion.

Through intentional partnering, partners establish a more binding relationship based on commitment. Partners create synergy, innovate, leverage power and influence each other's profession, bridge silos and have the potential to transform the healthcare experience for patients and for healthcare professionals. Partnering can transform the work environment. Reaping the benefits solidifies the relationship and strengthens interest in working with a partner and/or deepens a partnership that has already been established. Intentional partnering reveals that both partners think about why they are in the partnership, what they are hoping to achieve and what it is going to take to achieve the outcome. The model presented in Figure 5 represents this process.

Figure 5. Model illustrating the theory of Intentional partnering



The next section illustrates in more detail the properties of the key processes.

4.4. Accepting mutual necessity

The process of accepting mutual necessity gets intentional partnering moving once both partners accept that they cannot achieve their goals independently. Strategizing occurs as each partner realizes that they have to give up something in order to gain something. A negotiation takes place within oneself and with one's partner on the extent to which they are willing to give up certain aspects of their own agendas. It involves letting go, buying in, getting in tune with each other's big picture and capitalizing on each other's expertise.

4.4.1. Letting go. Each partner may be bound by professional duty or hold preconceptions about the other profession, but he or she needs to let go of these constraining ideas because they know it is strategic to advancing the bigger issue. Letting go of preconceptions and "duties" can have a different meaning for physicians and nurses. Nurse managers describe letting go of specific expectations of their physician partner by understanding their partner's professional context. For example, clinical nurse managers describe how they accept the surgeon's professional reality, which is different to their own. A clinical nurse manager stated:

> We have to understand their context. We are not in the same reality and I did not see that as a problem, but some people might respond by saying that they cannot be flexible and then they cannot work together. But me, no, I wanted to make sure that things would work because I am more flexible in my schedule. I don't see it as their choice but as their reality. (Clinical nurse manager, 19.8.2014)

For some medical managers, letting go of preconceptions involves an awareness that independent decision making is often ineffective. They are able to let go of "I can do this alone" and accept that it is a limited approach. One senior medical manager said:

> You can solve it [a problem] on your own or you can solve it with a group. In this situation in terms of patient flow, there are different issues. I know from a medical perspective what is best, but maybe from a nursing perspective it is not best. I don't know the nursing resources in order to make a decision on what is better from a nursing perspective. Nursing has this knowledge and it is needed in order to make a decision. I can see from my perspective where I want a patient to go to a specific floor, but the nurse can say no, I don't have the resources or I don't have the right conditions and that is not a good idea. (Executive medical manager, 6.5.2014)

In this example, the physician accepts that he needs the nurse's perspective to make the best decision for patient care. Physicians also describe how their medical training socialized them to be or to believe that they are independent players in the system but that what is required is a change in this behavior. This may be a matter of one's personality, but it is also learned through experience.

> I learned at young age that you cannot work alone and that you have to rely on other people despite going through medical school and thinking you are the boss. In my medical school we were never taught how to work with other people, but you have to RELY on other people to help you, their judgment, their expertise that you do not have. You may gain it over the years, but you cannot be an expert in everything, and you cannot work alone. (Clinical medical manager, 5.5.2014)

Physician managers note that their diagnostic training influences them to see how they approach problems in the situation. When partners align their agendas, the medical manager lets go of seeing only the road blocks or problems and is able to be more receptive to working with his or her nurse partner to brainstorm solutions. Letting go of professional preconceptions enables partners to buy into each other's position of influence

4.4.2. Buying into positions of influence. Both nurse and physician participants often refer to "getting buy in", a term they associate with how they approach others to gain influence. For participants, getting "buy in" also means buying into the necessity of each other's position of influence within the hierarchy of the institution. For nursing, buy in from physicians is essential. It means engaging physicians' interest in the issue. Nurses often do this by appealing to medical interests, such as highlighting the research implications, the prestige or the novelty of the project. One senior nurse manager stated:

> Buy in to me, and we work so hard to get it with physicians, is when they are going to say "Ok, we will try it." … But it is getting people's willingness to do something different, and with physicians it is absolutely and totally the hardest thing ... because they are entrepreneurs; and if you do not get their buy in, nothing happens. (Senior nurse manager, 19.2.2014)

Senior nurse leaders in particular employ a number of sophisticated strategies to get buy in and to influence decision making. They spend time planning agendas and leading meetings. The following excerpt from a field note illustrates how a senior nurse manager uses particular language in her meeting in order to get attention and move an issue forward:

> I shared my observation with SNM01 regarding the use of language, and how she wanted to 'shock' the MDs by using the term "bed loss" in the meeting yesterday and how they

had changed her language from the term "bed loss" to "optimal use of beds". She stated, "For me that was, yup, mission accomplished! I got their attention because by using the term "bed loss", it suggested a potential threat to their practice. [I think the fact that SMM01 and SMM02 were even discussing it was evidence enough for SNM01 that she had succeeded.] (Senior nurse manager, 12.9.2013)

Senior nurse managers carefully attend to and guide communication with their partners. Leading the meeting agenda allows them to determine what information will be shared, how it will be conveyed and to test reactions. Part of leading the agenda is knowing when to invite additional members to gain a better perspective on the issue.

In these situations, nurse managers work closely with their own partner and adjust to working in a triad. Complex surgical issues often involve not only surgeons and nurses but anesthetists. One senior nurse manager describes the complexities of leading the meeting agenda within a triad but notes the advantages. She stated:

> It is probably simpler in a dyad because I only have to worry about the angles that are important to him, whereas in the triad I have to worry to check many angles. But I find the triad is more powerful because there are often two people after a discussion who have a shared vision of something. Sometimes the three of us do, so I think the triad is more complicated but in a lot of ways more interesting and has more scope. (Senior nurse manager, 7.10.2013)

By having a third person present, tensions can also be neutralized when they occur.

> … to me the triad meetings were a little nerve wracking; but after a while I saw the two physicians go at it sometimes too, so I came to believe that it was a safe forum because

> even though they would have these disagreements or arguments with each other, you know at the end of the day they still work together. (Senior nurse manager, 19.2.2013)

Observing that others also have disagreements but continue to find ways to work together normalizes tensions. Moreover, leading the meeting is an effective way for senior nurse managers to stay informed and create communication channels.

For surgeons, getting buy in has to do with gaining influence outside of the dyad or within the hierarchy in order to move issues forward. One clinical physician manager describes "getting buy-in" as attracting administration support or interest in the issue. He stated:

> I realize now that if it is not important to the institution and whatever the institution is doing, then it is never going to happen. So I learned along the way, that, yes, you had to have some buy in and support, and it is interesting where your support comes from because very often it comes from the nurses more than anybody else, and the nurses can get things accomplished. (Clinical medical manager, 6.12.2013)

Physicians value nurses' support but also observe how nurses are able to facilitate buy in with key stakeholders. He stated:

> It did not matter what we brought up as a solution (to administration), it was always knocked down before we got started … and I am not sure what SNM01 (nurse partner) did to get it accomplished. I think what she really did was that she said, "This is about quality of care, this is a patient issue and we gotta get it done!" Anyway, it was amazing. That is exactly what it was, but somehow coming from the nurses, I think it was perceived differently. (Clinical medical manager, 6.12.2013)

The partner's ability to get buy in from powerful others levels the playing field. The partners recognize and admire each other's position of influence. This facilitates the partners' ability to

engage in their work together. By doing so, the partners begin to get in tune with each other's big picture.

4.4.3. Getting in tune with each other's big picture. Both nurses and physicians have "big picture" perspectives but see them in a different way. Physicians have a large scope in terms of wielding power and understanding the political layers involved in the larger health system. The nurse may have less exposure to this landscape and may not see the issues from this vantage point. One senior nurse manager describes how her partner introduced her to quality initiatives that other hospitals were implementing nationally and internationally and the difference it made to her desire to achieve the same thing in her Department. She said:

> … he (her partner) has exposed me to international stuff and I am just … I just want it so bad because it is the right thing to do. If mankind has figured something out in the best way, why on earth are we not doing that here! (Senior nurse manager, 19.2.2014)

Similarly, physicians note they have a lesser understanding of what goes on "behind the scenes", particularly around care that occurs while the patient is on the post-surgical ward. A clinical physician manager stated:

> There is a ward that runs somehow.... It is not only nursing, but nursing somehow has a much bigger view of that part of the picture. A doctor has an idea that this patient has a disease, I have learned about the disease, I know how to treat the disease and this is what I have to do, but I don't think most doctors realize … what goes on behind the scenes to let them accomplish the things they are doing. Matter of fact, what bothers me about doctors in terms of that is that they don't understand that it is not just them who are doing it, that they don't appreciate what other people are doing around them. (Clinical medical manager, 6.12.3013)

Similarly, another clinical physician manager noted about his nurse partner:

> I think she has more knowledge of the global picture, with multiple specialties, not just dealing with one's own cubby hole. As a physician you only have the one side. You don't know the nursing hours, you don't have the knowledge of the nursing expertise of what they can do and cannot do until you get the big picture. (Clinical medical manager, 5.5.2014)

Nurses and physicians accept that they need to get in tune with each other's big picture in order to advance their understanding of a situation. One senior physician manager describes how she relies on her nursing partner to get details of situations that help her to address the situation within her own professional group. She stated:

> Sometimes SNM01 knows things that have gone on that I did not because she heard it from nursing, such as an incident that happened with a patient. Whereas surgeons are not nearly as likely to share that with their chief of Surgery, that something happened. (Senior medical manager, 13.8.2014)

In addition, participants describe particular activities that allow them to get in tune with each other's big picture. Nurses describe how common activities, such as attending conferences together or being part of the same professional organization, provide opportunities to develop a common vision, get to know their physician partner as people outside of the work setting and develop a relationship. One clinical nurse manager said:

> I also want to say in terms of being part of a strong partnership, we are also part of the same organizations…. We are separate but also one, learning in common, belonging in common and having a common knowledge and a common understanding of what (our field) looks like in Canada.… You know what the common vision is and you know what

> the future issues are, the future directions.… We kind of grow together, we learn together, have a common sense of belonging and common connections so to speak. (Clinical nurse manager, 10.4.2014)

After attending a conference with her physician partner, a clinical nurse manager stated:

> it is almost like becoming friends with them, that they finally understand your point. For example, when we went to [a] conference with surgeons, that gave them the opportunity to see us differently and likewise, and through that we passed some comments but we got through. (Clinical nurse manager, 19.11.2013)

Getting in tune with each other's big picture involves appreciating each other's perspective and integrating it into one's own vision. This allows partners to capitalize on each other's expertise and move issues forward.

4.4.4. Capitalizing on expertise. By capitalizing on expertise, nurse and physician partners are able to draw on one another's knowledge and to recognize when to ask for support. They identify each other's strengths and use this to plan to address an issue. These strengths are often clinical and managerial and are illustrated in the following observational field note. The physician manager and his nurse partner were discussing how to address the surgeon's request for more skilled nursing expertise for a particular surgical procedure (P1= Medical manager, P2 = Nurse partner):

> P1: "I have issues that concern your nursing sphere so I need you!" [He presented his solutions to his partner.] One of the solutions is to have a nurse educator to review the present practice as way to brush up on skills. I have spoken to the Head Nurse regarding this option which she agreed to." [He then asked his nurse partner if she thought it would be reasonable.] P2: "I want them (surgeons) to have a nurse and I have given them

additional hours but they have to stop overusing resources. I have not seen them cut back on electives and still have nurses logging in overtime." (Field note, 5.3.2014)

Partners capitalize on each other's expertise by stating their goals to each other, asking for help, defining their boundaries and being explicit about how the partner can assist.

In summary, accepting mutual necessity involves a willingness to adopt different perspectives. This process is what allows the partners to "open up" and negotiate what they are going to give up and what they are going to maintain in order to align their agendas. It leads to a level "playing field" between the partners. Particular aspects of this process require greater effort from individuals.

Letting go of independent decision making is described by a physician manager as "running totally counter to what we were taught in medical school and totally counter to how one is trained as a surgeon and it is still a big problem … the world is not physician-centric although most physicians think it is" (Senior medical manager, 28.10.2013). Nurses, on the other hand, are able to accommodate because they are more familiar with their partner's practice setting. Buying in, however, may be more challenging for nurses, for it requires them to support the physician's position of power and influence in order to succeed with the proposed change. This action on the part of the nurse could also be perceived as accepting a subordinate position in the relationship. The process of accepting mutual necessity can either trigger the other processes of intentional partnering or limit the next steps, particularly if individual partners have difficulty in letting go of preconceptions or are not able to see each other's big picture.

Working in familiar ways or with fixed ideas is often comfortable for individuals. As one clinical medical manager stated:

> People protect themselves in their big walls, they are in their castle, and they feel comfortable there because nobody can challenge their way of behaving. When you open up, you are exposing yourself and it is going to be painful, but it is the only way to grow.... (Clinical medical manager, 17.12.2013)

Both nurse and physician managers describe how a surgeon's context creates limitations in seeing the big picture. For example, one clinical medical manager depicted a surgeon's practice and ways of doing things in the operating room as "the surgeon's domain". Surgeons are used to having things ready for them and to be anticipated by the operating room nurse. They focus on the task at hand, which can limit their exposure and understanding of the big picture. Yet, when partners go through the process of accepting mutual necessity, a greater balance of power may be achieved because both partners have to give up something related to their professional agenda.

4.5. Daring to risk (together)

The process of daring to risk (together) addresses the emotional undertones of partner work. Partners face the risk of working together: risk to the relationship, risk to one's reputation and/or risk to their agenda. They work through the "sensitive issues", weather storms, re-form and move onward by calculating how much they were willing to risk. This process illustrates how partners navigate the emotional undercurrents in aligning professional agendas and experiment with partnering.

4.5.1 Addressing the "elephant in the room". There is an understanding amongst nurse-physician partners that not talking about conflict or tensions and not working through them is destructive to the relationship. However, addressing the "real" issue or "elephant" in the room triggers apprehension as possible negative outcomes can ensue. It requires courage and the skill

to do it constructively. The following excerpt from an interview describes one clinical physician manager's hesitations (I = Interviewer, P = Participant):

> P: There is one example where we got into conflict that we did not resolve actually because I let it go. [Big sigh and pause] It was a mistake … I should have addressed it and I did not because I was trying to protect feelings, which ultimately brings you to a real conflict. [Pause] This is an unresolved issue that stays and continues to bother. It is like an abscess that you never bother to open. You treat it with antibiotics and it organizes, but it is never going to be cured, and you can live with it but it will still bother you. Every time you are going to sit on it, it is going to bother you; that is what is wrong with this. I have recently been in the process of saying, I feel confident enough that I should really sit down and get it on the table and I have realized the number of conflicts that have lingered for a while. Ultimately you get it off your chest, it is better for everybody.… Protecting somebody does not allow them to grow … it is very difficult and in order to be able to do that you have to be pretty strong yourself because you are going to expose a lot of things. (Clinical medical manager, 17.12.2013)

But whether the issue is resolved or not, even the gesture to address differences can be vitally important in partner work. It is what allows partners to move onward. A clinical nurse manager stated:

> There was a real clash (with her physician partner) on perspectives but we were able to talk about it. It upset him enough that he asked me to come to his office right away to talk about it; and I said, well we will agree to disagree, but it still bothered him because he did not really understand what the problem was. But I appreciate the gesture that he came forward and said that it bothered him and that we need clearer messages, and it was

> not left for each person to think up something else. There was an understanding that we work together, but there was something that did not flow here; let's sort that out. (Clinical nurse manager, 16.4.2014)

Having an open, transparent approach that allows partners to put sensitive issues or conflicts on the table and address them is important as opposed to allowing them to fester under the table. Taking risks together means that the partners are prepared and able to weather the storms when uncertainty or instability in the partnership occurs.

4.5.2. Weathering storms. Partners know how to step back when tensions get "heated". They allow personal emotions to diffuse and take the relationship at a slower pace. One senior nurse manager noted after a disagreement with her partner that weathering storms is a matter of time:

> I spoke with a colleague who knows us both quite well. She reassured me that he really respected me, that perhaps he was less likely to change. So I approached him and asked if we could talk. I told him that I was upset with what had happened and I think he was as well. Although he maintained his position, he was still respectful of my convictions. (Senior nurse manager, 8.8.2014)

Although partners often agree on most things they also know that they do not agree on everything or see things the same way. Weathering storms means voicing one's apprehensions or concerns to their partner. He or she is usually prepared to compromise and express humility. One clinical medical manager described how communication is crucial to this process:

> It takes a lot of communication and being able to say I was wrong, you were right; and I think that was the biggest asset we had because we were capable of saying that "I am wrong." (Clinical medical manager, 17.12.2013)

Partners weather storms by taking shelter when "lightning strikes" but still remain determined to get to their destination. One senior nurse manager avoids the storms by consistently setting a tone in meetings when she anticipates the sensitive topics and uses humor or a personal story that reveals her own vulnerability in some way. Addressing sensitive issues helps partners to re-form and move onward.

4.5.3. Re-forming and moving onward. "Fractures" in relationships are often caused by a lack of transparency or vested interests, such as when guarding/protecting agendas takes precedence in the relationship. Protecting or guarding, in particular, is often a fear response. The source of fear can be anxiety about losing something, such as power, influence, authority, empires, resources, control or about not living up to one's responsibility. What sustains the partnership through these challenges is a well- established foundation for communication

In some cases, "fractures" in the relationship provide an opportunity for re-forming priorities. After a heated discussion with her partner, a senior nurse manager states that what gets them past their interpersonal conflict is an "even bigger, more pressing and more urgent crisis", one that will have a greater consequence for the department. By permitting the differences in opinions or values to surface, the competing individual interests or misunderstandings of the issue are exposed. A bigger, more urgent crisis urges partners to reconsider what is important for them in the larger context in order to gain a better appreciation of why they have been working together. One senior medical manager exclaimed after reflecting on a recent issue that had created discord in the relationship, "This (issue) was just not the hill I was going to die on!" (Senior medical manager, 13.8.2014). Individual agendas become less guarded and partners engage in a collective effort to achieve the outcome. They use the more

urgent crisis as a diversion from the more sensitive and contentious issues in the relationship. This is one way to re-form and move onward.

Daring to risk is not only about confronting each other and taking a risk on the relationship itself, but about partners daring to risk together in order to move their issue forward. In this instance, nurse and physician managers demonstrate the ability to influence key stakeholders within their own professional context and divide the labor to work behind the scenes. Each partner manages doubts or discord from their respective professional colleagues. In doing so, they dare to risk the project, their reputation and the credibility of the partnership.

Additional hurdles to intentional partnering can occur in the process of daring to risk. In many instances, invitations to risk are offered but are either not received or not returned. A clinical nurse manager described how her physician partner acts more like a "cheerleader" than a co-leader as they attempted to gain resources for their post-surgical unit: "He would say, 'You know this, you can do this, you can say it, I am behind you.' It was more like I was leading the innovation and he was just following." (Clinical nurse manager, 26.6.2014)

While the partner provides support, support alone is not sufficient for partners to move to the next process of constructing a shared responsibility. In not responding to or sharing in the risk, partners lose interest and either choose to put less effort into the partnership or none at all.

In other examples, partners dared to risk, but the outcome was not expected, which created a fracture in the relationship. In such cases, partners have to be comfortable with ambiguity. As one senior nurse manager emphasized after a heated exchange with her partner, **"**Well, we still have to work together in order to address issues, but this is a whole new level. We shall see what happens!" (Senior nurse manager, 30.4.2014). The foundation of trust and respect becomes fundamental in these moments, for it is what allows individual partners to manage such

ambiguity. In effect, in daring to risk, the partner is experimenting with the integrity of the relationship. Building a strong foundation for partnering and effective communication can support the relationship through "trying" times; but if this foundation is not present, the relationship can dissolve.

In summary, this process reveals the emotional investment that individuals may have in their professional agendas and the ways this can play out as partners work to align them. The extent of their effort is often based on the level of commitment each individual has to his or her agenda. The process of daring to risk together allows partners to get to know how the other person operates or functions more personally, particularly in challenging circumstances where they are at odds with their partner's values, opinions or approach. This process illustrates how partners experiment with the relationship without being certain whether or not taking the risk will in fact work out. Learning how to address the "sensitive" issues allows partners to move forward in their relationship and to construct a shared responsibility.

4.6. Constructing a shared responsibility

Understanding that one has a responsibility to a management issue or what that responsibility might entail may not be clear to each partner in the initial stages of working together, particularly for surgeons, who may have only a vague idea of their management role. As one senior medical manager noted:

> Nurses are not totally responsible (for operational management) and physicians are not totally responsible; but to have the whole thing work, there is a shared responsibility.… It is one thing to say it is a shared responsibility, and it is another for the respective parties to recognize that and accept that they have a responsibility. (Senior medical manager, 28.10.2013)

Nurses note how clarity on responsibilities blurs as one moves up the hierarchy. Despite partners not always having a clear understanding of their responsibility, the process of constructing a shared responsibility illustrates how nurse and physician partners work to ensure that the relationship remains viable. In doing so, partners become more prepared to take responsibility for different aspects of managing clinical issues. For example, by being consistently on time, being accessible, or "delivering on their promises", partners are constructing a shared responsibility which is respected throughout their everyday actions and interactions of dependability and reliability. When this is not demonstrated, partners describe their work as being like "manning a huge ship with one oar and going around in circles" (Clinical nurse manager, 26.6.2014). This results in one of the partners feeling isolated, alone and frustrated. In this process of constructing a shared responsibility, partners strive for mutual rewards and patient interests, co-invest in the solution and hold each other accountable.

4.6.1. Striving for mutual rewards and patient interests. Partners recognize that if their partnership is going to work, their needs have to be addressed in such a way that each feels they are getting something out of their work together. One clinical nurse manager described how she set the stage for a win-win by exploring the expectations of her partner early on in the relationship:

> You have to go and meet the physician partner and explore their understanding of the project. What does he think is the goal of the project, and what is motivating him? What is the amount of time he wants to invest? Is it once a month? once a day?... If the expectations are different, then you need to discuss that. (Clinical nurse manager, 19.8.2014)

Striving for mutual rewards is often professional in nature (e.g. making a difference, driving change, improving patient experience, seeing an impact, engaging in healthy competition, having a sense of pride in best practice), intrinsic in nature (e.g. feeling valued, feeling recognized, personal growth, sense of belonging) and ideological in nature (e.g. personal integrity, being a good nurse, being a good doctor). Striving for mutual rewards allows partners to identify and share common professional and personal values, a normative glue in maintaining the relationship. When this occurs, partners discover a mutual understanding of patient interests.

In addition, achieving small successes is vitally important in affirming these rewards. Starting with smaller, concrete goals that are of importance to both the nurse and the physician partner creates a stronger chance for success. One clinical nurse manager noted how this facilitates working together:

> It is easier to work on goals when developing a nurse-physician partnership because it is more concrete; it is there. For a vision, you have to start discussing things that have not been worked on yet, and you need a more established relationship for that." (Clinical nurse manager, 21.8.2014)

The same participant also describes how the motivation to continue partnering can decrease when rewards are not seen or not shared.

The effort in striving for mutual rewards seems to have greater implications for nursing for the return on investment. Finding the 'right' reward that appeals to the physician's agenda can be used as a vehicle to get physician buy in. It demonstrates generosity and encourages the other partner to engage. There is also the certainty of reciprocity. One senior nurse manager stated:

> Like any relationship, there are times when one needs to invest more than the other for the relationship to function.… There are times, when I will take on more of the responsibilities of the project, but I know I am supported 100%. I know that if I needed him to do something, he will do it. (Senior nurse manager, 13.6.2013)

By striving for mutual rewards, partners feel they are part of the solution and become more prepared to co-invest and implicate themselves in accomplishing the goal.

4.6.2. Co-investing in the solution. As partners become more personally and actively involved in offering and finding solutions to issues, they also begin to take ownership for managing them. Partners look at why they are doing things in a certain way. One clinical nurse manager described how her medical partner, despite her having informed him of a situation, took the initiative to find out the details of the issue:

> … but he is good because he never takes anything at face value. He will say ok to me, but then will go and find out for himself. I think he needs to do that because I can have the wrong information as well and we know that. I don't mind that he goes and looks into it and he always follows up. (Clinical nurse manager, 26.6.2014)

While this particular incident could be construed by the nurse manager as the physician partner not trusting her, she is not defensive but rather knows how much goes into moving the issue forward and how important it is to get it right. Taking ownership for one's own part of the shared responsibility is often less clear for physician managers than nurse managers. It is often more forthcoming when personal interests are threatened.

Specific tools encourage the action of taking ownership. For example, a number of surgical specialties implemented a performance monitoring tool called the National Surgical Quality Improvement Program (NSQIP) (Hall et al., 2009). This tool measures selected quality

indicators, such as surgical site infections, that are measured across the participating hospitals and then made public. Participants noted how the NSQIP audit results encourage nurses and physicians to follow-up on issues and reinforce a shared accountability since the measure involves both nursing and medical practices. One clinical nurse manager described its effect on her relationship with her medical partner in the following way:

> It pushes us in our relationship like we cannot say that our relationship is done. It reminds us that we have to go back and sit.… NSQIP pushes us to not forget that we need to figure out the issues together; it pushes the rigor. (Clinical nurse manager, 12.6.2014)

Partners are constructing a shared responsibility by demonstrating responsibility for outcomes to others and to certain standards. This holds them accountable to each other.

4.6.3. Holding each other accountable. Holding each other accountable requires explicit ways of communicating expectations for follow-up on management issues. For example, a senior nurse manager observed:

> Well, if they (physician partners) are going to sit there and tell me that it is up to the chief to worry about this issue then my question back to them is who is going to make sure that the chief does it? (Senior nurse manager, 1.11.2013)

Individuals have to know they are accountable for something. Formalizing communication operates to ensure that accountability is upheld. One clinical medical manger said:

> You need to put in the systems where you make sure that they follow up on their commitment, and if they don't … you need to find the reason why they are not.... On a weekly basis you say, "Well, we agreed on this last week, where do we stand on it this week? Did we deliver on that? Are we in the process of delivering that; did we do the steps in order to deliver?" (Clinical medical manager, 17.12.2013)

One of the partners often takes the lead in establishing and maintaining continuity with a meeting agenda. One senior medical manager explained how this formality is extremely useful:

> Every week we came back to it (the agenda) and in addition to our new issues we addressed follow-up issues from the previous business arising; and if we said we were going to address something, we could always follow up. And although we did not always do that formally, the opportunity was there and I think that was helpful. (Senior medical manager, 30.10.2013)

Both the formal and informal opportunities to communicate eventually give rise to a set of routines that serve for the partners to hold each other accountable. Being accountable to each other also means actively keeping each other in the loop and knowing the partner's perspective on an issue. One clinical nurse manager described how she made sure her partner was aware of her perspective on the issues related to nursing so that he would not feel at a loss when it was discussed in a medical context:

> So I share these problems [about staffing] with him because I am sure they would discuss it in their meetings and that it is very important for me that he knows from me the reality rather than hearing it from others. (Clinical nurse manager, 1.4.2014)

These routines eventually allow partners to adopt a shared narrative of an issue in which each partner is comfortable to speak for the other in various settings and to different audiences. However, constructing a shared responsibility requires "recurring reinforcement". One senior medical manager stated, "People need to understand and be reminded that they are not islands, they work within a system, they work as part of a team and teams have responsibilities to themselves and to the goals of the team" (Senior medical manager, 28.10. 2013). This required

specific communication strategies and follow-up when members of the team displayed behaviors that were not consistent with teamwork.

In summary, constructing a shared responsibility explains how partners keep the partnership viable. This, in turn, prepares them to take responsibility for managing different aspects of a clinical issue. Although the partners may not have a shared understanding of an issue and may not understand it the same way, both partners operate in a way that allows them to identify common values and co-invest in finding solutions. Partners must be explicit in their communications concerning what they are accountable for and how they hold each other accountable.

More critical to the intentional partnering process is the role of face-to-face communication, which happens when partners physically come to the table. Face-to-face communication represents a common routine among partners working together at the table. Such exchanges allow them to learn cues (verbal and non-verbal) as they gather information about one another. They create a deeper basis for understanding each other as partners experience the processes of accepting mutual necessity, daring to risk (together) and constructing a shared responsibility.

There are certain essential conditions that enable these processes to develop, namely, being credible, earning trust from each other and safeguarding respect. These essential conditions derive from face-to-face communication and individual actions, abilities and characteristics that develop in conjunction with the processes. If these individual features are well developed, they not only encourage partners to try out partnering, but they represent the reasons why individuals come to the table, stay at the table and bring others to the table.

4.7. Building the foundation for partnering and effective communication

Building the foundation for partnering involves key conditions that initiate and support intentional partnering. With this foundation in place, partners are able to survive the threats and fractures that occur in their relationship and find a way to correct any misalignments. Being credible, earning trust and safeguarding respect are therefore essential to intentional partnering and represent the fundamental components for communicating effectively with one's partner. Both partners do not take these essential conditions for granted but rely upon them and nurture them within the relationship. Their existence signals maturity within the relationship.

4.7.1. Being credible. Being credible involves partners' being consistent in their actions. It reflects their performance in accomplishing a task, being efficient and showing their effort. Establishing credibility relates to competence, having specialized knowledge on the issue, being skillful in how one works through an issue and having influence among key stakeholders. These characteristics and abilities convey credibility to the partner, which is critical to establishing and sustaining their relationship. A senior physician manager described the properties of credibility:

> I think constancy (is important in being credible) so if you act a certain way all of the time or most of the time and you don't tend to fluctuate in any certain circumstance, that gives you credibility. I think if you try to be honest, try to be fair, that gives credibility. If people find out that you are telling a group something and another group something else, you know that will damage your credibility; so if you are constant with your message, people learn to trust you.… The same things hold true for a nurse manager; integrity, honesty, doing your best on any given day. To do their job to the best that they can, knowing full well that we all make mistakes but are willing to own up to them.

> Someone who gives me the same message they give to their nurses. (Senior medical manager, 13.8.2014*)*

For nurses, however, being credible with their physician partner requires the additional effort of proving clinical expertise and knowledge. One senior nurse manager stated:

> (Clinical knowledge) in this neck of the woods is like do or die. If you do not have knowledge about something and sometimes I do not have knowledge about a particular procedure, I never, ever wing it! I always say that I might not know about a particular thing and that keeps me credible. I don't talk about what I don't know, I don't venture that way. (Senior nurse manager, 7.10.2013*)*

Nurses demonstrate and prove their clinical knowledge and judgment in order to engage physicians. This kind of credibility is often established by the way issues, knowledge and positions are communicated. As one clinical nurse manager stated:

> Credibility is about you presenting your case, being credible and being confident in what you are saying, anticipating the questions, not presenting it as a complaint but presenting the statistics. If not, MDs are not going to engage. (Clinical nurse manager, 26.6.2014)

Once credibility is established, it is hard to lose unless competence, efficiency and effort radically change. It is through repeatedly demonstrating these characteristics and abilities that the partner's trust can be earned.

4.7.2 Earning trust. Unlike credibility, which focuses on demonstrating competence to do a job, earning trust occurs gradually over time. Earning trust is about how individual partners respond to each other and to situations. It involves their willingness to assume a position of openness and vulnerability. One senior physician manager noted:

> Earning trust is, I think, if you do what you say that you are going to do and you are there when you need to be there for the other person for whatever the issue is. I think trust just develops. I mean, you can't go out and say we are going to plan to have trust, it does not work that way; but it is a positive by-product of what you do and how you do it every day. I think by being available, by being sensitive to each other's issues and needs, it just bubbles up. (Senior medical manager, 28.10.2013)

By earning trust, partners show how they are willing to take each other's interests into account and give the other the benefit of the doubt. Each individual also gains knowledge of the other by seeing how he or she responds to a situation. Through these instances, individuals reveal personal values. Moreover, partners learn what they can expect from one another, and this adds stability and safety in working together. Earning trust eventually reduces uncertainty of actions and plays an important role in ambiguous, unpredictable or risky situations. Physicians, as autonomous non-employees with competing demands, may however be less prepared to accept a position of vulnerability; it may be more challenging to a professional trained to be an independent decision maker. As one clinical physician manager observed, *"*You have to deserve trust and maintain it, which is not easy… Trust is not something you get, you deserve it" (Clinical medical manager, 17.12.2013).

Nurse managers, on the other hand, often demonstrate particular actions that represent a willingness to be vulnerable, such as having the courage to "step it up and put it out there" if communication is not happening. This involves taking the initiative to clarify communications and rectify possible misunderstandings. One clinical nurse manager described how she would approach a physician partner if she felt they were not communicating well together (P = Participant, I= Interviewer):

P: I would take this surgeon for a coffee or a tea, sit down and talk as professionals. Don't talk about the job and what is frustrating you and what is frustrating him. Learn how to KNOW each other, listen to him, he will tell you what his frustrations are.

I: But what if he says he does not have time, what if I tell you that I am chasing him all the time, how will I get him to sit down in my office?

P: There is always time

I: But how do I get to him?

P: You take an appointment, you take the phone, you speak to his secretary and say, "I would like to have an appointment with the surgeon," and make it happen and persevere. (Clinical nurse manager, 14.10.2014)

Other nurse managers noted how stepping up communication was also about stepping into their partner's work context, for example, showing up during their partner's clinic hours. These types of actions encourage more face-to-face communication and a willingness to get to know and respond to the other.

4.7.3 Safeguarding respect. Safeguarding respect is about how to convey a point and how to listen with the intent of understanding the other's perspective. Nurse managers note the importance of partners' demonstrating respect in their communications together. A clinical nurse manager stated:

> Even if you are passionate about something, there is a way of delivering that belief in a helpful way and not ever feeling threatened or imposing your beliefs …you need to sit back and listen, be respectful to your partner. (Clinical nurse manager, 23.10.2013)

More importantly, it is about ensuring both perspectives are represented when addressing important issues. Respect is safeguarded by backing up the other and being prepared to defend

the other publicly. As one senior nurse manager said, "My partner defends me publicly, displays that respect and understands that I am also very busy" (Senior nurse manager, 6.6.2013). She noted how receiving positive feedback from her partner demonstrated gestures of respect and supported further discussion and work together:

> He gives me feedback, so I know that I am doing well. I was organizing all the meetings, putting together all the notes and Power Points and he was just very grateful and thanking me and giving me positive feedback. (Senior nurse manager, 6.6.2013)

Building the foundation for partnering illustrates the individual features that are needed for intentional partnering to occur. If one is not credible, not earning trust or not respectful, partnering does not go far. The dyadic processes feed off this foundation.

4.8. Providing momentum through senior leadership

Three key strategic actions stemming from senior leaders—sponsoring, role modeling and direct coaching—provides momentum to the process of intentional partnering.

4.8.1 Sponsoring. Sponsoring represents the strategic actions on the part of senior managers and executives to deliver a consistent message about the nurse-physician management model which defines, elevates and makes explicit the status of the nurse-physician partnership within the organization. One senior executive stated his efforts in the following way:

> So when I go out and show slides, I show the director of nursing and DPS hugging and it is at every level and in every unit.… It is absolutely intentional. I want people to draw the link between happiness and the model, and it is not subtle. I hit people over the head with it. I did not believe it when I came. I kind of thought about it. I now believe it with every bone in my body." (Senior executive medical manager, 12.9.2013)

He went on to say later in the interview:

> … and you have to talk about it, you have to believe it and every action has to be administrated and the moment you screw up and not include the nurse, to be able to say, which I have done, "Mea culpa, I screwed up and I regret terribly not having a nurse equivalent there or vice versa." And you have to do it every single meeting, every single day, breathe it, live it.… (Senior executive medical manager, 12.9.2014)

This message trickles down to the department level. A senior physician manager noted how nurse and physician management operationalized itself in the department. He stated:

> Well it [nurse physician partnering] seemed to be a rather natural sort of thing to unfold … it sort of made sense given how complex surgery is and it isn't just about surgeons. The governance structure should reflect the day-to-day functioning of the department of surgery, so it made perfect sense to have a partnered management structure to reflect the actual day-to-day functioning of what goes on in a Department of Surgery… this is part of the culture of the institution (Senior medical manager, 25.9.2013).

Yet, formalized structures are not thought to be necessarily crucial to the existence of nurse-physician partnerships. A senior nurse manager observed, "It (the nurse-physician model) is engrained as well as the interdependence. It would survive, maybe not with the name and maybe not so formalized, but it would be there" (Senior nurse executive manager, 25.4.2014).

Sponsoring also means that particular dyads are supported and promoted when given a task by senior managers. One clinical nurse manager pointed out how both senior nurse and physician partners together provided the mandate of a project to the clinical nurse and physician partners:

> We got the project together at the same time, met with them the same time, which was good because they set expectations at the same time together.... I think it is important that

> they are both there because it shows the importance that they are both concerned. So if they give their mandate to us, they are both concerned.… It says something about the value of partnership (Clinical nurse manager, 12.6.2014).

Providing a common mandate jointly sets expectations for partners to work together but also role models partnering. In addition, senior nurse managers indicated that they "matched" certain nurses and physicians that they felt would work well together.

4.8.2. Role modeling. Role modeling the partnership occurs when nurse-physician partners are present together and demonstrate working in partnership in front of others as a way to model how to work out issues. Role modeling by senior management partners in particular creates the expectation of a similar working relationship at the clinical management level. One nurse manager gave her impression of her senior nurse-physician managers' partnership:

> It has been a really great model because I think what works in this model is that here were two people who basically started together at the same time and they started out really green. You could see how they supported each other, you could see they grew to learn their way in the program. What was interesting was that it was even felt among the nursing director level because I was at meetings where some of the other directors would say "Huh, SNM01 and her partner" [said in a tone of admiration]. (Clinical nurse manager, 23.10.2013)

A clinical nurse manager noted how role modeling creates a "trickle-down effect" among clinicians and staff at the bedside:

> My staff saw him and I working together and they would tell me that. They saw and referred to us as a whole… It models it for them as they are working together. As we appreciate the nurse-MD model they can be more comfortable to come to us about issues

together. We model it and we expect them to do the same. (Senior nurse manager, 6.6.2013)

4.8.3. Direct coaching. Coaching involves the direct participation of a leader who shapes the circumstances to optimize the partnering experience for both partners. Coaching facilitates moving issues forward. Direct involvement from leaders is fundamental not only in having issues validated and understood but also in creating environments for effective communication to occur. One physician manager noted how the direct involvement of a senior nurse leader changed how he understood the notion of nurse-physician management:

> Because I had more contact with the nurse leader, I felt like I was part of the process, part of the solution…. This nurse leader was making a conscious effort to include surgeons versus just nurses alone. (Clinical medical manager, 5.5.2014)

Physician managers expressed the importance of having direct involvement from senior physician managers but more importantly needing their availability and willingness to implement changes. Yet having a surgical chief completely dedicated to administrative tasks did not seem feasible.

Sponsoring, role modeling and direct coaching are supporting strategies in the intentional partnering process that stem from senior leadership, yet direct coaching also plays a role in starting the process. One senior nurse manager described how she forced partners to come together:

> So I felt from a nursing point of view, we were struggling but also from a surgeon point of view they were struggling, so why don't I create a once-a-month, me and chief of surgery sit down with the two partners…. I thought if they are having difficulty creating a

table to talk to one another, why not I just force it. We always have an agenda. (Senior nurse manager, 1.11.2013)

Direct coaching plays an important role when partners are working through accepting mutual necessity and daring to risk. Opportunities for face-to-face interaction and a safe environment for communicating are critical for some partnerships, particularly when the foundation for partnering needs to be developed or supported. Partnerships that move to constructing a shared responsibility without leadership support need a strong foundation to build the partnership. Moreover, in some cases, where dyads may have been sponsored and promoted with a task by senior executives, it did not mean they were successful in aligning agendas. These partners still had to go through the three processes to make sustainable gains.

4.9. Reaping the benefits: Transforming the care experience

Aligning professional agendas through intentional partnering has the potential to transform the care experience for both the patient and healthcare professionals who engage in the process. Intentional partnering creates synergy, invites innovation, leverages the power and influence of each profession and bridges silos between professions.

4.9.1 Creating synergy and innovating. Combining the individual perspectives, resources and skills of each partner creates something new and valuable. Synergy therefore often refers to a whole that is greater than the sum of its parts. Relationships that are able to move through the intentional partnering process are able to create synergy and achieve a sense of working together that is supported by a level of comfort and trust within the partnership. A level of comfort is achieved in the relationship as partners feel confident knowing and anticipating each other's behaviors and intentions. As one senior nurse manager states, "I had the comfort in arguing and stating my opinion. I can challenge his thinking and be brutally

honest but we have built a relationship over time and that is why" (Senior nurse manager, 6.7.2012). Together, partners strive to resolve issues. They express a sense of accomplishment in their work together and a feeling of appreciation for each other. A senior nurse manager stated, "Working in partnership one knows what the other is living and doing. I understand his issues and he understands mine" (Senior nurse manager, 6.7.2012). Moreover, both partners realize their own value, their partner's value and what the partnership can achieve. Both partners express professional satisfaction as a result of partnering. Over time and in getting to know each other through various events, situations and challenges, partnerships mature. According to a clinical nurse manager, "The longer they get to work with you, the more they get to know you and things get easier (Clinical nurse manager, 5.11.2013). This synergy often results in creativity, "doing things differently" and innovating. Daring to risk with new ideas and new approaches is stimulating and achievable.

4.9.2 Leveraging the power and influence of each profession. Nurses, in particular, are astutely aware of the power imbalance created by the professional hierarchy, but this is not perceived as a barrier to be dismantled but rather as a tool to be used to get their message heard and advanced. As one senior nurse manager noted:

> Do I feel that MDs have more power than nurses in the building? Yes, I do. So I need to know that and be aware of that and then in my relationships remember that and see how I might leverage that to get what I need. What I believe is that what I have is a good relationship with Dr. X and that I have created a good relationship with him. This is a good thing for me because he is a very 'powerful' person in this institution and if I have him working with me, that is good. So when I go to him and he respects me and I say, I

have an issue and I need your help, he helps me and in the end the patient is helped. (Senior nurse manager, 6.7.2012)

Senior nurse managers strategically position themselves through their partners to gain influence. A senior nurse manager noted the importance of "using the right physician on the work group in order to influence the people who are driving the power" (Senior nurse manager, 25.4.2014). Positioning influence is not always about aligning oneself with a higher positioned physician but rather with "someone at a similar management level who for whatever reason has influence on a person." As one senior nurse manager said, "I think with physicians it is more of a strategy we have to use more often because the hierarchical thing does not always work." (Senior nurse manager, 19.2.2013)

Senior nurses are not naïve in terms of the power differential that exists between the professional structure and the hierarchy of the institution. These nurses want to be part of the "hockey game" and hear their physician colleagues interact and exchange. Working together out of political interests with their physician partners is often critical for advancing complex issues in a productive direction. Senior nurse managers anticipate and predict "plays" and are strategic in their actions to balance a power differential.

A senior physician manager, on the other hand, described how working together with a nurse optimizes decision making:

> Nurses have a far better, or have an easier time, are better at negotiating. They speak a language of compromise and doctors speak a language of absolutes.... Physicians feel isolation because the responsibility for patient death, accident or error falls on them and nurtures this concept of omnipotence or reinforces the behavior that we are trying to change, and so partnering with the nurse that they trust is quite helpful and reassures

them. I think a nurse with them, negotiating, allows them to compromise. It is easier to back away from a position when a nurse leader that they trust says to them, "Now don't you think we can think about this a different way?" They (nurses) are just better at it and maybe it is the way they are trained." (Executive medical manager, 12.9.2013)

For physicians, leveraging nurses' influence and power not only ensures the execution of decisions, but they rely on the particular assets of their partner's profession and training for achieving the outcome. One physician manager noted that for him, nurses are far more aware of the details of situations, and he relies on his partner to have this knowledge:

> I can play that role of overseeing situations and not necessarily be involved in all the details because there is a colleague who is ready to do that part for me, it works. It has been a model and it brings a feeling of respect.… It elevates the other to contribute equally but in a different capacity. (Senior medical manager, 6.7.2012)

Leveraging power comes from the capacity to partner, using the relationship as a way to influence and capitalize on the complementary strengths of each partner to achieve common goals. A senior physician manager described how the work of partnering between physicians and nurses is critical when managing issues related to practice change and modifying behaviors. The following excerpt describes the implementation of a surgical checklist in order to address operating wait times. The senior physician manager stated:

> Having a strong partnership empowers the nurse to basically say that this case does not go forward unless that surgical checklist is completed and the chief of surgery backs her up. We now have a 99% compliance rate with our surgical safety checklist … and the number of complaints of surgical behavior in the operating room has dropped dramatically simply because the nurses and surgeons work together…. They will never

> be equal in an operating room environment because the task of surgery is dominated by the medical person, but in the behavioral sense there is a much more equivalent status. I think it has had an enormous change in our operating rooms. We are the only operating center in the province that meets all of its wait times now. Now it is tight but I am totally convinced that it is because of great shared nurse-physician leadership. (Executive medical manager, 12.9.2013*)*

Through the process of partnering with a nurse manager, physician managers gain appreciation and a clearer understanding of the role and skills of their colleague. A physician manager stated:

> I have noticed that when you are on the front lines, you don't appreciate what the nurse managers actually do in the hospital until you are in the administrative process and how much of the responsibility they have taken over, and that is not a bad thing. It is a lot of the things that the surgeons don't want to do or have no talent at doing and so you learn to appreciate just how much of the work is being done by the nurses in the hospital. (Senior medical manager, 13.8.2014)

Reaping the benefits of each other's complementary strengths in effect supports the bridging of their professional silos.

4.9.3. Bridging professionals silos. Participants in the setting used the phrase 'working in silos'. One clinical physician manager described working in silos in the following way:

> I think that the changing healthcare environment today will not allow sustainability of those isolated behaviors....We are hitting a wall. If we are not going to change directions quickly, it will be more difficult to recover.… The work has become a world of networking and connectivity. (Clinical medical manager, 17.12.2013)

Silos represent isolation and self-containment. Yet intentional partnering breaks past the walls, allowing connections to be made. And as one clinical medical manager stated, "If you are not part of that (connectivity), you will be left behind. It is like when cars came around. You know you were ok on your horse, but soon the cars took over and soon your horse would not like it." (Clinical medical manager, 17.12.2013)

Intentional partnering bridges silos as partners experience the added value of working together and what can be achieved. Through intentional partnering, an environment can be shaped which becomes an "*accepted way of being around the institution*." As a senior nurse managers remarked, "You don't have major committees that don't have nurses on them. Nurses and physicians are on all major decision making committees, co-chaired, and all head nurses have medical partners. This is just the way we function!" (Senior nurse manager, 6.6.2012) Moreover, by nurse and physician managers partnering, they are able not only to overcome the resistance that is often perceived within the individual professions but also begin to optimize their human resources and capacity. A senior physician manager described how nurse and physician managers partnering was effective in an initiative that reduced time for the patient in the emergency department:

> Had we not had nurse and physician managers partnering, it would have failed. If we had it led by the medical chief, the nurses would have resisted; and if the head nurse had led it, the physicians would have resisted in their usual way; and by doing it this way, there was a sense of a team of conspirators committed to improving the situation. (Executive medical manager, 12.9.2013)

4.10. Conclusion

The theory of intentional partnering begins with professional agendas that include a set of interests: those shaped by professional concerns and those that play out when working together. These consist of the practical, political, patient, and personal interests that bring partners to the table. In formalized partnerships there can be varying degrees of clarity as to why one is working with a particular person. Partners, therefore, bring to the table a combination of these interests and with varied intensity. Embedded within professional agendas is how each member operationalizes his or her interests when working together. Not everything is shared at the start. Professional agendas are revealed or surface over time. Thus, they are not always explicit or overt.

For the intentional partnering process to be put into motion, individuals act on their interests to achieve an end through partnering. It is through the processes of accepting mutual necessity, daring to risk together and constructing a shared responsibility that partners align their professional agendas. These processes reveal the relational components of partnering and the strategizing that occurs within the interaction as each partner deliberates on what he or she is willing to accept, willing to risk or willing to do to keep the other on board in order to reap the benefits of partnering.

Accepting mutual necessity means adopting different perspectives that challenge one's professional preconceptions. It sets the stage for the other processes to evolve as the partners navigate and manage the emotional investment of working with one another. Partners dare to risk together and calculate the extent to which they were willing to risk individually and together in order to gain benefits. In the process, partners construct a shared responsibility by demonstrating through their daily actions the importance of working together, which ensures the

viability of the partnership. The essential conditions of being credible, earning trust and safeguarding respect initiates and sustains the process by building a foundation for partnering and effective communication. These conditions derive from individual actions and face-to-face communication. Finally, key actions from senior leaders provide momentum in the intentional partnering process through sponsoring the nurse-physician partnership, role modeling it and providing direct support through coaching.

Both senior and clinical managers go through the intentional partnering process; however, their experience may differ at each level of management. For example, clinical managers may need more coaching as they may have fewer opportunities for face-to-face communication. Through the process of intentional partnering, partners establish a more binding relationship based on commitment. Reaping the benefits solidifies the relationship and strengthens the motivation and interest to work with a partner and/or deepen the relationship that has been established.

CHAPTER FIVE: DISCUSSION AND IMPLICATIONS

The current "theoretical" literature concerning the field of interprofessional collaboration (IPC) is descriptive and focuses on the characteristics of this phenomenon (D'Amour et al., 2005). Further research is needed in IPC to explore how it begins in healthcare settings, the purposes it serves and the roles of different professional groups within these relationships. Developing theory is one way to enhance our understanding of these dynamic and interactive processes (Reeves & Hean, 2013). Moreover, the value of theory lies in its practical applications (Charmaz, 2006; Glaser & Strauss, 1967).

A similar gap has been identified in the research on leadership, particularly the need for a more comprehensive understanding of the dynamics and processes of different leadership approaches (Denis et al., 2013). This study speaks to these gaps as it proposes a grounded theory approach that uses a variety of data collection strategies, including participant observation, shadowing and interviews of middle, senior and executive managers in a hospital setting to explore how formalized nurse and physician managers work together to address clinical management issues.

The focus of this chapter is to discuss the theory of *intentional partnering* and its major concepts—accepting mutual necessity, daring to risk (together), constructing a shared responsibility and building a foundation for partnering and effective communication—in relation to the relevant literature. Although the findings will be considered with respect to the literature on communication studies, sociology and social psychology, the focus will be on situating the findings in the field of nursing administration. Therefore, the discussion will center on the IPC and healthcare management literature. In addition, the discussion will briefly address reasons for developing co-leadership in hospital settings. A second consideration for this chapter is to

discuss some of the implications and practical applications of the study findings in relation to developing and promoting co-leadership among nurse and physician managers. Finally, a brief discussion of the study's limitations and how the findings may be applied to healthcare management education will be provided.

5.1. The theory of intentional partnering

In this study, the interest to partner was related not only to patient care but also to political, practical and personal reasons. This finding extends the work of D'Amour and colleagues (2005), who contend that patients are the primary reason for interdependency between healthcare professionals. Perhaps the inclusion in the present study of clinical managers, senior and executive managers who have various interests and priorities allowed for the range of interests in partnering to emerge.

The theory of intentional partnering explains that partners are looking to have their own professional agenda addressed. The need to have one's own professional agenda met and the need for a partner to achieve it become the drivers for working together and are what defines partnering as intentional. But each partnership is different, not only because individuals' backgrounds are different in terms of their previous experience in partnering and their individual characteristics and abilities but also because their intentions to partner may differ. The findings suggest that a set of interests play out when working together and are based on the individual's level of management, his or her proximity to patient care, the nature of the issue and their professional affiliation. In order to develop the partnership, members need to focus on understanding and addressing various interests at play between them. The findings of this study reveal that there is also a shared interest that is discovered in the intentional partnering experience. Both partners achieve their own purpose and in the process engage in a collective

effort that can transform the healthcare experience for the partners and for those with whom they interact, including patients.

5.2. Accepting mutual necessity

Intentional partnering is initiated by accepting the need for the other and by learning about and accepting each other's professional agenda. In order to accept, individuals need to overcome or let go of their preconceptions and see in their partner a strength that compensates for any perceived shortcomings. The concept of collaborative advantage developed by Kanter (1994) and elaborated by Vangen and Huxham (2003) supports this finding.

According to this theory, collaborative initiatives do not simply happen and do not just remain successful. They demand a sophisticated set of skills, knowledge and ability to be developed and implemented. The collaborative advantage involves building partnerships purposefully and balancing the tensions between the advantages of autonomy and the strengths of interdependence (Canadian Health Leadership Network, 2014). This requires continuous adaptation and evolution. Yet, many of the differences in professional agendas derive from how our professional identities are constructed within our specialized and socialized training (Hall, 2005). For example, a number of physicians in the study referred to their medical training as promoting independence and autonomy, which created a barrier to working in collaboration with other healthcare professionals. The process of intentional partnering requires both partners to consider and evaluate how professional identities guide or shape one's actions and interactions.

According to Hall (2005), professional socialization occurs during the training period and serves to solidify each profession's unique worldview. She states: "This has led to each health care profession working within its own silo to ensure that its members have common experiences, values, approaches to problem solving and language for professional tools" (p. 190).

For example, the main outcome valued by physicians, particularly surgeons, is to save the patient's life. Their priority is to focus on treatment goals that cure the pathology and which are supported by scientific evidence. This suggests that the culture of physician training focuses on actions and outcomes more than on relationships (Reese & Sontag, 2001). In addition, the professional agenda of physicians is shaped by the expectation that they will be leading academics and researchers engaged in a robust clinical practice that generates income. This financial incentive places physicians in a situation where activities associated with direct patient care are more remunerative than other activities (Rodriguez, Langley, Beland, & Denis, 2007). Moreover, physicians are trained to assume responsibility for decisions and may be expected by other healthcare professionals to take on the leadership role.

Different models guide nursing practice, though the key concepts relate to the patient's environment, interaction, and the delivery of care during illness and to the promotion of health (Glen, 1999). Nurses may value the patient's story and may not rely on objective data as heavily as physicians do. Some authors have noted that the emphasis on standardized protocols associated with evidence-based practice may undermine the individualized values of caring that are traditionally associated with the nursing profession (Baker, 2000). Participants, being in formal management positions, may express their professional identities and dispositions as they function within these roles. In the proposed theory, the concept of accepting mutual necessity brings to light this phenomenon and suggests that the process of intentional partnering gets started first by each partner's accepting the need for the other. In doing so, partners begin to break down and challenge the conventional thinking which is often perpetuated within their professional training. Some partners will never get past this step in the process. There is a

complex array of factors that underlie professional dispositions, particularly in terms of perceptions and experiences of power that play out in the process of accepting mutual necessity.

In the literature, power is often discussed in terms of authority, status, territory and influence; yet it has many dimensions, including those that relate to gender, race, class and knowledge (Doering, 1992) that can have an impact on interprofessional relations (Baker, 2011). Significant contributions to the study of power can be found in the sociological literature that describes the development of professions as distinct occupations aimed at securing and protecting specific areas of knowledge and expertise in order to secure social and economic rewards (Freidson, 1970). In particular, Witz (1992) provides a conceptual model of "professional closure strategies" to explain relationships between professional groups. This model suggests that professions interact as organized bodies with traditions, strategic orientations and a desire to protect and advance their members' interests. Some professions will engage in exclusionary strategies as a way to create and protect boundaries around their 'turf'.

The notion of "professional orientation" or "professional modes of control" suggests that one's professional group can remain a dominant socialization agent because of the power and autonomy gained for members of the profession, their commitment to developing and retaining the power and prestige of the profession and their control of the knowledge system (Abbott, 1988). Some professional groups may be more prepared than others to compromise or negotiate their autonomy. An individual's professional orientation may vary, however, depending on the extent to which he or she is prepared to give up some of the expectations of the role to which he or she was socialized (Lurie, 1981).

A study by Baker and colleagues (2011) in the field of IPC used Witz's model and found that some physicians regarded interprofesssional collaboration as a potential threat to their status,

whereas non-medical professionals saw it as an opportunity to improve their standing in the health professions. The authors note that these attitudes are expressed through a type of protectionism in which it matters more to put forward one's own professional agenda than to find common ground. This can interfere with an individual's ability to partner. Their findings resonate with the undertones of power that weave their way through the process of accepting mutual necessity. After letting go of preconceptions, the nurse and physician managers in this study were able to accept each other's position of influence in the organization. In particular, physicians recognized how nurse managers could move the agenda forward through their operational expertise and ability to influence key stakeholders. This did not mean that the hierarchy was flattened out, but rather that the partners came to recognize one another's contributions and strategically used them to better the conditions for working together.

5.3. Daring to risk (together)

Partners recognized that they needed to take risks individually within the relationship and together in order to succeed. This required emotional competence as partners worked to integrate different points of view and learn when and how to address the sensitive issues that were likely to surface in close working relationships. The findings in this study reveal the importance of appreciating the emotional component when working and interacting together in management, as the study provides a more comprehensive understanding of the partnering process.

In the past, management scholars considered emotions as interference with rational decision making or as part of interpersonal conflict, but more recent literature suggests that there may be benefits to recognizing the value of emotions in the workplace (Humphrey, Pollack & Hawver, 2008; Khalili, 2012). McCallin and Bamford (2007) note that too often the perception

is that effective collaboration evolves because of individual personalities at certain points in time, not because purposeful interactions make attitude or behavioral change possible. They contend that we need to look more closely at how to understand and manage the emotional undertones that can impact interprofessional relations.

The IPC literature has also explored conflict management styles among nurses and physicians at various levels of management within a hospital setting. Skjorshammer (2001) noted that short-term avoidance was found to be a meaningful way for nurse and physician managers to deal with conflict. Avoidance allowed one or both parties time to regain composure and to think through the situation. However, the study did not address how conflict situations are resolved between the two parties. In terms of the findings of the present study, senior nurse managers, in particular, used various strategies to diffuse tension within the relationship and to re-align the agenda.

Although the IPC literature has focused on conflict, the emotional aspects of management and leadership have been receiving more attention in the management and healthcare leadership literature (Conte, 2005; Cummings, Hayduk, & Estabrooks, 2005; Goleman, 1998, Khalili, 2012; Blumer-Smith, Profetto-McGrath, & Cummings, 2009). An integrative review of the nursing leadership literature by Blumer-Smith, Profetto-McGrath, and Cummings (2009) noted that emotionally intelligent nursing leaders inspire trusting relationships, are sensitive to emotional signals and use emotional competencies to manage conflict, convey empathy and contextualize decisions. Other scholars suggest that the understanding, detecting and conveying of emotions is critical to a profession such as nursing that requires sensitivity within relationships (Freshwater & Stickley, 2004). A systematic review of physician leadership and emotional intelligence (EI) concludes that EI is a critical healthcare leadership competency and that further research is

required to advance our understanding of how to develop and nurture EI to enhance leadership skills in physicians (Mintz & Stoller, 2014).

Studies in leadership and management note the importance of the leader's own ability to manage his or her own emotional state (Kent, 2006; Gosling & Mintzberg, 2003). Freshman and Rubino (2002) contend that this aspect is a large part of EI, which should be a fundamental competency for healthcare managers today as many of the functions and tasks in their daily routine require the skills associated with EI.

Components of EI include self-awareness of one's emotions, strengths, weaknesses, needs and desires; self-regulation, whereby one has a propensity for reflection, the ability to adapt to change and to say no to impulsive urges; self-motivation to achieve and enjoy challenges; social awareness, whereby one thoughtfully considers someone's feelings when acting; and social skills to move people in the direction one desires (Freshman & Robino, 2002). The concept of daring to risk (together) illuminates this individual work that managers were effectively doing but also highlights how human emotions and qualities are developed through participation in one's social context and in social interaction. Moreover, the cultural context in which the leader performs has also been identified as influencing the rules and boundaries for feeling and expressing emotion (Fineman, 2000; Hochschild, 1979). This suggests that the cultural norms of the organization and the cultural norms of each profession such as nursing and medicine may be important to take into account in understanding the emotional challenges of working together.

5.4. Constructing a shared responsibility

As noted in Chapter two, Graen (1976) describes phases in terms of role sharing that involves role taking, role making and role routinization. The role taking phase involved each

member discovering the relevant talents and motivations of the other over a period of time. By the time roles were established (role routinization) each individual had a sound understanding of each other's strengths and weaknesses and capacity to solve problems. While similar concepts may correspond to those identified in *intentional partnering*, the process of *intentional partnering* suggests that partners are not preoccupied by working on roles *vis-à-vis* each other but on sharing responsibilities. Tuohy (2003) contends that the "location of responsibility" is a critical dimension in order to ensure accountability in the healthcare milieu. She defines this "location" in terms of the individual. However, the findings from this study demonstrate responsibility as being shared among the nurse and physician management partners. Partners' efforts were placed in keeping the other on board and working to hold each the other accountable, not just themselves. Practices in how they held each other accountable became a critical part of sharing responsibility, for it confirmed the relationship. In addition, *intentional partnering* highlights that the process of accepting mutual necessity is required to breakdown professional preconceptions prior to partners being able or prepared to identify the strengths of the other. This may be unique to the health care context where individuals are highly socialized within their professional training.

In constructing a shared responsibility, partners attempt to meet each other's needs and appreciate the benefits of working together. They are striving to achieve shared rewards. They have moved beyond "what is in it for me" to "how do we do this together in order to achieve our goal?" By striving for mutual rewards, partners operate in a way that helps them to identify and share common values. Once partners arrive at this understanding, they can rely upon each other and ease up on holding each other accountable.

Nurse and physician managers align their professional agendas by addressing each other's needs and wants and by making their professional and personal values explicit to each other. One's personal and professional values are also demonstrated by being credible, earning trust and safeguarding respect consistently and continuously throughout the intentional partnering process. The sustainability of the partnership is contingent upon establishing a shared responsibility.

5.5. Effective communication in building the foundation for partnering

Communication scholars have acknowledged the importance of intentionally claiming goals, analyzing targets and situations and selecting strategies that are calculated to maximize desired outcomes (Bowers & Bradac, 1984). Knapp and Daly (2011) in their review of the basic issues and approaches in communication scholarship conclude that there is agreement on some of the fundamental issues concerning intent. For example, there are multiple levels and degrees of intent in communicating; more than one intention can occur during a communicative act; intent can change during the act of communicating; and finally, communicators may be aware of a general goal and unaware of specific intentions for reaching that goal. This is consistent with how interests and priorities that shape professional agendas were often expressed. What should not be underestimated in this study's findings is that intentional partnering requires effort in understanding and negotiating intentions among partners while simultaneously building and maintaining a relationship. This process involved face-to-face communication, at least in the initial stages of building the foundation for partnering, when communication was a critical factor to achieving credibility with the other, earning trust from the other and safeguarding respect when interacting with the other. These individual attributes were pre-requisites for effective

communication but also served to mitigate the fluctuating and ambiguous nature of intentions so that they did not jeopardize the relationship.

McCallin and Bamford (2007) noted in their grounded theory study of interdisciplinary teamwork that initially trusting colleagues was based on competence but that, once confirmed, a colleague would listen carefully to one another and discuss issues more openly and honestly. Colleagues were able to challenge assumptions and try out new ideas once colleagues felt safe and comfortable in the relationship. When colleagues were emotionally secure with each other, individuals were offered and received input more readily and were able to put personal defensiveness and value judgements aside in the interests of the client. Their findings support the importance of navigating the emotional components required in partner work and the belief that earning trust cannot be neglected in developing and sustaining partnerships. Only a few studies have identified the concept of trust, mainly within the healthcare management literature. Although it was addressed in terms of inter-organizational relationships, it still has relevance in relation to the findings of this study.

Earlier work by Mayer, Davis, and Schoorman, (1995) conceptualized trust as a dispositional quality whereby individual judgments of the other's ability and integrity would have an important effect on trust, particularly at the beginning of a relationship. Vangen and Huxhan (2003) explored the mutual and reciprocal nature of trusting relationships. They describe the cyclical process of building trust as part of collaborative practice, which is consistent with concepts of intentional partnering. They also suggest that building trust is best understood in terms of expectations, risk and vulnerability. There is an incremental development of trust as parties repeatedly interact. They state:

> Each time partners act together, they take a risk and form expectations about the intended outcome and the way others will contribute to achieving it. Each time an outcome meets expectations, trusting attitudes are reinforced. The outcome becomes part of the history of the relationship, increasing the chance that partners will have positive expectations about joint actions in the future. The increased trust reduces the sense of risk for these future actions (Vangen & Huxham, 2003, p. 11).

This suggests that if trust does not already exist, it can emerge in the process of interacting and mutual learning. Mayer, Davis, and Schoorman (1995) contend that where there is no history of trust, parties must be willing to take a risk and become vulnerable to the actions of the other partner in order to initiate the cycle. In the present study, some professions were less prepared to assume a position of vulnerability. However, the perception of the other partner as "being credible" may have mitigated this risk and vulnerability in order to get the partnering process started. The iterative process in building trust over time provides the foundation for supporting emotional stability in the relationship and facilitates a readiness to risk.

Mayer and colleagues' work also makes a strong case for initiating a partnership through a modest, "small wins" approach in which developing an understanding of the partner's expectations is crucial at the initial stage of the partnership. Earning trust can therefore be developed gradually and move toward initiatives where partners are willing to take greater risks because a high level of trust exists. In terms of this study, some partnerships demonstrated a high level of trust but did not take the process of building and sustaining trust for granted.

Trust begins with the initial steps in the partnering journey and evolves throughout the relationship. Managing trust therefore implies the ability to cope in situations where trust is lacking, the ability to build trust in situations where this is possible and the ability to sustain trust

over time. It requires constant attention and represents an important "partnering competency". Issues concerned with power in relationships, such as a lack of transparency, glory seeking, fighting to take the lead, guarding territory or knowledge and seeking to claim credit, undermine the trust building process. Vangen and Huxham (2003) maintain that practitioners need to deal with power differences to minimize their negative impact in the trust building process. Given that power weaves it way through intentional partnering, nurse and physician managers have opportunities to address these factors at various points in the process. Furthermore, trust allows the partners to overcome the differences and barriers that might exist between them. This can lead to provider engagement, which encompasses satisfaction and commitment (Kaissi, 2012).

5.6. Reasons for developing co-leadership among hospital-based nurse and physician managers

Studies in many industries, including health care, suggest that leadership is a critical element in organizational performance (Baker, 2011). Other scholars contend that the health care environment today requires both leadership and management (Gosling & Mintzberg, 2003). The American Organization of Nurse Executives (2006), for example, recommends that nurse leaders acquire two major skill sets: the art of governance (leadership), which can influence people to change their behaviors; and the science of governance (management), which includes skills such as staffing a unit and managing resources. As issues in clinical care become more and more complex, professional and managerial issues get intertwined, which requires individuals in management positions to have both sets of skills in order to be effective (Gilmore, 2010; Kaissi, 2005). This section suggests that reasons for developing co-leadership are twofold. Developing leadership can encourage physician engagement in situations in which senior nurse leaders can make an important contribution. Secondly, a focus on common values among the two

professions fits in with the conceptualization of adaptive leadership that complex organizations such as hospitals require.

5.6.1. Physician engagement and the contribution of senior nurse leaders

A high priority among executive leaders in hospital and health systems today is to engage physicians in management projects and issues, as evidence suggests this is a necessary ingredient for the long-term success of organizations (Kaissi, 2012). Yet, challenges continue to preoccupy health care leaders and researchers in identifying the facilitators and barriers in engaging physicians as well as how to develop their leadership and management skills (Dickson, 2012, Kaissi, 2012, Denis et al., 2013).

Most physician managers today remain clinically active. Physicians may be ambivalent about taking on administrative roles at the expense of giving up some of their clinical care, research and income. They are often "promoted" into management positions but may lack the managerial or leadership training and skills to run a department or service (Birken, Lee, & Weiner, 2012). As Kaissi (2005) notes, the traditional professional training and socialization process for physicians lacks the framework for understanding, observing and learning what leadership is and how it makes a difference. Gilmore (2010) contends that a physician will step into a management role ambivalently and not have a significant amount of his or her identity tied to success in those aspects of the role.

However, in today's healthcare environment, physicians are expected to be accountable for the cost implications of all of their decisions (admissions, level of care, tests, medications etc.). This requires that they integrate the clinical and administrative aspects of their roles and integrate both clinical and leadership competencies, rather than hold the managerial role at a distance (Kaissi, 2005). These combined competencies are required for physicians to take an

active role in ensuring delivery of safe and high quality patient care (Goeschel, Wachter, & Pronovost, 2010). Physicians need support to be effective, which requires mentoring from other individuals who have the management experience in dealing with hospital staff and administrative issues (Avakian 2011). Kaissi (2008) suggests that nurse leaders can fulfill such a role and act as "translators" who can explain physicians' views to managers. The findings from this study highlight the role of senior nurse leaders in this type of coaching capacity. Nurse leaders may possess a number of these necessary skills for managing and leading within an evolved framework that combines their clinical and administrative competencies.

In addition, the findings also present some evidence for understanding and addressing the underlying characteristics and values of the "engaged" physician. Denis and colleagues (2013) identified engagement as a key variable for physician leadership and high-performing healthcare systems. They concluded that successful strategies to engage physicians need to go beyond appointing physicians in formal management positions and offering economic incentives. Strategies need to focus on developing physician's skills and competencies for leadership roles. This kind of focusing includes "interprofessional experiences and cultivating dyads of physicians and managers in charge of clinical departments" (Denis et al., 2013, p. 3) Nursing is in a prominent position to guide and initiate these experiences as nurses are most often directly and formally involved in clinical and administrative management but also have experience in coaching and communication.

In the present study the senior nurse leaders had both mobilizing and supportive roles in the intentional partnering process. In terms of their mobilizing role, senior nurses set and led the "collaborative" agenda with their medical partners by stating the conditions for achieving the goal; raising issues and implications of decisions; putting the 'brakes on' when the direction was

not clear; advocating for other nurse managers; acting as gate keepers; allowing time to vent frustrations; anticipating issues and coming prepared with possible solutions to address the concerns of the partner. These are key communication strategies in nursing leadership frameworks (AONE, 2011). Other strategies used by senior nurse managers in this study involved reflection. The senior nurse managers selectively used strategies based on how they perceived their partner's actions. Supportive roles of senior nurse managers included creating structures for clinical nurse-physician manager communication to occur. This involved finding the opportune moment and creating a safe environment in which sensitive issues could be addressed.

The findings from this study help clarify nursing's unique contribution in working within a management dyad. Nurses, in particular, use influence to gain power. It is not expressed overtly but rather in their actions and how they leverage a partnership in order to move their own agenda forward. Lawrence, Phillips, and Hardy (1999) note that much power and influence can be exercised on the direction of the collaboration by defining the issues and creating and disseminating text. By leading the meeting agendas, senior nurse managers were able to influence the issues and the way in which these issues became part of their joint efforts with their physician partner. They invested in coordinating meetings, following up and keeping themselves informed of their partner's interests and reality. These strategies occurred behind the scenes as these nurses learned about who influenced whom, exchanged information and gossip, knew the 'field' and created a network involving other key stakeholders. In contrast, physician managers may have perceived that their power to influence others lies in being seen as an expert. (Spehar, Frich, & Kjekhus, 2014).

Strategizing was essential in order to propose, uncover and align professional agendas to move issues forward. The findings reveal that to align professional agendas, partners needed to focus on common values. This is an important concept in the literature that relates to adaptive leadership.

5.6.2. Adaptive Leadership

According to Lichtenstein and colleagues (2006), leadership has been defined as being adaptive, going beyond the capabilities of individuals alone. They note that "it is a product of interaction, tension and exchange rules governing changes in perceptions and understanding" (Lichtenstein et al,, 2006, p.2). This leadership perspective places relationships and interactions as primary. Tensions in relationships are considered part of the complexity of the real world and can have the benefit of stimulating transformative change. Rules change when interactions in leadership events produce a new identity. According to an adaptive leadership perspective, this identity formation occurs over time as participants together define "who we are, what we are doing and why are we doing it" through their interactions. This is an interesting notion when considering the findings of the present study. As partners worked to construct a shared responsibility, they identified common professional values that encouraged a collective effort toward achieving a shared understanding of patient interests. This enabled them to align agendas and reap the benefits of creating synergy and arriving at innovative solutions.

According to Gilmore (2010), adaptive leadership means clarifying and addressing what matters most and surfacing conflicts in values and gaps between values and reality. In this study, however, individuals were not trying to change one another's values but were looking for common ground. This suggests that there may be a need for a professional cultural bilingualism.

Physicians may be less sensitive to this notion as they are the dominant profession, but nurses require a greater degree of fluency.

In conclusion, while maintaining and improving relationships with physicians will remain crucial to hospital and health systems' survival and success, the intentional partnering process can play a critical role in engaging physicians Although more research is needed, the findings reveal that there is an important role for senior nurse managers to play in leading and developing this process. Senior nurse managers in this study appeared to be not only more willing to take risks and work through the tensions and challenges of their nurse-physician partnership but also may have been more deliberate in their actions to maintain the relationship. One may question whether intentional partnering requires more investment from nursing because nursing may have more to lose in the power imbalance within the organizational and professional hierarchies. Do nurses want to invest? Are physicians open to nurses' investment?

5.7. Implications

The theory developed in this study has practical implications for researchers, clinical nurse and physician managers, healthcare leaders of organizations, and healthcare management educators. Three main implications will be discussed: 1) how to develop individual capacities for intentional partnering among nurse and physician managers; 2) organizational implications; and 3) directions for future research.

5.7.1. Developing capacity for *intentional partnering* in hospital-based nurse and physician managers.

There are a number of practical lessons from this study that may be considered in settings desiring to develop and/or strengthen nurse-physician partnered management. This section considers how to develop capacity for intentional partnering in nurses and physicians who are in various management positions.

Reflection was important for nurse-physician partners as they moved through the processes of intentional partnering. This ability has also been identified as an important component of leadership in current healthcare organizational leadership frameworks (LEADs – Canadian College of Healthcare Leadership). As Gosling and Mintzberg (2003) contend, by reflecting on one's actions and reactions, it becomes a learning experience for future reference. It is part of developing as a manager. "Everything an effective manager does is 'sandwiched' between action on the ground and reflection in the abstract. Action without reflection is thoughtless; reflection without action is passive" (p. 2). With this in mind, Table 3 provides actions and the corresponding reflective questions that were generated from the processes of accepting mutual necessity, daring to risk (together) and constructing a shared responsibility that comprised intentional partnering. These strategies can be used by both members of the partnership as they are derived from dyadic interactions. The actions and reflective questions can serve as a reference guide for individuals embarking on the intentional partnering process.

Table 3

Reflective questions for developing individual capacities for intentional partnering

Process	Action	Reflective questions
Accepting mutual necessity	**Consider the added value of partnering**	What are the likely costs and benefits? What are the reasons I am working with this partner? Is it for practical, political, patient and personal reasons? Does one particular reason predominate? Does this facilitate or constrain the working relationship?
	Explore each other's understanding of the work together.	What does each member think is the goal of the work together? What is the amount of time they can or want to invest?
	Discuss differences in expectations	Are the expectations described both in terms of individual and mutual goals? Review these expectations at various time points throughout working together as individual needs and agendas can change overtime.
	Evaluate previous	What made them positive experiences?

Process	Action	Reflective questions
	experiences in partnering	What made them negative experiences? If I am new to partnering, what does a positive partnering experience look like? What are the characteristics of such a partnership? How do I see my role in achieving this?
	Consider ways of getting to know one another as people	Can we join the same organization where there is a common vision for our patient population or for developing a management vision? Is there an opportunity to attend a conference together? Or present work together? How can we get to know each other outside of the professional context?
	Show appreciation for the partner's perspective	How have I integrated their perspective when interacting and exchanging ideas? What knowledge and skill set am I drawing from them? Have I explicitly stated their strengths and contribution to addressing the issue? Have I been explicit in how the other partner can assist or contribute?
	State goals and define boundaries around roles and tasks.	In what situations is it important to state goals and define boundaries around roles and tasks?
	Leverage influence from each other's position	Have we accepted our individual positions and powers to influence? For example, have we considered how our relative power might be used to position stakeholders, influence resources and make connections to powerful others such as senior management
Daring to risk (together)	**Consider when and how to address the "elephant" in the room**	How can I carefully make the gesture of addressing the "elephant?" Do I have the personal skills to address the "elephant"? Should there be an additional person present when addressing sensitive issues? What purpose will they serve? How do I set the tone (e.g. use of humor; revealing a personal story that presents my own vulnerability in some way)?
	Continually assess and attend to the foundation of the partnership	Is the foundation of the partnership strong enough to deal with ambiguity that could arise out of addressing the "elephant" issue(s)? What am I willing to risk? What am I willing to lose? What am I not willing to lose? Am I prepared to take a step back if the issue becomes 'heated'? Can I afford to take time to work through this issue? Am I

Process	Action	Reflective questions
		prepared to voice my apprehensions and concerns to the partner? Am I prepared to compromise? Can I express humility and state that I was wrong if necessary? Am I prepared to let differences surface or misunderstandings be exposed? Am I prepared to just listen? Have I achieved credibility in the partnership? What am I doing to develop credibility? How am I earning the other's trust? Do I consider the other's best interests? Am I feeling like I can take greater risks with my partner as we work together?
Constructing a shared responsibility	**Examine and re-examine the motivation of why we are partnering**.	What do **we** want to get out of this? Why is it important for **us** to work together?
	Re-consider and communicate expectations, needs and priorities that drive one's participation.	Am I walking my talk? Am I a cheerleader or am I a player? Which does my partner think I am? What do they need?
	Start with small, short-term goals where both partners are equally invested rather than tackle large vision issues	Can we design a goal that appeals to both partners and that requires both individuals to be directly involved and implicated? Can we define the outcomes that both partners want to achieve which are transparent and accessible?
	Determine an accountability structure to achieving the goal	How will we be individually accountable to these outcomes? How will we hold the other accountable? What are our formal communication strategies that allow us to establish and maintain continuity in addressing the work together? When are more formalized communication structures needed?
	Celebrate the short-term "wins" and identify mutual professional rewards	Are we acknowledging our accomplishments to each other and with others? What are ways we can do this together? Have we expressed to each other what we are getting out of our work together?
	Mutually define the patient's interests	How can I bring the patient story and experience to the forefront of our interactions?
	Keep each other in the loop	How can I share my perspectives and update my partner on important information?

Process	Action	Reflective questions
	Ensure partner's perspective is represented when making decisions	Is everyone at the table who needs to be at the table when making this decision?
Providing momentum	**Questions for leaders mobilizing and supporting clinical management partnerships**	
	Consider why is it important to coach this partnership	Is senior leader involvement a pre-requisite for building the foundation for this partnership? Or is involvement (such as direct coaching) only required at particular junctures? How am I optimizing this partnership experience? How am I creating an environment for effective communication for the partners? Am I role modeling partnership? If so, with whom and how?

5.7.2. Organizational implications. This study did not address the concept of organizational culture explicitly; however, expressions of culture in terms of underlying values were conveyed by organizational members (i.e. nurse and physician managers) in their reflections on their beliefs, assumptions, attitudes, feelings and professional norms. The organizational implications of this study will be considered both in terms of the "dominant culture" within healthcare organizations, that of the medical profession, and how leaders embody and practice the organization's values.

Rondeau and Wagar (1999) maintain that attempts to define organizational culture are usually inclusive of the following components: the dominant philosophy and values espoused by the organization and practiced by its members; observable behavioral regularities that occur whenever people interact; the norms of attitude and behavior that are shared by members; the "rules of the game" for getting along in the organization and the "ropes" that a newcomer must learn in order to become an accepted member; the feeling or climate that is conveyed in the

organization by the physical layout. They go on to state, "organizational culture allows people to have a sense of identity (facilitates commitment, initiative and communication) and provides a basis for stability, control and direction" (Rondeau & Wagar, 1999, p. xiv). They suggest that organizational leaders must be able to effectively mobilize organizational culture as a vehicle to facilitate strategic change.

In the case of hospitals, the dominant culture is that of the medical profession in which physicians often remain the prevailing socializing agent and have a high degree of "professional control" (Abernethy & Stoelwinder, 1995). Professional control refers to the external form of control that has its roots outside of the organization and stems from the social control imposed by individuals within the professional group (Orlinkowsky, 1991). However, complex organizational forms such as hospitals may have a number of competing sub-cultures, such as nursing, which may have different needs and objectives. Part of mobilizing the organizational culture may involve aligning the differences among the professional 'cultural' norms. In the theory of intentional partnering, the key aligning mechanism was in building the foundation for partnering and effective communication. This involved being credible, earning trust and safeguarding respect. It highlights how aligning the professional cultural norms of physicians and nurses relate to what they both share in common rather than what makes them different. Executive managers need to consider how they are supporting this to happen within their organizational culture if they wish to align the differences of professional cultural norms.

In addition, the demands on healthcare systems today in order to do more with less have created a myriad of conflicting goals for healthcare leaders, including access to services, high quality, cost containment, safety, effectiveness, convenience and patient-centeredness (Institute of Medicine, 2001). Porter (2010) contends that the "lack of clarity on goals has led to divergent

approaches, gaming of the system and slow progress in performance improvement" (p. 2477). The approach taken by many organizational leaders and the system in general has centered on cost reduction and the volume of services delivered. However, according to Porter (2010), by setting these goals without regard to actual patient health outcomes—what he describes as "value improvement"—healthcare reform efforts are doomed to fail. He suggests that 'value' be defined as patient health outcomes achieved relative to the costs of care. These costs of care reflect the total costs or the full cycle of care for the patient's condition, not just the costs involved in any one intervention or care episode. Should this strategy or trend for health reform evolve, the dominant organizational culture of evidence-based medicine aimed at interventions and outcomes that cure pathology will be redirected around outcomes that add 'value' for the patient as the central goal. Porter's work reflects how the culture of healthcare organizations is changing. The theory of *Intentional Partnering* addresses one aspect of this and identifies processes that individual professions such as nursing and medicine will need to experience in order to challenge conventional thinking and achieve a mutual understanding of patients' interests.

Furthermore, the strategies used by senior leaders in this study created an expectation for nurse and physician mangers to work together. They shaped the culture of the organization by sponsoring, matching and coaching nurse-physician clinical managers. Senior leaders should go further in articulating the need for nurse-physician management and present the model in a manner that supports the organization's commitment to improving collaborative practices for better patient care. In addition, the findings revealed that when people throughout the organization saw that their leaders personally embodied and practiced the organizational values

of working with their nurse or physician partner, this sent the message that these behaviors and actions were the defining and enduring cultural norms of the organization.

5.7.3. Directions for future research. A number of directions can be taken to advance and extend the findings of this study. The original analysis of the data was done to develop a theory; however, further exploration of particular concepts could provide additional contributions, particularly in developing interprofessional leadership competencies and understanding how roles can be shared. In addition the theory enhances our understanding of the complexities of the concepts and their properties and dimensions that can be used to assess the appropriateness of our current measurement instruments.

5.7.3.1. Interprofessional leadership competencies. The re-design of education for the health professions focuses on mutual learning and a competency-based approach (Frenk et al., 2010; Goudreau et al., 2009). Competency is defined as "being a complex, know-how that is based on combining and mobilizing knowledge, skills, attitudes and external resources and then applying them appropriately to specific types of situations" (Tardiff, 2006). Competency-based frameworks have been developed as standards for leadership practice (The Medical Leadership Competency Framework, Academy of Medical Royal Colleges and the National Health Services Institute for Innovation and Improvement, 2008; The AONE Nurse Executive Competencies, American Organization of Nurse Executives, 2011; Health Leadership Competency Model, 2006; Dickson & Tholl, LEADs in a Caring Environment, 2011). Each framework highlights domains such as "working with others", "managing relationships", and "engaging others", but the process of how this is accomplished has not been described. The key concepts of accepting mutual necessity, daring to risk (together) and constructing a shared responsibility explain the

key dyadic or relational processes at play in a nurse-physician management relationship as they work to align their professional agendas.

More research is needed that explores how nurse and physician managers learn and develop competencies to work in partnership in their clinical management roles. The findings from this study may inform the development of strategies to promote interprofessional leadership competencies. For example, future studies may consider working with expert managers to identify the most relevant processes for clinical managers on the front lines. Are strategies for navigating and addressing the emotional components of close working relationships a key consideration for interprofessional leadership competencies? In what context or in which situations do clinical managers need coaching from senior leaders? What needs to be put in place to ensure direct coaching is provided? Other interprofessional leadership competencies may relate to building trust. How do we develop and earn trust among nurse and physician managers? How is trust perceived and understood by the different professions? What are the conditions that facilitate and constrain the building of trust in healthcare organizations? Future studies may therefore want to consider the concepts of intentional partnering as a point of departure in interviews with individual managers or with nurse-physician dyads to flesh out these key areas.

In addition, there is little empirical literature on physicians' perceptions of the nurse management role, how they see their role in a co-leadership arrangement and how physicians describe their work together. This study provided a preliminary understanding and suggests that this would be an important area to explore in more detail. Learning more from physicians on what nurse managers are doing that makes them feel involved in management and leadership functions would be a valuable research direction. Moreover, exploring with both professions

where they feel their roles are complementary, such as in their use of influence, may inform co-leader role development and how roles can be shared. Further research is needed on how to develop a shared-role 'space' for managing together.

5.7.3.2. Instrument development and assessment. One major advantage of using grounded theory (GT) as a basis for instrument development and assessment is that it focuses attention on the matters of concern to participants and how they deal with these concerns within a social context (Hall & May, 2001). GT concepts are relevant and fit with day-to day life experiences that can inform or shape the content of an instrument. A well-developed GT will have a significant degree of concept specificity and provide a working definition of a concept that could be useful and amenable to measurement. The key for the researcher will be to identify properties and dimensions that are of particular significance and can be measured. This may require secondary analysis of the data. The relevance and complexity of the concepts derived from a grounded theory approach may help to critically assess the purpose and objectives of our current instruments and tools including the context and population at which they were originally targeted. Are they appropriate and are they measuring what is intended?

5.8. Limitations

Although a variety of partnerships were captured through theoretical sampling, there was little data on the "negative" case in which individuals did not want to partner or had tried partnering and decided not to continue the relationship. These individuals did not demonstrate interest in participating in the study at the time of recruitment. In retrospect, I could have been more vigilant in seeking out such participants later in the data collection as part of sampling for the negative case. Alternatively, I could have focused on negative experiences of partnering with participants in second interviews; however, time constraints within the interview period and the

challenges of arranging second encounters with physicians in particular were constraining factors. A preponderance of the data was collected at the senior management level, as this was where the partnering phenomenon occurred**.** Future studies may consider including one level of management across different hospital departments in order to develop a substantive theory pertaining to a specific level of management. Alternatively, one could design a study to explore how nurse and physician partnered managers affect the interactions at the staff level and the delivery of care at the bedside.

Future work may want to include outcome criteria and how daily interactions between nurse and physician partnered managers relate to job satisfaction, retention and recruitment of managers. Moreover, this study did not focus on contextual and structural factors, such as communication mechanisms and internal and external resources, which might have effects on the intentional partnering.

In addition, participant observation was an important data collection strategy that offered a precise lens for capturing interactional processes. Without it, the data would have been superficial in content and quality because describing how one works with another person was difficult for some respondents to articulate. Future studies need to consider the value of incorporating participant observation in the design.

As a novice student researcher in grounded theory, I decided to focus on one division within the hospital setting. Although I did exploratory interviews of another division of the hospital for comparative purposes, these data were not extensive. Conducting this study in other departments and services of the hospital would allow me to explore and compare how intentional partnering works in other contexts. Moreover, it would be important to consider different professional groups. What does intentional partnering look like with different professional

partners such as physiotherapists, psychologists and social workers? How do other professions work through the process of intentional partnering? How is it different and how is it the same?

Finally, there are concepts and relationships within the theory that appear to develop gradually or through stages. For example, earning trust had a temporal component that would benefit from a study design that examined trust in dyads that are at different places or stages in the alignment process.

5.9. Conclusion

The particular lens this study has looked through is that of dyadic interaction and attempting to reveal the nature of these interactions. The findings suggest that dyads may experience similar dynamics as identified in group development, such as forming, storming, norming and performing (Tuckman, 1965), but have a stronger ability to bind given that accountability is shared more closely. Intentional partnering captures the essential conditions for achieving greater unity and joint responsibility that Becker and Useem (1942) defined as unique characteristics of dyads. It is less clear what these responsibilities might entail for nurse and physician managers working together.

Langley and Denis (2010) argue that organizational innovation will fail unless the patterns of interests, values and power relationships that surround organizations are taken into account. Their observations support the finding of this research study that different values may underlie particular interests. Langley and Denis (2010) state:

> Different professional groups and providers tend to see the world in different ways, in correspondence with their training and experience ... dealing with disagreements about goals and values requires richer information exchange involving face to face discussions to find room for mutual understanding (p. 45).

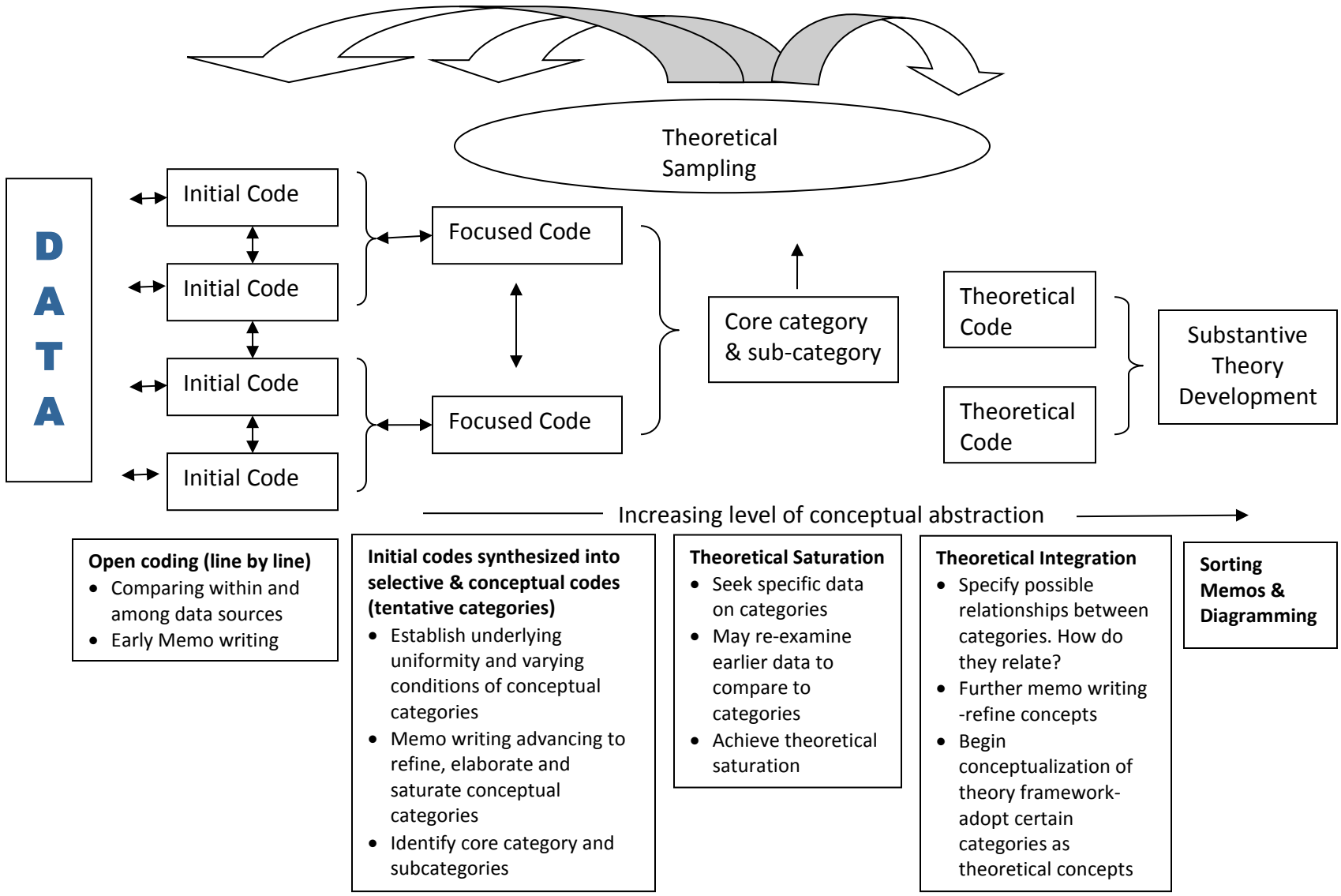
The theory of intentional partnering reveals the strategic actions within the context of face-to-face communication that are purposeful and carefully considered among partners in order to work through these dynamics. When partners are clear on why they are at the table, perhaps the process of intentional partnering changes. Certainly, in circumstances where individuals are more apt to protect agendas, actions not only need to be more deliberate but require a reflective mind-set. The findings also suggest that as nurses and physicians align professional agendas, the patient becomes the clear reason or motivation for working together. This is supported through identifying and sharing common professional and personal values.

Furthermore, intentional partnering highlights that although management issues, including issues related to the patient's interest, can be seen from different perspectives, both dialogues are required to make sustainable gains. Integrating these differences creates the partnership advantage but necessitates a foundation based on being credible, earning trust and safeguarding respect. According to Hodgson, Levinson, and Zaleznik (1965) and Denis and colleagues (2010), members of a collective leadership should have distinct roles based on their own skills, expertise and sources of influence but should work in a concerted manner towards the same end goal. Thus, a high degree of complementarity must exist between the members of the leadership team in order for collective leadership to be effective and for strategic change to be implemented. The process of intentional partnering highlights some of the distinct skills and expertise among nurse and physician managers. It also reinforces Alvarez and Svejenova's view (2005) that in addition to complementarity, commonality is a necessary element in working together, and that this is often discovered in the process and experience of working closely together.

The importance of intentional partnering for healthcare organizations cannot be understated. If individuals accept that the true purpose of organizations is to enable healthcare professionals to achieve in partnering what they could not achieve alone, then the main focus for senior leaders should be on how to develop strong partnerships (Hansen & Nohria, 2005). Senior nurse leaders can be instrumental in developing such initiatives. Furthermore, in order to achieve the maximum benefits of physician engagement, strategies must focus on developing capacities at the individual, relational, organizational and systems levels that will bridge and integrate professional cultures (Denis et al., 2013).

This research provides a theory of *Intentional Partnering* of the nurse and physician relationship that introduces an original perspective and adds value to nurse and physician management dyads at a time when the healthcare system is bringing in innovations that will lead to better outcomes for patients at lower costs. It considers the unique contribution of each profession in terms of healthcare management. The findings from this study describe and explain the essential conditions and key processes that can develop and support relational capacities in particular. The study maintains that 'successful' partnering requires a focus on processes in addition to outcomes. It illustrates that features relating to how partners interact are equally important to what is achieved by the partnership. Positive outcomes are, in effect, a natural by-product of the partnership. What needs to be considered is 'process' success, which includes the level of commitment and engagement of partners, agreement about the purpose and need for the partnership, high levels of trust, credibility and respect between partners as well as an environment conducive to partnering. The theory of *Intentional Partnering* is in this way a unique contribution to the body of knowledge on healthcare administration.

Figure 1. Schematic Conceptualization of Analysis Process



Appendix A

Example of Literature Search Strategy for Nurse-Physician Management Dyad

1. **Determined eligibility criteria for relevant literature**

   - Inclusion:
     - Nurse and physician, co-leader or co-manager, hospital or community setting, senior levels of management (i.e. department, service, or division).
     - No time limit
     - English
     - Peer-reviewed journals, books or periodicals
   - Exclusion:
     - Nurse-practitioner, nurse anesthetist, nurse midwife, as their scope of practice is autonomous, thus creating a unique relationship with a physician as partners. We are also interested in MDs, not physician assistants, as their scope of practice is also quite different.

2. **Identified information sources - A combination of the following sources were used in order to broaden the scope of the search**

   - **Bibliographic Databases:** *CINAHL, Medline, Medline in Process, Embase, PsychInfo, ABI Inform, Business Source Complete*
   - **Personal Files**
   - **Existing Literature Reviews:**

   a. Corser, W.D. (1998). A conceptual model of collaborative nurse-physician interactions: The management of traditional influences and personal tendencies. *Scholarly Inquiry for Nursing Practice: An International Journal, 12* (4), 325-341.

   b. D'Amour, D., Ferrada-Videla, M., San Martin-Rodriguez, L., & Beaulieu, MD. (2005). The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks. *Journal of Interprofessional Care, 19* (Supplement 1, 116-131.

   c. San Martin-Rodriguez, L., Beaulieu, MD., D'Amour, D., & Ferrada-Videla, M. (2005). The determinants of successful collaboration: A review of theoretical

and empirical studies. *Journal of Interprofessional Care, 19* (Supplement 1), 132-147

d. Sweet, S.J. & Norman, I.J. (1995). The nurse-doctor relationship: a selective literature review. *Journal of Advanced Nursing, 22*, 165-170.

e. Zwarenstein, M. & Bryant, W. (2005). Interventions to promote collaboration between nurses and doctors (Cochrane Review). In *The Cochrane Library,* Issue 4.Chichester, UK: John Wiley & Sons.

- **Manual search** in the list of references of included publications

3. Created Search Strategy and Conducted Search

- The process for identifying potentially relevant records or studies were guided by a specialized librarian
- Both a subject heading search for the specific database as well as a text word search was completed. The former normally leads to more relevant results.
- Endnote software was used in order to identify and remove duplicates

Example of Electronic Search

Database: Ovid MEDLINE(R) <1948 to May Week 4 2011>
Search Strategy:
---

1 ((nurses/ or nurse administrators/) and physicians/) or Physician-Nurse Relations/ (4120)
2 leadership/ or exp "Organization and Administration"/ (916186)
3 exp empirical research/ (12523)
4 1 and 2 and 3 (39)
5 nurse anesthetists/ or nurse clinicians/ or nurse midwives/ or nurse practitioners/ (26959)
6 4 not 5 (26)
7 limit 6 to english (26)
8 ((nurse or nurses) and (physician* or doctor* or MD or MDs)).ti,ab. (20496)
9 (collabor* or leader* or management or administrat* or govern*).ti,ab. (1216192)
10 (empiric* or qualit* or quantit* or mixed).ti,ab. (1079363)
11 8 and 9 and 10 (1723)
12 (nurse practition* or nurse assist* or nursing assist* or midwi* or physician assist*).ti,ab. (22903)
13 11 not 12 (1472)
14 leader*.ti,ab. (36007)
15 13 and 14 (173)
16 limit 15 to english (159)
17 7 or 16 (184)
18 from 17 keep 1,11-12,32,42,56-59,73,75,81,83,88,102,106,113,129,133,145 (20)

4. Selected Relevant Studies

- Screened titles
- Retained articles that referred to concept of ‘nurse-physician’ relationship with sample participants being managers.
    - In articles that were not clear, reviewed abstract for ‘nurse-physician’ relations, excluded on basis of exclusion criteria
- Retrieved full text articles corresponding to retained records
- Selected full text articles based on eligibility criteria

Appendix B

1. Summary of Study Participants

Participant Code	Sex	Age	Level of Management	Yrs. in Management	# of formal interviews	Obs. Data (Y/N)	Type of Obs. Data (Shadow, Meeting, Dyad, Triad)
EMM01	M	60s	Executive	25+	1	No	---
EMM02	M	60s	Executive	25+	1	Yes	M
ENM01	F	50s	Executive	25+	1	Yes	M
SMM01	M	50s	Senior	25+	2	Yes	M,D,T,
NSMM01	F	50s	Senior	1	1	Yes	M,D, T
SMM02M	M	60s	Senior	20-25	1	Yes	D,T
SNM02M	F	50s	Senior	20-25	1	Yes	D,T
SNM01	F	50s	Senior	20-25	7	Yes	S,M,D, T
SMM02	M	50s	Senior	25+	2	Yes	M, D, T
CMM01	M	50s	Clinical	20-25	2	Yes	M,D
CNM01	F	20s	Clinical	1-5	2	Yes	S,M
CNM01B	F	30s	Clinical	10-15	2	Yes	M,D
CNM02	F	50s	Clinical	25+	1	No	---
CNM03	F	30s	Clinical	5-10	1	Yes	M
CNM04	F	50s	Clinical	10-15	2	Yes	S,M
CMM04	M	50s	Clinical	20-25	1	Yes	M
CNM06	F	40s	Clinical	10-15	1	Yes	M,T
CMM07	M	50s	Clinical	20-25	2	Yes	M
CNS07	F	50s	Clinical	15-20	1	Yes	M
CNS01	F	50s	Clinical	20-25	3	Yes	M
NM.NSQIP	F	40s	Clinical	10-15	1	No	M
Total Participants= 21 N=12 (All female) P=9 (1 Female, 8 Male) Mode of age (N=50s; P=50s)			**Senior= 16 interviews Clinical= 15 interviews**	**Mode N=10-15 years P=20+ years**	**Total # of formal, transcribed interviews= 36**	**Senior=110 hrs. Clinical= 32 hrs. Total obs. time= 142 hrs.**	**S =18 hrs. M=61 hrs. D=28 hrs. T=35 hrs.**

***Ethics approval was obtained to include data from exploratory interviews and observations. These participants are included in this sample. This data was also helpful in establishing theoretical sufficiency and provides a comparison partnership outside of Surgery.**

2. Summary of Dyads

Dyad	Level of management	Years working together	Previous experience working in management dyad	Data collected
SNM01/SMM01	Senior	5-10	N	Obs & I
SNM01/NSMM01	Senior	<1	Y	Obs & I
SNM01/SMM02	Senior	5-10	Y	Obs & I
SNM02M/SMM02M	Senior	5-10	Y	Obs & I
CNM01/CMM01	Clinical	5-10	N	Obs & I
CNM01B/CMM01	Clinical	<1	N	Obs & I
CNM02/SMM02	Clinical & Senior	20-25	N	I
CNM03/CMM03	Clinical	5-10	N	I CNM03 only
CNM04/CMM04	Clinical	10-15	N	I
CNS07/CMM07	Clinical	5-10	Y	Obs & I
CNS01	Clinical	1-5	N	I

Appendix C

Letter of Approval from Ethics

Hôpital général juif
Jewish General Hospital

BUREAU D'ÉTHIQUE DE LA RECHERCHE
RESEARCH ETHICS OFFICE

Vasiliki Bessy Bitzas, N, PhD(C), CHPCN(C).
Chair, Research Ethics Committee
Bureau / Room: A-925
Tel: 514-340-8222 x 2445
Fax: 514-340-7951
Email: bbitzas@jgh.mcgill.ca
Website : jgh.ca/rec

September 3, 2013

Ms. Christina Clausen
Department of Nursing
SMBD-Jewish General Hospital

SUBJECT: **Protocol #13-104 entitled** "The Nurse-Physician Management Dyad: The Process of Working Together to Address Clinical Management Issues in a Hospital Setting"

Dear Ms. Clausen,

Thank you for submitting the following documents pertaining to the above-mentioned protocol to the Research Ethics Office for review:

- Revised Protocol dated May 24, 2013
- English revised consent form version 3 dated 2013-09-03

The Research Ethics Committee of the Jewish General Hospital (Federalwide Assurance Number: 0796) is designated by the province (MSSS) and follows the published guidelines of the TCPS 2 - Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (2010), in compliance with the "Plan d'action ministériel en éthique de la recherche et en intégrité scientifique" (MSSS, 1998), and the membership requirements for Research Ethics Board defined in Part C Division 5 of the Food and Drugs Regulations; and acts in conformity with standards set forth in the United States Code of Federal Regulations governing human subjects research, and functions in a manner consistent with internationally accepted principles of good clinical practice.

As this study involves no more than minimal risk in accordance with TCPS 2 article 6.12, this protocol received a delegated research ethics review. We are pleased to inform you that the above-mentioned documents are granted Delegated Approval for the period of one year.

For quality assurance purposes, you must use the approved REO stamped consent form when obtaining consent by making copies of the enclosed one. Please note that a French Consent

Form, as required by law, must be forwarded to the Research Ethics Office as soon as possible. For your information, the above-mentioned protocol will be presented for corroborative approval at the next meeting of the Research Ethics Committee to be held on September 20, 2013.

Delegated Approval Date:	**September 3, 2013**
Expiration date of Delegated Approval:	**September 2, 2014**

Your "Continuing Review Application" must be received by the Research Ethics Office **one month** before the expiration date above in order to ensure timely review. Otherwise, the study will be terminated. If any modification to the study occurs (amendment) over the next twelve months, or should this study be completed during this period, please submit appropriate documentation to the Research Ethics Office. Visit our website for information www.jgh.ca/rec and to access our downloadable forms, or contact us.

Sincerely,

Vasiliki Bessy Bitzas, N, PhD(C), CHPCN(C)
Chair, Research Ethics Committee

VBB/lm
13-104FinalExpeditedApproval.doc

Hôpital général juif
Jewish General Hospital

BUREAU D'ÉTHIQUE DE LA RECHERCHE
RESEARCH ETHICS OFFICE

Franca Cantini, M.Sc.N.
Chief, Research Ethics Office
BUREAU / ROOM: A-925
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EMAIL: fcantini@jgh.mcgill.ca
Website : jgh.ca/rec

August 30, 2013

Ms. Christina Clausen
Department of Nursing
SMBD-Jewish General Hospital

SUBJECT: Protocol #13-104 entitled "The Nurse-Physician Management Dyad: The Process of Working Together to Address Clinical Management Issues in a Hospital Setting"

Dear Ms. Clausen,

Thank you for submitting the above-mentioned protocol to the Feasibility Committee for review.

ACTION: The above-mentioned study was granted approval by the Feasibility Committee.

Please note that no study-related procedures or activities may begin unless final approval has been granted by the Research Ethics Committee and the Science Review Committee. Please ensure that Clinical Trial Agreement(s) are executed by the Institution prior to the initiation of the study.

Sincerely,

Franca Cantini, M.Sc.N.
Chair, Feasibility Committee

13-104FeasibilityApp.doc
Cc: Research Ethics Committee

Appendix D

Study Information Sheet

How do nurse-physician management dyads work together to address clinical management issues?

Christina Clausen, PhD candidate, McGill University
Supervisors: Dr. Melanie Lavoie-Tremblay, Ingram School of Nursing
Dr. Margaret Purden, Ingram School of Nursing, Scientific Director, Centre for Nursing Research, JGH

You are being invited to participate in this research study which is designed to look at nurse-physician manager interactions because you are a manager working in a formalized nurse-physician dyad in the Department of Surgery. You have the right to know about the purpose and procedures that are used in this research study, and to be informed about the potential benefits, risks, alternatives and discomforts in this study. Before you give consent to be a participant, it is important that you read the following information and ask as many questions as is necessary in order to understand what you can expect should you decide to participate. It is also important that you understand that you do not have to take part in this study.

Purpose of the study:
There is increasing interest to implement co-leadership/co-management models in healthcare organizations in order to improve performance, accountability, quality, and effectiveness of care; however little is known on how collaboration between leaders develops, evolves, or operates in healthcare settings. This study will explore how nurse and physician managers work together in formalized dyads to address clinical management issues as well as the factors that influence this work. Findings may shed light on how to support successful implementation of similar models. Throughout the data collection stage the researcher will observe and note phenomena related to nurse-physician manager interactions including verbal/nonverbal communication and contextual events that shed further light on the research questions. This can complement the data collected from individual interviews.

What can I expect if I take part in this study?
If you agree to participate in this study, the student researcher (Christina Clausen) will:

- Ask you to sign a written consent form if you wish to take part in the interviews and/or specific observation (scheduled dyad meetings and/or shadow) sessions. You can participate in the study and still request that certain conversations, statements or interactions not be documented.
- Contact you via email and/or telephone to arrange a time when she can attend your dyad meetings
- Ask to shadow and/or interview you. Shadowing will occur in the workplace (unit and/or office) and last for a time period that is convenient to you. It can range from 30 minutes to 4 hours. Informal questions may be asked during the shadowing session. The

semi-structured interview will be conducted in English, last 45 to 60 minutes and be conducted in a convenient and preferred location to you.
- Ask to have a brief follow up meeting (10-15 minutes) to clarify and elaborate on particular themes generated from the qualitative data analysis

How long will the data collection stage of this study take?
Data collection is expected to take place from September, 2013 to March, 2014

Are there any potential risks or discomforts that I can expect from this study?
Being observed or accompanied may make you feel uncomfortable and may be inconvenient. You may need to interact with someone who has not given written consent to participate in this project. If so, I will ask this person for consent prior to, or after the interaction, where such a request is unobtrusive to the situation at hand. If this is not granted, then this interaction will not be recorded. Please note that I am describing your activities, NOT evaluating them.

Are there any potential benefits if I participate?
You will not benefit directly from your participation in the research. The findings of this study may clarify nursing and medicine's unique contribution and role in working within a management dyad and suggest strategies for working in a dyad. Knowledge gained in this study may be translated to other settings where initiatives of co-managing/co-leading are being considered or implemented. Your department will be informed of the findings of this research.

Will information about me and my participation be kept confidential?
Any information that is obtained in connection with this study and that can identify you will be treated confidentially within the limits of the law. Confidentiality will be maintained by means of providing anonymizing codes to the data immediately after the observations and interviews; keeping codes and transcripts in separate, lockable filing cabinets; password-protecting the copies of electronic transcripts; and publishing data excerpts and general findings in such a way that you will not be able to be identified. You have the right to review, edit, or erase the research tapes or hand-written data of your participation in whole or in part.

What are my rights if I take part in this study?
- Your participation in this study is voluntary. You may choose to participate now and decide to stop your participation at any time. Whatever decision you make, there will be no penalty to you and no loss of benefits to which you were otherwise entitled.
- You may refuse to answer any questions that you do not want to answer and still remain in the study.
- I will not record events, statements, or conversations if you request them either not to be recorded or to be deleted during the observation or subsequently.

Cost and compensation
You will not receive any compensation to participate in this study.

Who can I contact if I have any questions about this study?

If you have questions about your rights while taking part in this study, you can contact Christina Clausen (340-8222 ext 5832 or email: christina.clausen@mail.mcgill.ca). If you have concerns or suggestions and you want to talk to someone other than me about the study, please call or email Dr. Melanie Lavoie Tremblay 514-398-8161/ melanie.lavoie-tremblay@mcgill.ca or Dr. Margaret Purden, 340-8222 ext 4871/ margaret.purden@mcgill.ca. If you have any questions about your rights as a participant, or wish to file a complaint you can communicate with the Local Commissioner of Complaints and Quality Services, Ms. Rosemary Steinberg ext.5833

Appendix E

Study Timeline

Data Collection Activity	Data Analysis	Date
Meet with Senior Nursing Manager		Aug.22, 2013
Meet with Chief of Surgery, Chief of Anesthesia and Associate Director of Nursing (TRIAD) to introduce study		Aug. 28,2013
Ethics Approval		Sept. 4, 2013
Reflexivity memo		
Observation begins with senior managers	Attending Triad, Nursing Executive, Nursing Directors, Shadowing SNM01 Recording field notes, initial memos	Sept. 11, 2013
Interview (EMM01)	Transcription, Field notes	Sept. 12, 2013
Practice interviews with:		
Physician colleague		Aug. 28, 2013
Committee member		Sept. 13, 2013
Interview (SMM01)	Transcription, Field notes, memos Open Coding	Sept. 25, 2013
Interview (SNM01) #1	Transcription, Field notes, memos Open coding	Sept. 26, 2013
Meeting with Supervisors	Review data collection strategy - how to plan, where to target observations Preparing for recruitment presentations	Oct. 3, 2013
Interview (SNM01) #2	Transcription, Field notes, memos Open Coding	Oct. 8, 2013
Recruitment presentation Surgical Divisional (HN, CNS)	Field notes	Oct. 8, 2013
Interview (SMM01) #2	Transcription, Field notes Open coding Constant comparisons –across interviews, observations, individual professions	Oct. 17, 2013
Modification for ethics recruitment approved		Oct. 17, 2013
Recruitment presentation Surgical Committee (All Surgical Chiefs of Departments)	Field notes	Oct. 21, 2013
Recruitment emails sent CNM01, CMM01, CNS01, CMM04, CNM04	Sent information sheet	Oct. 23, 2013
Interview (CNM02) #2	Transcription, open coding	Oct. 23, 2013
Recruitment interview to		Oct. 24, 2013

Data Collection Activity	Data Analysis	Date
explain study + consent CNS01		
Recruitment interview to explain study + consent (CNM04)		Oct. 24, 2013
Recruitment interview to explain study + consent (CMM04)		Oct. 24. 2013
Recruitment interview to explain study + consent (CNM01A)		Oct. 24. 2013
Recruitment emails sent to CMM07, CMM03	Sent information sheet	Oct. 28, 2013
Interview (SMM02) #1	Transcription, open coding	Oct. 30, 2013
Thesis Supervisor meeting	Compare coding with excerpts of data (Observations X2, interviews X2) Review recruitment and data collection plan given position changes in the organization, review interview schedule	Nov. 1. 2013
Begin observations at clinical management level		Nov. 1, 2013
Recruitment interview + consent (CNM03)		Nov. 4, 2013
Shadow CNM01A	Memo	Nov. 5, 2013 Nov. 6, 2013
Shadow CNM04	Memo	Nov. 11, 2013
Shadow CNM01	Memo	Nov.12, 2013
Surgical Committee	Field note, memo	Nov. 18, 2013
Interview CNM04	Transcription, field note	Nov. 19, 2013
Interview CNM03	Transcription, field note	Nov. 19,2013
	Coding moved into N-Vivo, Attend N-vivo workshop (Toronto, ON)	Nov. 25, 2013
	Skype meeting with classic GT methodologist, share excerpts from interviews x2 and observations x2 Decide to start theoretically sampling on recurrent concept in the data i.e. accountability in the next interviews. Discuss the basic shared concern around aligning professional agendas	Dec. 5, 2013
Interview (CMM01) #1		Dec. 6, 2013
Interview (CMM07) #1		Dec. 17, 2013
Interview (SNM02) #2		Jan. 8, 2014
Surgical Committee		Jan. 13, 2014
	Skype interview with classic GT methodologist	Jan. 29, 2014

Data Collection Activity	Data Analysis	Date
	Discuss limitations of using N-vivo as leaving codes at a descriptive level, fossilizing codes, not facilitating conceptual thinking Seeing main concern around bridging professional silos Review how basic social process is one way on how theory becomes structured Focus interviews around concepts related to this, building credibility, trust, what does it mean to work in a silo?	
Meet with supervisors	Gave update on data collection process Shared feedback from GT expert Shared limits regarding using software for coding. Make decision to move to paper and use of tables. Comparing clinical and senior management levels	Jan. 30, 2014
Interview (SNM01) #3	Observational data indicating that recurrent pattern identified Constant comparison across dyads Advanced memoing	
Meetings with Senior nurse executive begin to prepare OIIQ presentation	Saturating concepts Theoretically sampling during discussion of presentation	Feb. 21, 2014
Update on study with thesis committee members as not able to convene in one meeting	Presented basic social concern, diagrams, preliminary concepts and categories, power point on data collection process	Feb. 28, 2014 (LL) Mar. 3, 2014 (HE)
Interview (CNM01) #2	Theoretically sampling	Mar. 3, 2014
Meeting with thesis supervisors	Relay feedback from other members Present basic social concern, related categories Suggest to start writing out categories with data to support and submitting them – request to bring committee members closer to the data	Mar. 13, 2014
Surgical committee		Mar. 17, 2014
Full thesis committee meeting	Identifying various strategies used in managing the dyadic relationship. Decide to spend time on teasing them out. Write first draft of theory and consider core category as intentional partnering	Mar. 31, 2014
Shadow (CNM04)	Not able to capture observational data	Apr. 1, 2014

Data Collection Activity	Data Analysis	Date
	among the partners Decide to no longer use shadowing with clinical nurse and physician managers Had follow up informal interview with participant Saturating concepts and continue to theoretically sample	
Review with ethics the inclusion of particular manager for purposes of theoretically sampling however not part of a formalized dyads	Ethics agrees that including individual as participant fits with scope of the protocol provided	Apr. 1, 2014
Meet with senior nurse managers for OIIQ presentation	Advanced memoing on concepts identified in meeting – saturating concepts	Apr. 2, 9, 2014
Interview (CNS07) #1	Theoretically sampling	Apr. 10, 2014
Interview (SNM01) #4	Theoretically sampling Model emerging with categories and concepts	Apr. 23, 2014
Interview (ENM01)	Identify more categories around context, structure, organization Theoretically sampling Indicates I should speak with EMM02 and will facilitate the connection	Apr. 25, 2014
Recruit (CNM01B)	Consent obtained. Participant returning from Maternity leave. Long term partner of CMM01	Apr. 28, 2014
Recruit EMM02		Apr. 28, 2014
Surgical Committee		Apr. 28, 2014
Interview (CNS-NSQIP)	Theoretical sampling	Apr. 29, 2014
Interview (CMM04)	Theoretically sampling	May, 5, 2014
Interview EMM02		May, 6, 2014
Meeting with thesis committee member	Informant feedback Saturating concepts	May, 8, 2014
Continue observations	Saturating concepts Identifying new concept with fracturing relationships, resolving conflict	May 28, 2014
Present at the National Health Leadership Conference (NHLC), Banff Springs, AB	Write out categories, present a preliminary model – highly descriptive	June 2-8, 2014
Interview CNS 01	Theoretically Sampling	June 12, 2014
Interview CNM01B	Comparing with long term relationship Advanced memoing around concepts, diagramming, sorting, identify category of Accepting mutual necessity – core	June 17, 2014

Data Collection Activity	Data Analysis	Date
	category	
	Meet with B. Glaser	July, 30, 31, 2014
Interview SNM01 #5		Aug. 11, 2014
Receive ethics approval to use retrospective data from first exploratory interviews in another department to be included in data set	Obtain consent from participants who agreed to exploratory interviews (SNM02Med, SMM01Med)	Aug. 13, 2014
Interview NSMM01	Theoretically sampling	Aug. 13, 2014
Interview CNS01 #2	Theoretically sampling	Aug. 19, 2014
	Submit first draft of theory to supervisors – core category around accepting mutual necessity	Sept. 2014
	Meet with supervisors to look at data again and facilitate more conceptual thinking. Process reflects axial coding	Nov. 12, 2014 Dec. 15, 2014
	Commit to core category as Intentional partnering, identify 3 main categories, refine related concepts	
Informant feedback		Jan.20, 2015
Thesis committee meeting	Feedback on revised findings chapter	Jan. 21, 2015
Meeting with supervisors	Review data excerpts to refine and elaborate on concepts related to individual and organization	Feb. 9, 2015
Interview (SNM01) #6	Modified member checking, theoretical sampling	Feb. 19, 2015
Interview (CNS01) #3	Modified member checking, theoretical sampling	Mar. 6, 2015
Interview (CMM07) #2	Modified member checking, theoretical sampling	Mar. 9, 2015
Dyadic Interview (CMM01, CNM01B)	Modified member checking, theoretical sampling	Mar. 13, 2015
Thesis committee	Submit Methodology and Findings chapter to thesis committee members	Mar. 18, 2015
Thesis committee	Feedback on Methodology and Findings Chapters	Mar. 24, 2015
Interview (SNM01) #7	Comments and feedback from Findings chapter from SNM01	Apr. 22, 2015
Thesis committee	Submit Discussion & Implications Chapter to thesis committee	Apr. 24, 2015
Thesis committee	Feedback on Discussion & Implications from Committee	May 4-May 9
Thesis committee	Submit Draft 1 of Completed Dissertation	May 29, 2015
Thesis supervisors	Submit Draft 2	June 26, 2015

Appendix F

Example of Initial Semi-structured Interview Guide

Introduction & Purpose of Interview

I am interested in how nurse and physician managers work together to address clinical management issues. The interview should take 45-60 minutes. I will ask you to focus on concrete examples based on your experience and may ask you to elaborate on some of your responses. In many cases, I will ask you to provide further examples. Please do not hesitate at any time to ask questions. I would like you to be candid in your responses. None of the data is shared with senior or executive managers. I will make every effort to protect your confidentiality and anonymity.

Question

1. **Can you please tell me about how you started to work with your nurse/physician partner?** ***Please note that what I mean by formal partner is the nurse or physician that was or has been appointed to work with you to manage and lead a program, department or division of care. They should have a management position.***
2. **Please describe a recent, management issue or problem that you worked on with your formal nurse/physician manager partner. Prompts:**

   Tell me more about …

   Can you elaborate on …

   What happens when …

   Can you give me another example of …

In order to obtain variety of incidents, if the interviewee describes an issue that was effectively handled, I will ask them to describe one that was not so well managed and vice versa. Interviewees will be guided to describe the setting, what occurred, and the consequences of the situation, their successes and challenges.

3. **What helps you work effectively with a nurse/physician partner? What makes it harder to work together?**
   a. What type of support or resources do you use to work together?
   b. Has the organization been helpful? If so, how? If not, what needs to be put into place?

4. **What difference would it make to you working with or without a nurse/physician partner? Would you approach the situation differently? Yes or no and why?**
5. **What advice would you give to new managers who are being asked to work with a nurse/physician partner?**

6. **Is there anything else that would be important or useful for me to know?**

    - **Is there anything you would like to ask me?**
    - **Is there anything that you might not have thought about before that occurred to you during this interview?**
    - **Is there someone else that I should interview or a meeting that I should observe in order to learn more about what we have been discussing?**

7. **As I listen to the transcript of this interview, I may have questions about what was said or may want to clarify my understanding. If so, may I call you back for a brief follow-up?**

Socio-demographic Information

Gender __M____F
Approximate age ___30s, ___40s,___50s,___60s+
Number of years at this institution____
Number of years working in management____
Education in leadership and/or management_____
Number of years working in current management dyad____
Previous experience working in a dyad_____

Appendix G

Consent forms

How nurse-physician management dyads work together to address clinical management issues

Christina Clausen, PhD candidate, McGillUniversity
Supervisors: Dr. Melanie Lavoie-Tremblay, Ingram School of Nursing
Dr. Margaret Purden, IngramSchool of Nursing, Scientific Director, Centre for Nursing Research, JGH

You are being invited to participate in this research study which is designed to look at nurse-physician manager interactions because you are a manager working in a formalized nurse-physician dyad in the Department of Surgery. You have the right to know about the purpose and procedures that are used in this research study, and to be informed about the potential benefits, risks, alternatives and discomforts in this study. Before you give consent to be a participant, it is important that you read the following information and ask as many questions as is necessary in order to understand what you can expect should you decide to participate. It is also important that you understand that you do not have to take part in this study.

Purpose of the study:
There is increasing interest to implement co-leadership/co-management models in healthcare organizations in order to improve performance, accountability, quality and effectiveness of care; however little is known on how collaboration between leaders develops, evolves or operates in healthcare settings. This study will explore how nurse and physician managers work together in formalized dyads to address clinical management issues as well as the factors that influence this work. Findings may shed light on how to support successful implementation of similar models.

What can I expect if I take part in this study?
If you agree to participate in this study, the student researcher (Christina Clausen) will:

- Ask you to sign a written consent form if you wish to take part in the interviews and/or observation (dyad meetings and/or shadow) sessions. You can participate in the study and still request that certain conversations, statements or interactions not be documented.
- Contact you via email and/or telephone to arrange a time when she can attend your dyad meetings
- Ask to shadow and/or interview you. Shadowing will occur in the workplace (unit and/or office) and last for a time period that is convenient to you. It can range from 30 minutes to 4 hours. Informal questions may be asked during the shadowing session. The semi-structured interview will be conducted in English, last 45 to 60 minutes and be conducted in a convenient and preferred location to you.
- Ask to have a brief follow up meeting (10-15 minutes) to clarify and elaborate on particular themes generated from the qualitative data analysis

How long will the data collection stage of this study take?
Data collection is expected to take place from September 2013 to April 2014

Are there any potential risks or discomforts that I can expect from this study?
There are not any known risks for participants of this study however; interviews may impact your time and energy. Some people may find that discussing their experiences may raise unpleasant or upsetting feelings, thoughts, or memories. If you become tired or uncomfortable at any time during the interview, you may ask to pause or stop the interview. Being observed or accompanied may make you feel uncomfortable and may be inconvenient. You may need to interact with someone who has not given written consent to participate in this project. If so, I will ask this person for consent prior to, or after the interaction, where such a request is unobtrusive to the situation at hand. If this is not granted, then this interaction will not be recorded. Please note that I am describing your activities, NOT evaluating them.

Are there any potential benefits if I participate?
You will not benefit directly from your participation in the research. The findings of this study may clarify nursing and medicine's unique contribution and role in working within a management dyad and suggest strategies for working in a dyad. Knowledge gained in this study can translate to other settings where initiatives of co-managing/co-leading are being considered or implemented. Your department will be informed of the findings of this research.

Will information about me and my participation be kept confidential?
Any information that is obtained in connection with this study and that can identify you will be treated confidentially within the limits of the law. Confidentiality will be maintained by means of providing codes to the data immediately after the observations and interviews; keeping codes and transcripts in separate, lockable filing cabinetsin the Centre for Nursing Research of the JGH, password-protecting the copies of electronic transcripts and publishing data excerpts and general findings in such a way that you will not be able to be identified. Data will be kept for a period of 10 years. You have the right to review, edit or erase the research tapes or hand-written data of your participation in whole or in part.Only my supervisors/committee members and methodological experts involved in data analysis and I will have access to raw transcripts and field notes.

What are my rights if I take part in this study?

- Your participation in this study is voluntary. You may choose to participate now and decide to stop your participation at any time. Whatever decision you make, there will be no penalty to you and no loss of benefits to which you were otherwise entitled.
- You may refuse to answer any questions that you do not want to answer and still remain in the study.
- I will not record events, statements or conversations if you request them either not to be recorded or to be deleted during the observation or subsequently.

Cost and compensation
You will not receive any compensation to participate in this study.

Who can I contact if I have any questions about this study?

If you have questions about your rights while taking part in this study, you can contact Christina Clausen (340-8222 ext 5832 or email: christina.clausen@mail.mcgill.ca). If you have concerns or suggestions and you want to talk to someone other than me about the study, please call or email Dr. Melanie Lavoie Tremblay 514-398-8161/ melanie.lavoie-tremblay@mcgill.ca or Dr. Margaret Purden, 340-8222 ext 4871/ margaret.purden@mcgill.ca.

If you have any questions about your rights as a participant, or wish to file a complaint you can communicate with the Local Commissioner of Complaints & Quality Services, Ms. Rosemary Steinberg ext.5833

STATEMENT OF CONSENT

How nurse-physician management dyads work together to address clinical management issues

I have read the above information and my questions were answered to my satisfaction. A copy of this signed consent form will be given to me. My participation is voluntary and I can withdraw from the study at any time without giving reasons, without penalty to me and with no loss of benefits to which I am otherwise entitled now or later. I do not give up any of my legal rights by signing this consent form. I agree to participate in this study.

Signature of Study Participant

Name of Participant:_____

I agree to take part in an interview □ yes □no
I agree to being observed for a period of time □ yes □no

Signature of Participant:_____

Date:_____

Consent form administered and explained in person by:

Name of Person Obtaining Consent:_____

Signature of Person Obtaining Consent:_____

Date:_____

Content for Consent Form – CEO, DoN, DPS

How nurse-physician management dyads work together to address clinical management issues

Christina Clausen, PhD candidate, McGillUniversity
Supervisors: Dr. Melanie Lavoie-Tremblay, Ingram School of Nursing
Dr. Margaret Purden, IngramSchool of Nursing, Scientific Director, Centre for Nursing Research, JGH

You are being invited to participate in a research study designed to look at nurse-physician management dyads. You are being asked to take part because you are a senior manager/executive within the Jewish General Hospital who has influenced formalization of these dyads. You have the right to know about the purpose and procedures that are used in this research study, and to be informed about the potential benefits, risks, alternatives and discomforts in this study. Before you give consent to be a participant, it is important that you read the following information and ask as many questions as is necessary in order to understand what you can expect should you decide to participate. It is also important that you understand that you do not have to take part in this study.

Purpose of the study:
There is increasing interest to implement co-leadership/co-management models in healthcare organizations in order to improve performance, accountability, quality and effectiveness of care; however little is known on how collaboration between leaders develops, evolves or operates in healthcare settings. This study will explore how nurse and physician managers work together in formalized dyads to address clinical management issues as well as the factors that influence this work. Findings may shed light on how to support successful implementation of similar models.

What can I expect if I take part in this study?
If you agree to participate in this study, the student researcher (Christina Clausen) will:

- Ask you to sign a written consent form if you wish to take part in the interviews. You can participate in the study and still request that certain conversations, statements or interactions not be documented.
- Ask to interview you. The semi-structured interview will be conducted in English, last 45 to 60 minutes and be conducted in a convenient and preferred location to you.
- Ask to have a brief follow up meeting (10-15 minutes) to clarify and elaborate on particular themes generated from the qualitative data analysis

How long will the data collection stage of this study take?
Data collection is expected to take place from September 2013 to April 2014

Are there any potential risks or discomforts that I can expect from this study?
There are not any known risks for participants of this study however, interviews may impact your time and energy. Some people may find that discussing their experiences may raise

unpleasant or upsetting feelings, thoughts, or memories. If you become tired or uncomfortable at any time during the interview, you may ask to pause or stop the interview.

Are there any potential benefits if I participate?
You will not benefit directly from your participation in the research. The findings of this study may clarify nursing and medicine's unique contribution and role in working within a management dyad and suggest strategies for working in a dyad. Knowledge gained in this study can translate to other settings where initiatives of co-managing/co-leading are being considered or implemented. It may also inform current management education initiatives in the setting and within the each professional discipline. You will be informed of the findings of this research.

Will information about me and my participation be kept confidential?
Any information that is obtained in connection with this study and that can identify you will be treated confidentially within the limits of the law. Confidentiality will be maintained by means of providing codes to the data immediately after the observations and interviews; keeping codes and transcripts in separate, lockable filing cabinets in the Centre for Nursing Research of the JGH, password-protecting the copies of electronic transcripts and publishing data excerpts and general findings in such a way that you will not be able to be identified.Data will be kept for a period of 10 years. You have the right to review, edit or erase the research tapes or hand-written data of your participation in whole or in part. Only my supervisors/committee members and methodological experts involved in data analysis and I will have access to raw transcripts and field notes.

What are my rights if I take part in this study?

- Your participation in this study is voluntary. You may choose to participate now and decide to stop your participation at any time. Whatever decision you make, there will be no penalty to you and no loss of benefits to which you were otherwise entitled.
- You may refuse to answer any questions that you do not want to answer and still remain in the study.
- I will not record events, statements or conversations if you request them either not to be recorded or to be deleted during the observation or subsequently.

Cost and compensation
You will not receive any compensation to participate in this study.

Who can I contact if I have any questions about this study?
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If you have any questions about your rights as a participant, or wish to file a complaint you can communicate with the Local Commissioner of Complaints & Quality Services, Ms. Rosemary Steinberg ext.5833

STATEMENT OF CONSENT

How nurse-physician management dyads work together to address clinical management issues

I have read the above information and my questions were answered to my satisfaction. A copy of this signed consent form will be given to me. My participation is voluntary and I can withdraw from the study at any time without giving reasons, without penalty to me and with no loss of benefits to which I am otherwise entitled now or later. I do not give up any of my legal rights by signing this consent form. I agree to participate in this study.

Signature of Study Participant

Name of Participant:_____

I agree to take part in an interview ☐ yes ☐no

Signature of Participant:_____

Date:_____

Consent form administered and explained in person by:

Name of Person Obtaining Consent:_____

Signature of Person Obtaining Consent:_____

Date:_____

Appendix H

Oral Consent Script
(For participants of unplanned observations)

My name is Christina Clausen. I am a doctoral candidate in Nursing Administration at McGill University. My project examines the interactions between nurse and physician managers as they address management issues. I was hoping to note this conversation. You may decline to participate without any adverse consequences. It is completely confidential and anonymous. I can give you a study information sheet with your rights with you like, including to be able to decline to participate after this event. May I note your conversation?

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