

**Drawing Professional Boundaries:  
Professional organizations, communication and  
interprofessional collaboration in health care**

by

**Bernard Gauthier**

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# Abstract

This study aims to shed light on the process of drawing boundaries between cultural groups. Specifically, the study looks at how professional organizations draw boundaries by disseminating messages via their own websites, events and journals, and via more public channels such as advertising and media relations. The underlying assumption is that health professions function in many respects as cultural groups and that instances of interprofessional communication are effectively moments of intercultural communication. As with many such moments, questions of power must be considered as a cultural group's economic, political and symbolic power can affect how messages are both sent and interpreted.

The research is focused on a nurse practitioners and pharmacists during a period of time (2008-2011) in which the legislation in Ontario governing the acts that members of these professions can perform was subjected to a broad consultation and revisions. This generated considerable communication activity by professional organizations. As such, the move to renew the *Regulated Health Professions Act* (Bill 179) provided an important opportunity to observe the communication activity of professional organizations, and to assess the manner in which these messages are engaged and interpreted.

The study used a blend of focus groups with members of the pharmacy and nurse practitioner professions, individual interviews with executives of professional

organizations and with journalists, and a qualitative textual analysis of more than 200 texts drawn from professional journals and websites, and the news media.

The study found that messages – by a professional’s own organization and by other professions – attract the attention of health professionals, especially when these celebrate a profession’s identity or challenge a group’s claim to professional identity. The findings also suggest that these messages can create shared understanding and shared identity, serving to reduce the perceived differences between groups, and lowering the level of anxiety members of each group feel as they collaborate. On the other hand, messages can interfere with shared understanding, stress difference over commonality, and heighten anxiety. The actual experience of collaborating with members of other professions was found, however, to have a greater impact on attitudes and working relations in the long term.

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# List of Abbreviations

CFPC	College of Family Physicians of Canada
CMA	Canadian Medical Association
CMAJ	Canadian Medical Association Journal
CNA	Canadian Nurses Association
CNO	College of Nurses of Ontario
CPhA	Canadian Pharmacists Association
CPO	College of Pharmacists of Ontario
CPSO	College of Physicians and Surgeons of Ontario
DEA	Drug Enforcement Agency
HIV	Human immunodeficiency virus
HPRAC	Health Professions Regulatory Advisory Committee
JAMA	Journal of the American Medical Association
NEJM	New England Journal of Medicine
NPAO	Nurse Practitioners Association of Ontario
OMA	Ontario Medical Association
OPA	Ontario Pharmacists' Association
PA	Physician Assistant
PharmD	Doctor of Pharmacy
RNAO	Registered Nurses Association of Ontario
SGFP	Section on General and Family Practice

# Chapter One - Introduction

In the field of communication studies, there is a diverse and rich tradition of research into the particular challenges of communication between members of different cultural groups. For many (notably Rogers, 1999) who have studied the history of intercultural communication research, that tradition started with Georg Simmel and the Chicago School, and now extends more than 100 years. Two scholars from the Chicago School in particular proposed concepts that are explored and extended in this dissertation. Simmel (1903) proposed that cohesive cultural group identity is often forged as members of one group contrast and distance themselves from members of another group. Writing from the increasingly diverse Berlin at the turn of the 20<sup>th</sup> century, Simmel described how, when an individual encounters a member of a different group, he or she asserts him or herself through opposition: “the first instinct with which it affirms itself is negation of the other party” (p. 503). On a social scale, the same pattern of self-affirmation through opposition to the other is evident: “society likewise requires some quantitative relation of harmony and disharmony, association and dissociation, liking and disliking, in order to attain a definite formation” (p. 491). Simmel adds, paradoxically, that enmity between people of different groups makes possible “a secure and complete community life” (p. 492).

Harold D. Lasswell also contributed much to the understanding of intercultural communication and provided an important theoretical framework for this study. In

particular, Lasswell (1935) understood that symbols in the media could play a role in invoking the association/disassociation dynamic<sup>1</sup>, in forming stereotypes, and in setting a stage for the individual contact that might follow. The symbolic environment could precipitate insecurities, he argued, often leading to the elaboration of rival symbols: “Hence vehement campaigns of denunciation in the foreign press may be expected to arouse hostile forms of counter expression” (p. 7). Finally, Lasswell understood that “local interests can profit by propagating insecurity,” and that the dissemination of symbols that provoke an insecurity reaction among members of a group could be deliberate and strategic.

Raymond Williams’ understanding of the role of power and equality in intercultural communication is also important to this dissertation. “The inequalities of many kinds which still divide our communities,” he wrote in *Culture & Society* (1958), “make effective communication difficult or impossible.” Differing levels of economic, political and symbolic power can themselves be the basis for the association/disassociation dynamic and can render communication between members of different groups all the more challenging.

These, then, are the processes which this study will attempt to observe and illuminate: how messages in the mass media invoke the association/disassociation and invite or incite members of groups to draw boundaries. As they engage, interpret and

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<sup>1</sup> Lasswell (1935) used the terms “affirmation” and “counteraffirmation” (p. 33).

respond to these messages, individuals can express their cultural identity in opposition to members of another group.

At a time when increasing numbers of individuals and cultural groups have access to multiple channels of communication, the opportunity for these kinds of symbols and rival symbols is multiplying with each new website, social media account, uploaded video, letter to the editor and media interview. In a crowded media environment, boundaries are being drawn by ever more groups and in ever more ways. With each boundary, an in-group is identified and drawn closer together, while simultaneously an out-group is set off from the others. As Stuart Hall expresses unequivocally: “Throughout their careers, identities can function as points of identification and attachment only *because* of their capacity to exclude, to leave out, to render ‘outside’, abjected” (1996, p. 5). Wodak et al. (2009) similarly describe how in “imagining national singularity and homogeneity, members of a national community simultaneously construct the distinctions between themselves and other nations, most notably when the other nationality is believed to exhibit traits similar to one’s own national community, similar to what Freud called “the narcissism of small differences” (p. 4). The drawing of boundaries and distinctions through messages in mass media channels, Said (1994) cautions, can result in a society defined by “the rigidly binomial opposition of ‘ours’ and ‘theirs’” (p. 227).

### **Professions as Cultural Groups**

The aim of this study is to observe and shed light on the processes of drawing boundaries between professions. That process includes moments when professional organizations disseminate messages via their own channels (e.g., website, events and

journals) and via more public channels such as advertising and media relations. The underlying assumption here is that health professions function in many important respects as cultural groups and that, as such, instances of interprofessional communication are effectively moments of intercultural communication. John R. Hall's (1990) definition of culture offers a useful starting point for clarifying and supporting the assumption.

Culture, for Hall, has both symbolic and material components:

Culture, counterposed to society and social action, may be understood as (1) the 'knowledge' and recipes, (2) humanly fabricated tools, and (3) products of social action that in turn may be drawn upon in the further conduct of social life... we had best recognize culture as involving not only symbols and ideas but also social practices in relation to self, others, and material objects (p. 20).

The knowledge and recipes of a profession can include both technical knowledge (e.g., clinical guidelines for a particular surgical procedure) and ethical norms. The humanly fabricated tools of a profession can range from particular items of clothing (e.g., a judge's robe and wig) to precision tools (a physician's stethoscope or surgeon's scalpel). The products of social action can include the prestige and collegiality that define conduct involving professionals. Professions as cultural groups, I would argue, *do* create powerful and enduring symbols, enduring social practices and material objects.

I am careful, however, to acknowledge important limits in the extent to which professions function as cultural groups. Here, Raymond Williams' definition of culture in *The Long Revolution* (1961) is helpful. Williams suggested culture is composed of three integrated components: a set of ideals, a body of work, and a total way of life (p. 41).

Professions, as I suggested above, do set and transmit ideals – ethical and technical – for their members. Through education, professional journals, continuing professional development and intra-professional interaction, professions also create, transmit and preserve a vast and growing body of knowledge. It is fair to say, however, that professions fall somewhat short on Williams’ third dimension of culture. As compared to cultural groups built around shared nationality and/or religious beliefs, professions do not foster as widely shared and as *total* a way of life.<sup>2</sup>

A number of academic disciplines provide support for the idea that professions function in many ways as cultural groups. Within sociology and communication studies literature, Simmel listed “occupational groups” as an example of group affiliation (1922/1955, p. 138), while Cooley wrote of physicians as “something of a psychological unit,” (1924, p. 209), and Lasswell suggested that cultural identity with others can come from attending the same college or acquiring the same skill (1935). In *The Student Physician*, Merton defined the socialization of medical students as “the process through which individuals are inducted into their culture” (1957, pp. 40 – 41). In *The Boys in White*, Becker, Geer, Hughes and Strauss described the emphasis on clinical experience and medical responsibility as key concepts from “medical culture” (1961, p. 239) and explored, from a symbolic interactionist perspective, how medical students assimilate the values of this culture as part of their formation as physicians. More recently, Eliot

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<sup>2</sup> This does not preclude the possibility that members of a profession share certain elements of a way of life. The specialized knowledge they apply, their common aptitudes, their shared education, common occupation, their common levels of power and shared economic status all suggest that the lifestyles and experiences of members of a given profession may indeed be shared.

Freidson (2001) argued that a shared ideology is a defining feature of professionalism. He points to a shared education, common practice challenges and a common need for more advanced knowledge and techniques as the driving forces behind this ideology. Though he consciously avoids the term “culture,”<sup>3</sup> Freidson argues that members of a profession develop “a strong sense of occupational community” that “sustains the occupation as a whole, its reputation, its jurisdiction, and its practicing discipline” (p. 100). Indeed, echoing Simmel’s notion of association and disassociation, Freidson argues that a profession “cannot help but be exclusive. If it did not exclude from membership those who lacked any consciousness of common experience, interest and commitment, it would be an entirely different kind of group, perhaps not a group at all” (p. 202).

Anthropology also offers support for the idea that professions function as cultural groups. Margaret Locke, for example, demonstrates how, far beyond the imposition or sharing of techniques and technical information, professional biomedicine represents a distinct culture that imposes certain assumptions and structures, challenging and interacting with local cultures. Locke argues that biomedicine imposes a particular and hegemonic conception of the human body on physicians – “the universal body” (1993, p. 331) that is biologically determined and hence constant across time, cultures and locations. She contrasts this with her conception of “local biologies” (ibid.), citing her research into the experience of menopause in North America and Japan. Good and Good, in their anthropological study of students at the Harvard Medical School, make a similar

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<sup>3</sup> Freidson derides the term culture as a “formless, catch-all term which can refer to almost anything” (2001, p. 106).

case, arguing that the medical world is “literally constructed in the experience of the students” (1993, p. 84). The shared experience of medical professionals around the world contributes to their shared culture and sense of identity. They document how biomedicine provides its practitioners with “an alternative way of seeing” (p. 96) determined by a scientific perspective. Good and Good also introduce the notion of hybridity when they note that “non-Western physicians of Western medicine are shown to bring their culture to their medical knowledge and practice” (1993, p. 82). Similarly, Sassen raises the possibility of physicians (among other urbanized professional immigrants) “identifying with larger communities of practice or membership (which) can bring about the partial unmooring of identities... While this does not necessarily neutralise attachments to a country or national cause, it does shift this attachment to include trans-local communities of practice and/or membership” (2002, p. 230). The individual physician’s identity, then, may emerge as a hybrid that integrates their national identity, their identity as a medical professional, and more particular identities related to work setting and specialization.

Historical approaches to the study of professions have also provided support for the position that professions function as cultural groups. Rosemary O’Day (2000) in particular traces the history of modern professions to 17<sup>th</sup> century clubs of physicians and lay people with an interest in medical sciences. The definitive move of medical studies to the university and later to hospitals allowed for both the institutionalization of medical knowledge and teaching, as well as an intensification of the interaction between physicians. It is at this point, O’Day argues, that a distinct identity emerged and the profession of medicine became a community with the “emergence of an *esprit de corps*” (p. 191). O’Day very much echoes Simmel’s notion of the complementary role of

association and disassociation when she writes that the shared background, training and worldview of physicians “separated their members from the rest of society” and allowed them to “dissociate themselves from the practical training of their lower branches” (p. 43).

### **Professional Cultures as Barriers**

The challenges of intercultural communication are widely recognized in the context of health care, where members of many different professions must communicate and collaborate on a daily basis, often in high pressure, fast-paced situations. Interprofessional collaboration is defined as more than simply members of different professions providing care to shared patients in the same setting – what Pecukonis, Doyle and Bliss (2008) label multidisciplinary practice. Rather, interprofessional collaboration or interdisciplinary practice “incorporates a collaborative and integrated program of care that celebrates and utilizes the interdependent knowledge, skills, attitudes, values and methods each profession brings to the health care system” (p. 419). The authors go on to note how culture can serve as a barrier to collaboration and integration. Professional culture, they argue, helps shape the distribution of power in the workplace and provides meaning to core concepts such as health, illness and treatment success. Drawing from the work on ethnocentrism of American sociologist William Graham Sumner, they also argue that members of professions can exhibit profession-centrism as “each group nourishes its own pride and vanity, boasts itself superior, exalts its own divinities and looks with contempt on outsiders” (Sumner, 1906, p. 13).

Mary-T. Dombeck similarly argues that “historical background, training, territoriality, boundary issues, integrity and tolerance for differences are similar between professional groups, as they are between other social and cultural groups” (1997, p. 10). Pippa Hall in her article “Interprofessional teamwork: Professional cultures as barriers” makes the same point: “Each health care profession has a different culture, including values, beliefs, attitudes, customs and behaviours” (2005, p. 188). She further argues that differing levels of power can render communication between members of different professions all the more challenging: “Gender and social class issues have been factors in the friction and conflict that has existed between professions until present day. They colour the basic values and world view of all the professions” (p. 189).

Stevens and Rogers (2009) likewise argue that enhanced communication and patient safety require “the elimination of local politics and traditions” (p. 92). Wackerhausen echoed Pippa Hall’s emphasis by equating “Professional identities, boundaries and barriers” (2009, p. 458) and by arguing that to become a fully acknowledged member of a profession, the neophyte must “acquire and behave according to the (tacit) ‘cultural dimensions’ of the profession” (p. 459). Wackerhausen also articulates one of the key points of this study when he cautions that “... if professional self-esteem and identity rely too much on negative narratives about neighboring professions, interprofessional collaboration can be severely hampered” (p. 461).

## **Communication and Interprofessional Collaboration**

Communication is widely recognized as key contributor to effective interprofessional collaboration. A study by the Joint Commission on Health Care

Accreditation in the U.S., for example, found that 60% of what it terms sentinel adverse events between 1995 and 2004 were the result of poor communication (as quoted in Velji et al., 2007). Leonard, Graham and Bonacum (2004) similarly assert that the complexity of modern health care makes it “critically important that clinicians have standardized communication tools, create an environment in which individuals can speak up and express concerns, and share common ‘critical language’ to alert team members to unsafe situations” (2004, p. i85). The authors build on the notion of shared language to discuss how members of different health professions are taught to communicate using different styles, creating barriers to effective communication and collaboration. Pecukonis et al. (2008) also argue that communication is a central process within collaboration, stressing that success depends on the extent to which the clinical assessments of all members of an interprofessional team “are systematically codified, shared, discussed, coordinated and implemented...” (p. 419).

### **Professions and Professional Journals**

To return to Raymond Williams’ definition of culture, one of the principal reasons why many professions have successfully performed as cultural groups for so long is that they possess not only ideals but also an enduring and influential body of work: recognized and authoritative journals, conferences, websites and media spokespeople that together transmit the ideals of the profession to members and, quite often, to the lay

public. To be certain, the microphysics<sup>4</sup> of professional culture – the interpersonal communication between members and aspiring members in the classroom<sup>5</sup>, workplace and social milieu – is of great importance in the maintenance and evolution of professional culture and the subject of much research on the topic of professional culture and of interprofessional collaboration. My interest for this study, however, is the macrophysics of professional culture: how the mass media and channels of professional communication are put to the service of defining, maintaining and repairing the culture of professions, and how these practices might affect relations and collaboration between members of different professions. Since much of the textual analysis for this study will focus on professional journals, it is important to establish that these are influential and worthy of close scrutiny.

Much of the literature on the socialization of professionals does not focus on journals or other publications, seeing post-secondary education instead as the premiere site of socialization.<sup>6</sup> Studies of socialization in medical schools (from Merton et al., 1957 and Becker et al., 1961 to Haas & Shaffir, 1991) are plentiful, and studies of students in other health disciplines (i.e. Loseke & Cahill, 1986; Horsburgh et al., 2006;

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<sup>4</sup> I borrow the term, and its opposite – macrophysics – from Michelle and Armand Mattelart (1992) and their discussion of the various means by which power is exercised.

<sup>5</sup> The Future of Medical Education in Canada MD Education Project, in its final report on how to modernize undergraduate medical education, used the term “hidden curriculum” to describe the interaction between medical students and physicians, noting that this informal and influential curriculum often runs counter to the official curriculum found in more formal channels such as text books and medical journals (Future of Medical Education in Canada, 2009, p. 23).

<sup>6</sup> The attitude is summed up well by Merton et al. (1957): “The school is regarded as a decisive middle term between the native and previously trained capacities of selected individuals and the emergence of the professional self, the identification of these individuals, by themselves and by society, as medical doctors” (op. cit., p. viii).

Pecukonis et al., 2008; Björke & Haavie, 2006) are also common. Interest in medical journals as a contributor to socialization is secondary – a position summed up by Freidson: “... what is left to concerned leaders of the profession is exhortation and, hopefully, instruction of anonymous practitioners by means of articles in professional journals which may not be read” (1970, p. 198). Williamson similarly sums up his position on the role of personal influence in the adoption of new drugs as compared to articles in professional journals: “There are numerous studies which attest to the fact that information alone is insufficient for adoption” (1975, p. 235).

A second body of work does consider the influence of journals, though as a source of indirect influence. Katz, following up on his highly influential work with Lazarsfeld (Katz & Lazarsfeld, 1955), focuses on medical journals as a site of professional socialization, expanding on his idea of the two-step flow of communication – from opinion leaders who consume the mass media to their friends, colleagues, family and acquaintances. Katz and Menzel (1956) found that opinion leaders in medicine were more likely to cite articles in journals as the most common source of information on new drugs they had recently begun prescribing. Geertsma, Parker and Whitbourne arrive at similar conclusions from their interviews with physicians on how these viewed the process of change in their practice. “Any of a variety of informational sources may focus a change,” they wrote, “but follow-up is overridingly dependent on colleague communication (representing local professional opinion) and journals (representing an authoritative professional perspective)” (1982, p. 752). Citing the readership research of the *Canadian Medical Association Journal* (CMAJ), Woods confirms the two-step flow process proposed by Katz and Lazarsfeld by stating: “Fundamentally, what readers are looking

for is editorial material that will make them look smart to their peers” (1985, p. 261). This two-step perspective leaves journals as still a secondary source of influence but nonetheless recognizes the catalytic role they can play.

Other authors suggest a more direct role for journals in maintaining and repairing a particular professional culture or paradigm *after* education. Kuhn, for example, writes that “What quantum mechanics means to each of them depends upon what courses he has had, what texts he has read, and which journals he studies” (1962, p. 50). Cerling similarly suggests “medical journals are the rhetorical handbooks of medical practice” and “effectively constitute the vocabulary, grammar, argumentative fields and rhetorical practices of medical practice” (1989, pp. 94-95). Elias (2008) suggests that students and recent graduates of auditing programs who read professional journals are demonstrating greater professional commitment by participating in anticipatory socialization; as such, they are more likely to respect the ethical codes of the profession.

As Scientific Editor of the *CMAJ*, Morgan argues that while journals are “a poor substitute for grand rounds or a clinicopathological conference,” their “generally well read and influential editorials” (1985, p. 263) are the closest approximation in writing of live interaction with peers and opinion leaders. This emphasis on the editorials of medical journals (as opposed to their more scientific articles) is taken up by other, often critical authors, who note the considerable influence these editorials can have on media coverage, public debate and government policy. Dysart (2000) chronicles the rhetorical strategy and influence of two articles on physician-assisted suicide in the *New England Journal of Medicine* (*NEJM*) and the *Journal of the American Medical Association* (*JAMA*). Kates (1995) laments the influence of the *NEJM* on the debate on gun control in the U.S., while

Martin (1994) calls into question the extent to which articles in *JAMA* on the cigarette marketing character Joe Camel comply with ethical guidelines for social science research. Implicit in the decision to critique these articles is the idea that medical journals do influence coverage, debate and policy.

Altman (1981) introduces another dimension of potential influence when he reminds readers of the *British Medical Journal* that publication of a paper in any peer reviewed journal “may influence both medical practice and further research by other scientists, and if the subject is of general interest the ‘mass media’ may report the findings” (p. 44). This potential for influence via the mass media has been widely studied by both health and communication scholars (i.e. Caudill & Ashdown, 1989; Molitor, 1993; Martin, 1994; Kiernan, 1998; Blumenthal, 1998; Pratt, Ha & Pratt, 2002; Ford, 2006; Moriarty & Stryker, 2008). Gasher et al. neatly sum up the role of the medical journal, citing Canadian health reporter Brad Evenson of the *National Post*: “The foundation of the beat is really the medical journals” (2007, p. 564). Often using content analysis, these researchers trace the influence of articles and editorials in medical journals on the resulting coverage of medical conditions and treatments in the mass media.<sup>7</sup>

Still other researchers have explored the influence of advertisements that appear in medical journals. As early as 1960, Ferber and Wegner studied medical journals as advertising channels and found that these publications “enjoy a high degree of readership among physicians and, therefore, are an important instrument in the pharmaceutical

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<sup>7</sup> Kiernan (2003) completes the circle when he finds that coverage in daily newspapers, in turn, led to more citations of these studies in other medical scientific journals.

marketing process” (1960, p. 65). Walton (1980) arrived at a similar conclusion twenty years later, finding that exposure to pharmaceutical ads in medical journals increased the likelihood of a physician prescribing the advertised drugs. Aber and Hawkins meanwhile studied the way women were portrayed in medical journal advertisements (Hawkins & Aber, 1988) and, later, the “outdated and stereotypical” way nurses were portrayed in ads that appeared in both medical and nursing journals (Aber & Hawkins, 1992, p. 291). This focus on the representation of women in medical journals is joined by similarly oriented research into the representation of Chinese immigrants in early-1900 California medical journals (Power, 1995), representations of people with the Human immunodeficiency virus (HIV) and hepatitis C (Körner & Treloar, 2006), representation of infectious diseases in Africa (Pratt & Pratt, 2002) and the portrayal of heart disease (Clarke & Binns, 2006). Here again, the decision to analyze representation in medical journals suggests the authors are concerned about the impact of these publications on their readers directly and on society at large.

What these studies suggest is that the official publications of health professions are an important and influential catalyst that can shape future interaction between members of the profession. The messages transmitted by these channels are often read and circulated by many and the manner in which certain segments of the population are represented within their pages is worthy of close attention by communication scholars.

## **Methodology**

This study used a blend of qualitative methodologies that include focus groups with professionals, and qualitative textual analysis of the professional channels of mass

communication. This dual methodology is intended to overcome the shortcoming identified by Liebes and Katz (1990) that as “critical theorists became aware they were studying texts without readers, gratifications researchers came to realize that they were studying readers without texts” ( p. 18). This study, then, considers both the texts and the readers, positioning it as a “reception study” that “considers analyses of both the programme and the interviews” (Hoijer, 1990). In addition, the study included interviews with executives and communication professionals working in associations that represent health professions as well as with journalists who cover health professions. In this way, the study considered the texts, the readers and the producers of the texts.

## **The Context**

The specific case at core of this study is the introduction and passage of Bill 179 (the *Regulated Health Professions Act*) in Ontario. Passed in 2009, the *Act* redraws the jurisdictional boundaries between physicians, nurse practitioners and pharmacists, with the latter two professions acquiring the right to prescribe certain medications and order certain diagnostic tests in certain conditions – rights that had been held exclusively by physicians.

This shift in traditional roles prompted considerable professional communication, advertising and media relations activity in the province. Notably, on September 23, 2009 an article by Canadian Press reporter Keith Leslie (see Appendix 1.2) appeared in certain newspapers and on news gathering websites with a headline that read: “Letting pharmacists prescribe drugs like letting flight attendant fly plane: OMA” (Leslie, 2009). The headline paraphrased a quote in the story by Dr. David Bridgeo, Chair of the Ontario

Medical Association's (OMA) Section on General and Family Practice (SGFP). That same week, a full-page advertisement appeared in *Maclean's* magazine (see Appendix 1.4) featuring a bold photograph of a fearful eye peering through hands clutched protectively around a face. The ad warned that "when healthcare professionals work without the involvement of a physician, patient care and patient safety can suffer" (Section on General and Family Practice, 2009). The sophisticated public relations and advertising effort of the SGFP prompted an immediate response from pharmacists and nurse practitioners in the province, and in particular their respective professional associations. Through letters to the editor, media releases and messages on association websites, the two professions reassured the public and the provincial government by stressing their education, capabilities and ethical standards.<sup>8</sup> There was, to return to the Chicago School concepts introduced at the start of this chapter, considerable use of symbols in the media to invoke the association/disassociation dynamic. The initial symbols prompted strong rival symbols, many of which appear to have been designed to provoke anxiety – an insecurity reaction.

The study, then, is largely focused on the nurse practitioner and pharmacist professions in Ontario. Both professions were directly affected by Bill 179, gaining new privileges which had previously been available only to physicians in the province. Moreover, both professions were specifically referenced in many of the messages disseminated by the medical profession. Given this, the professional organizations

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<sup>8</sup> The Ontario Pharmacists' Association, for example, issued a media release stating: "Like doctors, pharmacists are highly trained and regulated healthcare professionals with clear standards of practice designed to protect patient safety" (Ontario Pharmacists' Association, 2009).

serving pharmacists and nurse practitioners were most involved in disseminating rebuttal texts after the SGFP campaign.

## **Methodology – Focus Group**

The focus groups were conducted first so that the findings could inform the deductive category development (Mayring, 2000) that would later guided the qualitative textual analysis. The focus groups were designed to shed light on the types of texts and images that most engage professional audiences and those that prompt professionals to engage in boundary work, foster professional identity and heighten perceived differences.

The methodology mirrored in many respects the approach used by Liebes and Katz in *The Export of Meaning: Cross-Cultural Readings of Dallas*. Participants were shown a series of texts which had been produced by the medical profession as well as texts produced by their own profession (see appendices 1.1 through 1.12 for the texts shared with participants). Using a consistent moderator’s guide (see Appendix 2.1), participants were then invited to discuss how they engaged and interpreted each text. Discussion then shifted to whether and how the texts might influence the interprofessional communication and collaboration between them and their colleagues. Using a range of texts and unstructured questions<sup>9</sup> served to minimize the direction in this aspect of the study and allowed participants to decide and express collectively which of

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<sup>9</sup> The approach was originally advocated by Merton and Kendall in their influential 1946 article on “the focused interview” (Merton & Kendall, 1946)

the texts are the most engaging and which, if any, prompt boundary work and the formation of professional identity.

The group context may have indirectly suppressed or limited the expression of particular points of view (Kitzinger & Barbour, 1999) and it is possible that the findings may have been different had individual interviews been undertaken instead. Given that focus of the study is primarily on shared cultural identity, and given the manner in which “focus groups facilitate the collection of data on group norms” (Kitzinger, 1994, p. 109), it was felt that the advantages of a group setting outweighed the disadvantages. The groups were composed entirely of members of a single given profession, such that the conversation between members who share similar experiences in health care would create a comfortable environment in which members would feel at ease discussing professional issues<sup>10</sup>.

Though Bill 179 affected roles and responsibilities for numerous health professions in Ontario, the focus groups for this study were conducted solely with nurse practitioners and pharmacists. As mentioned, these were the two professions most represented by the SGFP campaign and most engaged in rebuttal efforts. Focus groups with physicians were also considered for this study but not undertaken for two reasons. First and foremost, my interest lies in how members of professions that wield *less* cultural, economic and political power than medicine interpret the messages of medical organizations. This study focuses on how members of a professional group engage with,

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<sup>10</sup> Kitzinger cites this as one of the principal advantages of such an approach for research related to health care (Kitzinger, 1995)

interpret and mobilize a response to texts that are about them but created by another, more powerful group. Second, and more pragmatically, the costs of conducting focus groups with physicians can be prohibitive since physicians are often recruited for focus groups by pharmaceutical companies, who reward physicians for their time with cash incentives and create heightened expectations for significant compensation for participating in focus group. It's clear that there is a place for a complementary study that explores how physicians themselves interpret their association's messages and those of rival campaigns. Such a study, however, was beyond the limited resources available for this study and not as closely aligned with my interests. This being said, the perspective of the medical profession is captured in this study, thanks to interviews with executives from medical organizations and textual analysis of medical publications and websites.

Potential participants were approached in person at their place of work or, in the case of nurse practitioners, at a provincial conference using space provided by the NPAO specifically for research recruitment. In addition, the Ontario Pharmacists' Association (OPA) and NPAO both agreed to send a brief message to members via email alerting them to the study and providing the author's contact information for those who were interested in participating. Participants were screened via telephone or face-to-face interview to ensure they were practicing as either nurse practitioners or pharmacists in the Province of Ontario, this being the jurisdiction directly affected by Bill 179 (see Appendix 2.2 for the screening questionnaires). Qualified participants were given a letter of information and consent (see Appendix 2.3) and a signed consent form was secured for all.

The groups were not pre-existing groups but instead composed of individual nurse practitioners or pharmacists drawn from Ottawa, Kingston and the Greater Toronto Area. This being said, as professional communities can be quite small in a given city, it did occur that participants in the groups knew one another. While this raised ethical issues regarding confidentiality, the recruitment letter and moderator’s guide both made clear to participants that this risk existed and encouraged participants to keep the results of the conversation confidential after the group. All agreed to proceed.

A total of eight focus groups were held: five groups with nurse practitioners and three with pharmacists. Originally, four groups with members of each profession were planned but the recruiting efforts with nurse practitioners proved more successful. The groups varied in size, owing to uneven recruiting success. The smallest group featured two participants, while the largest featured nine. Thematic analysis revealed great consistency among all groups, suggesting that group size did not unduly influence the conversation.

Table 1 below shows a breakdown of participants for each group.

Group	Date	City	Participants
Pharmacists #1	November 8, 2010	Ottawa	6
Pharmacists #2	November 15, 2010	Ottawa	7
Pharmacists #3	November 23, 2010	Ottawa	2
Nurse Practitioner #1	November 24, 2010	Kingston	5
Nurse Practitioner #2	December 2, 2010	Ottawa	3
Nurse Practitioner #3	December 6, 2010	Mississauga	3
Nurse Practitioner #4	December 7, 2010	Toronto	9
Nurse Practitioner #5	December 8, 2010	Scarborough	6
<b>TOTAL PARTICIPANTS</b>			<b>41</b>

**Table 1 Summary of Focus Group Participants**

The homogeneity of the participants<sup>11</sup> allowed for saturation to be achieved around a number of key themes. As a qualitative study, the intent here is not to yield findings that can necessarily be generalized to the larger population. Rather, the study sought insights into, and discoveries about, the nature of the communication that develops in professional contexts.<sup>12</sup>

A qualitative content analysis methodology was used to analyze the transcripts from the focus groups. Content analysis has a long history within the field of communication studies, with Lasswell (1949) being an early proponent, refiner and codifier of the methodology.<sup>13</sup> More recently, health researchers have recognized and increasingly turned to qualitative content analysis as a means to explore and classify into categories of similar meaning data gathered through open-ended survey questions, conversations (e.g., interviews, focus groups, field observation) and published or broadcast texts (Hsieh & Shannon, 2005). Carefully analyzing transcripts from the focus groups in this way revealed a series of categories (e.g., types of content, specific topic areas, sources of messages) and themes (e.g., anxiety, collaboration, exclusion) that most engage the participants and that most elicit the association/disassociation dynamic.

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<sup>11</sup> All are non-medical, regulated health professionals in Ontario, whose scope of practice is being expanded by Bill 179.

<sup>12</sup> The idea is drawn from Säljö (1986) and is cited in (Hojjer, 1990, p. 50).

<sup>13</sup> The point is well documented by Peters and Simonson in their introduction to Lasswell's chapter (Peters & Simonson, 2004, p. 47)

## Methodology – Interviews

In all, 13 individual interviews were completed between May 2011 and January 2012. As Table 2 below indicates, participants played a range of roles in their respective professional and media organizations.

Organization Type	Role in the Organization	Number of Interviewees
Professional Organization - Medicine	Executive	1
Professional Journal – Medicine	Editor	1
Professional Organization – Pharmacy	Executive, Board Member	4
Professional Journal – Pharmacy	Writer, Editor	1
Professional Organization – Nursing/ Nurse Practitioners	Executive, Board Member	3
Professional Journal – Nursing/Nurse Practitioners	Writer, Editor	1
News Outlet	Reporter	2
<b>TOTAL INTERVIEWEES</b>		<b>13</b>

**Table 2 Profile of Interviewees**

Candidates for the interviews were identified using the organizations' websites (including contact information) and were approached by the author with a letter of information and consent (see Appendix 2.4). The response to the invitation to participate was very positive, with only one organization not replying to the invitation and subsequent follow-up messages.

In keeping with the research ethics approval that governed this study, the identity of the interview participants has been kept confidential and the transcripts have been cleaned of any identifying information. As such, where participants referred to their members and readers as nurses, physicians or pharmacists, the words have been substituted, in italics, to further shield the identity of the participant and the organization he or she represents.

The interviews lasted between 20 and 40 minutes and were conducted on the phone, guided by an approved interview moderator's guide that included general

questions asked of all participants and specific questions for association executives and for reporters and editors (see Appendix 2.5 for the interview moderator's guide). The questions for association and regulatory college executives covered five principal topics:

1. Why Bill 179 and interprofessional collaboration are important stories
2. The communication campaign: resources and processes
3. The campaign's impact
4. Links between interprofessional trust and collaboration
5. Closing thoughts

The questions for reporters and editors covered four principal topics:

1. Why this story?
2. The editorial process
3. Coverage and impact
4. Closing thoughts

Though the general structure of the interview guides was respected and the wording of the questions kept largely consistent, each interview was unique, with participants able to direct the topic of conversation and explore the issues from their perspectives. The discussions were audio recorded (with the informed consent of participants and in keeping with the requirements of the Carleton University Research Ethics Board) and later transcribed. As was the case with the focus groups, the interview transcripts were analysed using qualitative content analysis in an effort to identify broad themes that cut across the specific questions in the interview guide and the individual participants. The author conducted all interviews, transcribed all conversations and conducted all of the qualitative content analysis for these.

The intent of the analysis was to approach these transcripts with a fresh perspective, allowing the themes to emerge from the words of the interview participants,

rather than searching solely for the same themes that emerged from analysis of the focus groups. Nonetheless, the analysis did reveal a number of parallels between the focus group and interview themes. This symmetry is perhaps not surprising given that many association executives and editors are themselves former members of the profession they represent, with some still practising on a part-time basis.

### **Methodology – Textual Analysis**

The content for the textual analysis was gathered from online and print editions of professional journals and the news media. The journals of 11 professional associations and regulatory colleges for nursing and nurse practitioners, pharmacy and medicine were selected (see Table 3 for a list of publications and authoring organizations). These organizations represent the professions of medicine, nursing and pharmacy at the national and provincial levels (Ontario). In the case of medicine, the decision was made to include both the Canadian Medical Association (CMA) and the College of Family Physicians of Canada (CFPC). Although the CMA is the principal advocacy association for medicine in Canada, the CFPC both represents the interests of family physicians (i.e., in the manner of an association) and sets standards for training, certification and continuing medical education (i.e., in the manner of a regulatory college). Since so much of the interprofessional collaboration in Ontario is occurring in Family Health Teams, the perspective of family medicine is particularly relevant (as evidenced by the very visible role of the Section on General and Family Practice of the OMA). Similarly, both the Registered Nurses Association of Ontario (RNAO) and the NPAO were included in the study. The NPAO is an expert group of the RNAO and communicates both with its

members and the media, in close collaboration with RNAO. The provincial regulatory colleges for all three professions were also selected.

With the exception of the NPAO, all organizations regularly publish a journal or magazine for members. In addition to reviewing each of these, the websites of the organizations were carefully reviewed for other key documents such as media releases, official statements, advertisements and brochures. In some instances, the review was limited by the number of years of archival material contained on the site and the availability of printed versions in libraries accessible to the author.

Where possible, the websites and professional journals of each organization were searched using online search engines (searching for a combination of the terms “Bill 179,” “interprofessional collaboration,” “nurse practitioner,” “pharmacy/ist” and “scope of practice”). In addition, the individual issues of those journals published between January 2008 and December 2011<sup>14</sup> were hand-searched to ensure all relevant articles and editorials were identified and included. Finally, the online media database FP-Infomart was used to conduct a search for the same search terms and the same period of time. The combination of search techniques yielded 207 individual articles, including journal articles and editorials, news media articles, letters to the editor, posters and advertisements.

In the next stage of the textual analysis, all of the articles were read thoroughly and the components of the articles (i.e., sentences or paragraphs) were placed in one of

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<sup>14</sup> This period of time covers the introduction of Bill 179, the consultation and debate surrounding the Bill, as well as its passage.

four categories. These four categories (interaction and trust; professional identity; communication; and anxiety) were drawn from the four major themes that emerged from an analysis of both the focus group transcripts and interview transcripts. Many of the articles included more than one paragraph or sentence which was complete and relevant to one of more categories. These complete and relevant sections of the articles are hereafter referred to as texts. This led to a total of 924 texts analysed and categorized, from the 207 articles.

Table 3 summarizes the list of organizations, journals and websites included in the textual analysis.

Profession	Organization	Publication & Website	Number of Articles	Texts categorized
Medicine	CFPC	<i>Canadian Family Physician</i> , <a href="http://www.cfpc.ca">www.cfpc.ca</a>	24	395
	CMA	<i>Canadian Medical Association Journal</i> , <a href="http://www.cma.ca">www.cma.ca</a>	14	
	OMA	<i>Ontario Medical Review</i> , <a href="http://www.ome.org">www.ome.org</a>	49	
	CPSO	<i>MD Dialogue</i> , <a href="http://www.cpso.on.ca">www.cpso.on.ca</a>	7	
	<b>TOTAL FOR MEDICINE</b>			
Nursing	CNA	<i>Canadian Nurse</i> , <a href="http://www.cna-aic.ca">www.cna-aic.ca</a>	21	231
	RNAO	<i>Registered Nurse Journal</i> , <a href="http://www.rnao.ca">www.rnao.ca</a>	29	
	NPAO	<a href="http://www.npao.org">www.npao.org</a>	5	
	CNO	<i>The Standard</i> , <a href="http://www.cno.org">www.cno.org</a>	4	
	<b>TOTAL FOR NURSING</b>			
Pharmacy	CPhA	<i>Canadian Pharmacists Journal</i> , <a href="http://www.pharmacists.ca">www.pharmacists.ca</a>	24	298
	OPA	<i>The Ontario Pharmacist</i> , <a href="http://www.opatoday.com">www.opatoday.com</a>	23	
	OCP	<i>Pharmacy Connections</i> , <a href="http://www.ocpinfo.com">www.ocpinfo.com</a>	7	
	<b>TOTAL FOR PHARMACY</b>			

**Table 3 Professional Organizations and Publications**

The intent here was very much to conduct a qualitative analysis of the articles and texts. No key words were searched and counted. Rather, each text was read closely and attention paid to the context of the specific article, advertisement, media release or news story. The intended audience, the time and place of the text and the sending organization

were carefully considered before the component texts were categorized. Though some of the analysis that follows includes numerical tables and references to the prevalence of a particular theme, this is in no way intended to imply quantitative precision, but rather to comment on the weight of one category relative to others.

## **Conclusion**

There is clearly, in the language of Andrew Abbott (1988), a battle for jurisdictional claims underway in this province. That battle, as Abbott suggested, is waged not only behind closed committee room doors but also in the public arena, since “it is ultimately through public opinion that professions establish the power that enables them to achieve legal protection” (p. 60). Professional identity and professional culture are in flux as the working boundaries between different health care professions are being redrawn and power relations renegotiated. The key questions I propose to explore, then, are the following: (1) To what extent and with what messages or narratives do professions use channels of mass media and professional communication to forge a cohesive sense of cultural identity among members and stress differences and disassociation from other professions? (2) What impact do these communication practices have on levels of anxiety or trust between members of different professions? (3) How might these levels of trust and anxiety shape future instances of interprofessional collaboration?

## Chapter Two – Context

This chapter will provide additional context to the debate over Bill 179 in Ontario and the move to greater interprofessional collaboration in health care. A brief history of medicine, pharmacy and nursing in Canada will be presented, with particular attention to how the boundaries and power relations between the three professions were formed. While Bill 179 is the catalyst for this study and for much of the content analysed, the move to new, more interprofessional models of delivering health care dates back further and is rooted in several important trends in health care. In addition, this chapter will discuss some of the broader political, economic, social and technological conditions of late modernity.

### **A Brief History of Professional Boundaries**

In providing a very brief glimpse of the history of the two professions covered in this study, the hope is to point out that the boundaries that now exist between professions are hundreds of years old and that they have often been permeable boundaries with significant interaction and even movement between professions. From the early days of health care professions in England and what was then the British Empire, there have existed what Dominique Sila-Khan called “thresholds,” (2004, p. 6) which permitted various modes of interaction between members of different groups, such as alliances, the sharing time and space, and the borrowing of ideas from art and philosophy. Though Sila-Khan wrote specifically about religious identities in South Asia, this brief history will

suggest that alliances, borrowing and sharing have been features of health care and continue to be.

## **Pharmacy**

### **Early Origins**

Many historians of pharmacy and medicine point out that the two professions sprung from the same ancient origins. Sonnedecker (1976) and Becelaere (1929), for example, trace the origins of both professions to common origins in ancient Egypt. Madge (1987), focuses his history of pharmacy on three regions of the globe: (1) the Mediterranean and the work of Egyptian, Greek, Roman and Arabic physicians, scholars and translators; (2) South Asia and the Ayurvedic system of medicine; and (3) the Chinese system of medicine, which included the work of Shen Nung, whom Madge describes as “the father of Chinese medicine and pharmacy” (p. 169). All three traditions blended research and practice in both medicine and pharmacy, diagnosing patients, prescribing treatment and administering medications<sup>15</sup>.

For the purposes of this study, the focus of this brief history will be on the development of the pharmaceutical profession in England, since this model influenced the Canadian model more than others, owing to the country’s history. Sonnedecker’s *History of Pharmacy (4<sup>th</sup> edition)* traces the origins of European pharmacy to the Mediterranean tradition (notably Egyptian and Greco-Roman works) and the work of

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<sup>15</sup> Becelaere (1929) notes that occupational groups in ancient Egypt were charged with preparing medicines and that the Greek translation of the occupations was “farmakopoloj” and “farmakodikoj” (p. 48).

Arabic scholars who gathered and preserved these texts, translated them into Latin, and extended the knowledge.<sup>16</sup> He also points out that many of these texts concerned both medicine and pharmacy, with no formal division between the two practices.<sup>17</sup>

### **Medieval Physicians and Apothecaries**

From its early origins, our history of pharmacy turns to the medieval period in Europe when, as Carr-Saunders and Wilson (1933) note the guild, as an institutional form, “began to sweep like a wave over the cities of Europe. Reaching this country somewhat later, the movement led to the formation of associations round many aspects of social life, and among them the performance of specialized functions and the carrying on of specialized crafts” (p. 289). The history of pharmacy in England is to a large extent the history of three such associations: The Royal College of Physicians of London, the Society of Apothecaries and the General Association of Chemists and Druggists. In this way, the origins of the pharmacy profession are at once integrated with, and distinct from the origins of medicine.

The Royal College of Physicians of London was incorporated in 1518 and granted a charter by Henry VIII. That charter granted its members power to control admission to the medical profession within a seven mile radius of London and the exclusive right to

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<sup>16</sup> Madge makes a similar point about the pharmaceutical research by Arabic scholars: “The Arabic world considered that God gave disease but also the cure. It was man’s job to find it, hence research and development of pharmaceutical and medical science lay for centuries in the Near East” (Madge, 1987, p. 169).

<sup>17</sup> “... even before the 15th century, some key pharmaco-medical works originated or dominated by Arabic thought were off the press (Sonnedecker, 1976, p. 33).

provide medical care.<sup>18</sup> Membership in the medical profession was thus exclusive, restricted to graduates of Oxford and Cambridge universities. The power to grant membership was exercised by the Royal College and, outside the seven-mile limit, by the church.

Sonnedecker (1976) reports that physicians of the day often turned to spicers for the raw ingredients required to make medicinal compounds. Gradually the “more knowledgeable and skillful spicers specialized increasingly in dispensing and compounding medicines” (p. 100). By the 13<sup>th</sup> century, some began to adopt the title of apothecary and in 1428, the Worshipful Company of Grocers was granted a Royal Charter, bringing together the guilds of pepperers and spicers. It wasn’t until 1617 that the spicer-apothecaries were able to secede from the Grocers and form their own association – the Worshipful Society of Apothecaries of London ([www.apothecaries.org](http://www.apothecaries.org)).

Though apothecaries of the era functioned very much as modern pharmacists, preparing and dispensing medications, they had more medical ambitions. Owing to the relatively small number of physicians and the considerable costs of their services, people turned to apothecaries for medical advice and medicine. The status of apothecaries as medical practitioners was enhanced during the plague in London of 1665, when most physicians left the city, following their wealthy clientele, while apothecaries stayed behind with their clientele (Madge, 1987). In 1703, the status of apothecaries as medical practitioners was confirmed when the House of Lords sided with the apothecaries and

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<sup>18</sup> Carr-Saunders and Wilson (1933) quote from the Charter: “that no person... be suffered to exercise and practice physic but only those persons that be profound, sad and discreet, groundedly learned, and deeply studied in physic” (p. 68).

against the Royal College of Physicians, agreeing that “the function of apothecary consisted not only in compounding and dispensing, but also in directing and ordering the remedies to be employed in the treatment of disease. Thenceforward the apothecaries came to form an inferior order of medical practitioners” (Carr-Saunders & Wilson, p. 73). Carr-Saunders and Wilson report that the status of apothecaries was further advanced in the eighteenth century, as increasing numbers of apothecaries also earned a license to practice surgery and surgeon-apothecaries became an important aspect of health care in England. The professional boundary between medicine and pharmacy was all but eliminated among these hybrid practitioners and, in 1815, with the passing of the *Apothecary Act*, the formal status of apothecaries as medical practitioners was made into law. The Act brought together apothecaries, apothecary-surgeons and general practitioners, all of whom would eventually adopt the title of general practitioner. The profession which had seemingly laid the foundation for the pharmacy profession was abandoning this position and moving towards medicine. Thanks to this legislated alliance, the boundaries around the medical profession had been enlarged to allow for new practitioners. The knowledge, tools and social standing were to be shared between the professions.

### **The Pharmacy Profession**

The *Apothecary Act* also laid a new foundation for the pharmacy profession with a clause stating that nothing in the *Act* was “to offend in any way the trade or business of a Chemist and Druggist in the buying, preparation, compounding, dispensing and vending of drugs, medicines, and medicinal compounds wholesale and retail” (Madge, 1987, p.

170). Thus it was that the boundary set and the power relations between medicine and pharmacy were set. Physicians (whether Fellows of the Royal College – who today are licensed as specialists – or general practitioners) would diagnose and prescribe treatment in the form of surgery or medicine. Pharmacists, formerly druggists and chemists, would compound and dispense the prescribed medications, as directed by the physicians. Shortly after the passage of the Act, The Pharmaceutical Society of Great Britain was founded in 1841, immediately setting out to raise the status of its members through regulations, examinations, the publication of a professional journal and the establishment of a the School of Pharmacy (Madge, 1987).

The interaction between medicine and pharmacy goes beyond the shared histories of physicians, apothecaries, druggists and chemists. Advances in one field frequently translate into advances in the other, as knowledge and tools are shared. Sonnedecker sums up the relationship concisely:

Every change in the medical concepts that influenced therapy made itself felt in the practice of pharmacy... changing medical theories could still alter the combinations of remedies. They could influence physicians in their choice of drugs. Finally, through the medical profession, theories could deny the usefulness of drugs altogether (p. 53).

Influence could also flow from pharmacy and chemistry to medicine, as new drugs were discovered and made available to physicians and their patients. Sonnedecker points to the influence of German physician and scientist Paul Ehrlich, while Madge points to the earlier work of Paracelsus in introducing many chemical and metal-based medications that changed the practice of medicine.

Though the boundary between pharmacy and medicine has been shifting and permeable for several hundred years, elements of it have remained remarkably consistent since the passage of the *Apothecaries Act* in 1815. The respective roles of physicians and pharmacists have remained largely unchanged until very recent efforts in the past decades to expand the scope of practice of pharmacists in favour of greater diagnosis, counsel to patients and prescribing rights. The interaction between pharmacists and physicians has also been largely constant: the relationship is predominantly one of supply chain, as physicians write prescriptions which pharmacists check and fill. As we shall see, that relationship has changed in the past decades.

## **Nursing**

### **Early Origins**

The origins of nursing as a profession are similarly ancient, with the earliest nursing care carried out by family members in the home. In the medieval era, monastic orders began offering nursing to the poor as part of fulfilling their corporal works of mercy<sup>19</sup> (Carr-Saunders & Wilson, 1933; Dolan, 1973; Griffin & Griffin, 1973). Before the Reformation, much of nursing care in the Western world was associated with the Catholic Church<sup>20</sup>, with the result that the influence of the medical profession was limited

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<sup>19</sup> Dolan (1973) lists the seven corporal works of mercy in the Christian tradition: "To feed the hungry; To give water to the thirsty; To clothe the naked; To visit the imprisoned; To shelter the homeless; To care for the sick; To bury the dead." (p. 49).

<sup>20</sup> The origins of organized nursing in the Western world is most often traced to Saint Vincent de Paul and the establishment of the *Filles de Charité* in France in 1630. The group later changed its name to the *Soeurs de Charité*. Members of the non-cloistered order provided care in the homes of the sick poor.

(Griffin & Griffin, 1973). After the Reformation, some nursing care in Protestant countries was delivered by deaconesses affiliated with Protestant churches. Dolan describes how deaconesses served as forerunners of public health nurses and social workers, visiting the ill, assessing their condition and distributing medications. Interaction with physicians was infrequent and limited to instances when medical care was deemed necessary by the nurse:

When a nursing assessment was determined, intervention was provided by nurses if nursing care was indicated, otherwise the observation was interpreted to the physician if medical care was needed or to the spiritual advisor if spiritual care was warranted (Dolan, 1973, p. 54).

### **The Move to Modern Nursing**

The nursing care provided by those nurses who were not affiliated with the church is often described as having been “so hard and cruel that the very name of ‘Nurse’ was held in horror and contempt” (Williams, K., 1980, p. 43). In contrast to physicians of the era, nurses were often illiterate and from the lower economic strata of English society (Huntsman, Bruin & Holtum, 2002). Their care was largely limited to providing food and drink, cleaning the ward and watching over patients at night so they could alert the physician to any changes in the patient’s condition. Physicians of the era began to see the need for a different class of nurse, though not necessarily one with more medical knowledge. Quoting from a history of nursing published in the June, 1897 edition of the *British Medical Journal*, Williams notes the growing demand among physicians in 1830 for a different class of nurse:

The physician at the bedside and the surgeon in the operating theatre had the conviction forced upon them that if they were to do the best possible for their patients, they wanted hands, gentle, skilful, and sympathetic, which would work with them and for them at the bedside (Williams, K., 1980, p. 45).

The source of nurses deemed more gentle, skilful and sympathetic would, for many English physicians of the era, be the Institution of Nursing Sisters, founded by Elizabeth Fry in 1840. Determined to address the conditions she saw in London hospitals and prisons, and inspired by her visit to the Deaconess Institute in Kaiserworth, Germany,<sup>21</sup> Fry set out to provide "experienced, conscientious, and Christian Nurses for the sick-and also to raise the standard of this useful and important occupation" (Huntsman et al., 2002, p. 358). Many of the nurses in the Institution of Nursing Sisters delivered private care in the homes of people, where contact and collaboration with physicians was more limited. Nonetheless, there was some, often indirect<sup>22</sup> contact and influence as the nurses in Fry's Institution spent three months working and learning in London hospitals. The hospital became an important threshold, permitting sharing of space and time, as well as the exchange of knowledge between medicine and nursing.

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<sup>21</sup> Fry had earlier inspired Pastor Theodore Fliedner and his wife to assist prisoners in the parish and to establish a home for convicts recently released. Their work continued with the establishment of a hospital to train deaconesses – what many consider to be the first nursing school in the western world. Later, Florence Nightingale would train at the Institute (Huntsman et al., 2002).

<sup>22</sup> Katherine Williams (1980) writes that instruction from physicians came only to the head nurse: "She receives the directions of the physician or surgeon to whose ward she is attached and she reports to the apothecary or house-surgeon in their absence, any circumstances which call for immediate attention" (p. 59). From the head nurse, the information would be passed to regular nurses.

Elizabeth Fry and the Institute of Nursing Sisters (and, by extension, of the Fliedners and their Deaconess Institute) made a number of significant contributions to the evolution of nursing as a profession. Chief among these was the careful attention to recruiting candidates for private nursing with desirable qualities (e.g., literate, sober, gentle and Christian) and the effort to educate the candidates with practical training in a hospital setting. On an institutional level, Fry helped found an organization that Huntsman et al. describe as “an efficient, female controlled health care organization run by ‘part-time amateurs’ and functioning from the early years of Queen Victoria's reign until 1939” (Huntsman et al., 2002, p. 362). As the reputation of the Institution grew, hospitals began to apply for a supply of their nurses, which effectively granted Fry’s organization the power to assess hospitals:

The refusal of the prestigious Institution of Nursing Sisters to supply nursing staff because of unsatisfactory working conditions or salary, must have been embarrassing to a hospital's governing body and provided a powerful impetus for improvement (Huntsman et al., 2002, pp. 373-374).

MacMillan (2012) also credits Fry with shifting control of nursing away from the medical profession by insisting that her nurses report not to a physician but to a “Lady Superintendent” (p. 413). These changes all served to limit the extent of physicians’ influence on nursing as it evolved into a profession.<sup>23</sup>

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<sup>23</sup> It should be noted, however, that the head office of the Institute was located immediately adjacent to the London Hospital, where the Institute’s nurses received their training at the invitation of the hospital (Huntsman et al., 2002, p. 365).

In the first half of the 19<sup>th</sup> century, rapid urbanization in England brought about a significant increase in the number of hospitals and the number of patients in those hospitals (Huntsman et al., 2002). This, along with the increasing complexity of medicine noted above, increased demand for qualified nurses. The modernization of hospital nursing is most often attributed to Florence Nightingale. Like Fry, Nightingale was inspired by her time at the Kaiserswerth Deaconess Institute and by the suffering she witnessed in the absence of effective nursing care, particularly in the Crimean War (1853-1856). Upon her return from the war and in recognition of the immense reputation she gained for her efforts there, a fund was established in her name and proceeds used to fund a nursing school at St. Thomas's Hospital in London in 1860. The school featured considerably more education than Elizabeth Fry's Institution of Nursing Sisters: three years of lectures and practical training, as compared to several months (Williams, K., 1980).

Williams adds that the Nightingale Fund ensured control of nurse training was ultimately in the hands of nurses; training and duties were logged in a book which was examined regularly by the matron on site at the hospital and annually by a committee of the Fund.: "A nurse's probation was thus controlled from outside the ward as fulfillment of the principles of probation, as well as within the ward in fulfillment of the nurse's obligations of service to the hospital" (Williams, K., pp. 70-71). Nightingale's influence had global reach as nursing schools following her model were soon established throughout the British Empire, including the Mack School of Nursing established in Hamilton, Ontario in 1874 by Dr. Theophilus Mack (McDonagh, 2004). As training for nurses expanded in this way, nursing became what Nightingale had originally conceived:

a “legitimate paid lay occupations for women within the existing social structures, albeit in a public sphere (MacMillan, 2012, p. 411).

### **Interaction and Tension with Medicine**

The medical community’s view of this additional learning and professionalization – the borrowing of practices and knowledge that had been the exclusive domain of medicine – was not universally positive. Katherine Williams cites the history of nursing published in 1897 in the *British Medical Journal*:

In moderation there could be nothing but praise for this system, but there is no doubt that the theoretical side has been overdone; the style and method of training being on same lines as those of the medical student, have not proved equally suitable to the sick nurse, whose work is essentially practical and whose efficiency depends more on skilful handling and observation than on acquaintance with the minutiae of physiology or anatomy (1980, p. 47).<sup>24</sup>

Similarly, efforts in 1887 to organize nurses into a British Nurses Association were met with resistance by both hospitals and practicing nurses who rejected the notion of mandatory registration and the educational standards this would impose (Carr-Saunders & Wilson, 1933). In a move that calls to mind Andrew Abbott’s notion of the

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<sup>24</sup> Huntsman et al. (2002) similarly report that an 1877 editorial in *The Lancet* declared that nurses “possess just enough knowledge to make them dangerous” (p. 356).

power of a profession to introduce new subordinate professions under its power,<sup>25</sup> the British Medical Association in 1895 lobbied for state registration of nurses, setting the stage for the founding of the Society for State Registration for Trained Nurses in 1902; that body included representation by physicians as well as nurses and lay representatives (Carr-Saunders & Wilson, 1933). In this instance, medicine did not create the nursing profession but sought to place it in a subordinate position aligned with a more limited medical definition of nursing care. Katherine Williams (1980) sums up this definition:

...a set of practices, deriving mainly from medical knowledge but also comprising metaphysics, termed “the laws of life and health,”<sup>26</sup> and the unspecified duties involved in attending to the daily comfort and well-being of patients (p. 53).

The influence of the medical profession on nursing, especially in the hospital setting, came from numerous practices in the late 19<sup>th</sup> century and early 20<sup>th</sup> century. In the first instance, a modern order of nurses could only practice in a hospital if invited by the senior medical staff there (Williams, K., 1980).<sup>27</sup> Keddy et al. (1986) similarly note that the doctors of Florence Nightingale’s era – be it in hospitals or in the army – had “the

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<sup>25</sup> Abbott (1988) notes that the jurisdictional control of an established profession brings with it the power to create new subordinate professions, allowing the dominant professions to delegate more routine work to the subordinate group, without any loss of prestige or power. Work becomes less routinized and, in some instances, more profitable for the dominant profession.

<sup>26</sup> The term was used as the title of a book by physician Alexander Bryce (1912) focused on personal hygiene and health. Topics listed in the book’s table of contents include food, drink, work, rest, arts, exercise, cleanliness, protection, moderation, cheerfulness and re-generation.

<sup>27</sup> Williams describes how the St. John’s Sisterhood was invited to King’s College Hospital by Dr. William Bowman and notes that the order was modeled on the Kaiserworth Deaconess Institute, a model more in line with physicians’ expectations of the day.

power to either prove or disprove nursing's worth" (p. 746). The authors also suggest that physicians continued to influence nursing by being in a position to approve which nurses were hired at their hospital up until the 1930s. Finally, a number of scholars (Williams, K., 1980; Huntsman et al., 2002; Keddy et al., 1986) note that much of the training for nurses was delivered by physicians – either directly or through the ward sister with whom the physician interacts - allowing them to determine the knowledge that nurses would have and how it would be applied to carry out the physician's orders.

Clearly, then, there was interaction – sharing, borrowing and alliances of a sort – between physicians and nurses, especially in the hospital setting, from the late 19<sup>th</sup> century to the present. That interaction was not true collaboration, however. Nurses and physicians were not “acknowledged equals who bring different knowledge and expertise to the achievement of shared clinical goals” (Keddy et al., 1986, p. 410) and the communication between members of the two professions was challenged by the unequal status. The authors describe the “Doctor-Nurse Game” that has long taken place when nurses interact with physicians. The rules of the game (show doctors respect; nurses cannot openly diagnose or make recommendations to doctors; no open disagreement or confrontation allowed) render communication “nebulous” and collaboration more challenging (Keddy et al., 1986, pp. 748-749).

### **The Introduction of Nurse Practitioners**

The nurse practitioner movement began in 1965 at the University of Colorado, where public health nurse Loretta “Lee” Ford and pediatrician Henry Silver collaborated

to create a new university program designed to expand the nurse's role in the delivery of health care. The program was in response to the shortage of physicians the United States was experiencing at the time, especially in rural and remote areas of the state (which is where Ford had practiced). The program and the expanded role for nursing met with resistance. Ford recalls, in an article published on the University of Colorado website (Revolutionary Nurse, 2012): "Innovation is not accepted very easily in the health professions. My goal was not to substitute for physicians. It was to help nurses do what they were already doing but do it better and to the full extent of their preparation."

Ontario was also a pioneering jurisdiction in this regard, with nurse practitioners beginning to work in Ontario in the early 1970s. Much as they had been in Colorado, Ontario nurse practitioners were put in place to meet the needs of northern and rural communities with inadequate access to medical care. Funding for the education of NPs was cut in 1983. Persistent advocacy efforts by the first generation of NPs and a continuing shortage of physicians in northern and rural communities convinced the Ontario government to restore the funding for university programs for NPs in 1995. The Expanded Nursing Services for Patients Act was passed into law in 1998, granting NPs the right to communicate a diagnosis to patients, prescribe certain medications and order certain diagnostic tests (Nurse practitioner history in Ontario, 2012). NPs in Ontario can be delegated the right to perform additional acts, though the delegation must be made by a physician. NPs are also required by the Act to "consult with a physician if they encounter patient care needs that are beyond their scope of practice" (About Nurse Practitioners – Frequently Asked Questions, 2012).

## **The Contemporary Drive to Interprofessional Collaboration**

The more recent efforts by health professions, administrators, governments and other funding agencies to bring about greater interprofessional collaboration – more effective sharing of time and space, more alliances, and increased borrowing of ideas – stems principally from four closely inter-related priorities: (1) the need to enhance patient safety; (2) the effort to deliver health care more efficiently in the face of climbing costs and lengthening wait times; (3) the move to approach health and health care from a more holistic and patient-centered perspective; and (4) the desire among non-medical care providers to secure equal access to funding from government and private insurers and, hence, greater job satisfaction.

### **Patient Safety**

Horsburgh, Perkins, Coyle and Degeling trace recent efforts to promote interprofessional collaboration in health care back to high-profile cases of errors in clinical practice in the U.S., New Zealand and the U.K. and point to how the events led to the recognition of “the need for a systems approach to health care organization and delivery” (2006, p. 425). In Canada, the Canadian Patient Safety Institute echoes the strong link between safety and interprofessional collaboration in its publication *The Safety Competencies: Enhancing Patient Safety Across the Health Professions* in which one of the six domains of competency covered is “Work in teams for patient safety” (Frank & Brien, 2009, p. 9). The document explains: “High-performing interprofessional health care teams demonstrate the knowledge, skills, and attitudes that are essential to efficient, effective, and safe collaborative practice. These teams define and make a

commitment to shared objectives, clear roles and responsibilities, and interdependent decision-making” (2009, p. 9). Stevens and Rogers (2009) similarly recognize the role of improved communication in enhancing patient safety and, in particular, the second-order problem solving that finds solutions to longer-term, systemic safety issues. “Moving to second-order problem-solving,” they write, “requires, for example, improved communication among team members, a safe environment in which to discuss errors and problems, and a reliable, predictable way for the unit or operating room to function as a team” (Stevens & Rogers, 2009, p. 92).

### **Efficiency**

There is also growing evidence and consensus around the idea that interprofessional collaboration can enhance access to health care while lowering costs. Barrett, Curran, Glynn and Godwin (2007) summarize their review of published literature, government research reports and policy papers by stating that there is increasing evidence that “interprofessional collaboration models can provide a broader range of services, more efficient resource utilization, better access to services, shorter wait times, better coordination of care, and more comprehensive care, compared to a uni-professional model of primary healthcare delivery” (2007, p. iii). Similarly, HealthForce Ontario, the government agency mandated to foster better interprofessional collaboration in the province’s health care system, is clear that the need to deliver more health care with finite resources is a key driver of the move to interprofessional collaboration. In its publication *Interprofessional Care: A Blueprint for Action*, the agency links interprofessional care to “health care system renewal and improved sustainability”

(HealthForce Ontario, 2007, p. 7). The authors point to studies that link enhanced collaboration to reduced costs from fewer medical errors, the elimination of redundancies (e.g., diagnostic tests repeated rather than results from one test being shared), the reduction of malpractice suits, and a decline in unexpected outcomes for patients (i.e. cardiac arrests while in hospital).

### **Whole-Patient Practice**

Irvine et al. look further back and find the roots of a move to interprofessional collaboration in the shift to a new “whole-patient” (2002, p. 200) practice ideology in the 1970s. George L. Engel has long<sup>28</sup> been an advocate for a whole-patient perspective – a more holistic view of health care and the patient that challenges the “reductionistic biomedical model” (Engel, 1977, p. 131). Engel calls for a model that takes into account “the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of illness... a biopsychosocial model” (1977, p. 132).

Increasingly, patient advocates and care providers recognize that illness and disease create physical needs for patients as well as psychological and social needs. Getting better or coping with the illness or disease require interventions in all three areas if the whole patient is to be cared for. Adler and Page summarize the gaps that cancer

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<sup>28</sup> As early as 1961, Engel was calling for a broader conception of disease that would consider how grief is a disease and, hence, that the environment in which the individual lives and works is an important variable in sustaining the health of the individual (Engle, 1961).

patients, for example, experience from a lack of interprofessional collaboration across medical, social and psychological boundaries:

... the remarkable advances in biomedical care for cancer have not been matched by achievements in providing high-quality care for the psychological and social effects of cancer. Numerous cancer survivors and their caregivers report that cancer care providers did not understand their psychosocial needs, failed to recognize and adequately address depression and other symptoms of stress, were unaware of or did not refer them to available resources, and generally did not consider psychosocial support to be an integral part of quality cancer care (Adler & Page, 2008, p. 23).

As a chronic condition, cancer requires continual, interprofessional collaboration on the part of physicians (family physicians, oncologists and other medical specialists), medical radiation technologists, pharmacists, psychologists, psychiatrists, social workers, occupational therapists, clergy and others.

### **Professional Satisfaction**

The call for more interprofessional collaboration is also being led by members of non-medical health professions in the interest of greater patient access to their services and more equitable distribution of funding and prestige. Recently, the national professional associations representing four such allied health professions (speech-language pathologists, audiologists, physiotherapists and occupational therapists)

gathered for a national Leadership Summit to raise the level of ability of their leaders to advocate on behalf of advancing interdisciplinary collaboration in primary health care.<sup>29</sup> In their list of seven outcomes for the summit, organizers included a call to “Advocate for funding models that allow these health professionals to practice according to the principles of primary health care and interprofessional collaboration,” noting in the same background paper that “public funding now covers almost all physician services, but less than half of the costs of services provided by other health professionals” (Canadian Association of Speech-Language Pathologists and Audiologists, 2008).

Many non-medical health care providers are also seeking to improve the nature of their interactions with other members of the interprofessional team. As Health Canada summarizes, health care providers value an opportunity to truly participate in clinical decision making, in an environment of “respect for disciplinary contributions of all professionals” (Health Canada, 2003).

The drive to interprofessional collaboration – while not universally endorsed<sup>30</sup> – is championed by administrators, patient advocates and numerous health professions. Indeed, even leaders in the medical profession have called for greater interprofessional collaboration and education.<sup>31</sup> These diverse players see in interprofessional collaboration

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<sup>29</sup> I was retained by conference organizers to provide training in media relations to some 80 of the conference delegates.

<sup>30</sup> While many researchers are increasingly convinced of the benefits of interprofessional collaboration in health care, others remain more skeptical of any measurable impact on health outcomes. Wood, for example, suggests in her editorial that “good data to support the proposition remain scanty, despite most people’s intuition that it must be a ‘good thing’” (2004, p. 684).

<sup>31</sup> Consider, for example, that Task Force Two – a collaboration between Canada’s principal medical associations struck to develop a human resource strategy for physicians in this country – called specifically for greater interprofessional collaboration, suggesting that “bringing together physicians and other health

a possible solution to health, economic, socio-psychological and occupational issues. With so many champions and so many rationales for support, the drive towards interprofessional collaboration seems likely to be a sustained one.

## **Health Care in Late Modernity**

In their introduction to *Canonic Texts in Media Research* (2003), Katz, Peters, Liebes and Orloff introduce their chapter on the Chicago School of media research with a description of that city's "convulsive modernity – with industrialization, urbanization, and immigration exploding at a speed unparalleled anywhere in the nineteenth century" (p. 104). As this dissertation will draw heavily from the Chicago School to shed light on interprofessional collaboration as an instance of intercultural communication (see Chapter 3), it is important and fitting to consider the extent to which contemporary conditions – and in particular those affecting health care – are indeed comparable to the convulsions and explosive speed of the early 20<sup>th</sup> century. Anthony Giddens has paid particular attention to the important trends shaping society in the late 20<sup>th</sup> and 21<sup>st</sup> centuries. For the published version of his BBC Reith Lectures in 1999, Giddens (2003) chose the title *Runaway World* and argued that there are "good, objective reasons to believe that we are living through a major period of historical transition" (p. 1). He goes on to trace how the transition is being shaped and propelled by five forces: (1) globalisation, (2) new and heightened risks tied to scientific and technological advances,

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professionals to work in teams can be an important part of the solution to challenges such as access to care, wait times for patients, shortages and burn out for professionals" (Task Force Two, 2006, p. iv).

(3) the changing nature of tradition, (4) an erosion in public faith in democratic institutions, and (5) an increase in public faith in democracy and demand for democratic participation in much of the world. Though Giddens was writing of social life as a whole and not just health care, all five areas of change on which he focuses are having a profound impact on health care and health care professionals.<sup>32</sup>

### **Globalization**

Globalization, to begin, is a prominent feature of health care professions in Canada. A shortage of trained health care professionals and an increase in the standardization<sup>33</sup> of health care education across national boundaries have rendered physicians, nurses, pharmacists and other health care providers among the most mobile and transnational of professionals. The case of physicians is illustrative. Consider, for example, that more than one in five (20.4%) of physician respondents to the 2007 National Physician Survey in Canada reported having been born and raised outside of this country. Moreover, 20.1% of physician respondents indicated they received their undergraduate medical education outside of Canada, including 47.4% of physicians

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<sup>32</sup> Indeed, many of the examples Giddens draws upon to illustrate his points are drawn from health care and medicine.

<sup>33</sup> According to the Foundation for Advancement of International Medical Education and Research's (FAIMER) *International Medical Education Directory*, as of January 2013, there were 2,470 recognized and operating medical schools in 189 countries (Foundation for Advancement of Medical Education and Research, 2013). All share their information with FAIMER, a global organization which focuses on developing faculty and informing health workforce policy around the world. A similar organization, the World Federation for Medical Education (WFME) worked with the United Nation's World Health Organization to define international standards in medical education. In a 2011 status report on its work, the WFME writes: "In keeping with its constitution, as the international body representing all medical teachers and medical teaching institutions, WFME undertakes to promote the highest scientific and ethical standards in medical education, initiating new learning methods, new instructional tools, and innovative management of medical education" (2011, p. 3).

currently practicing in the Province of Saskatchewan (National Physician Survey, 2008). This inflow of physicians educated in countries other than Canada is paralleled by a flow of Canadian physicians *out* of the country. The number of Canadian physicians leaving the country peaked at 678 in 1994, though since then has declined to the point where there are more Canadian physicians returning from abroad, resulting in a net increase of physicians in this country (Canadian Institute for Health Information, 2009). The flow of people into Canada to practice medicine is tightly controlled by the profession of medicine, though the current shortage of physicians is prompting national and provincial governments to encourage regulatory bodies to ease the transition for what are termed International Medical Graduates, or IMGs. Programs are now established in many Canadian provinces and cities to assist IMGs with the transition and efforts are underway by regulatory bodies to streamline the process of having credentials recognized, examinations written and skills demonstrated.<sup>34</sup>

## **Risk**

The nature of the medical risks faced by the public and dealt with by health professionals has also changed dramatically, much of it driven by the increased scientific and technological knowledge and development. The increase in ease and frequency of air travel, for example, has created new risks for the rapid transmission of viruses and bacteria across international borders (Mangili & Gendreau, 2005; Khan, 2009). Similarly,

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<sup>34</sup> The Government of Ontario, for example, boasts on the web site of its HealthForce Ontario agency: “We’re opening doors to international health professionals.” The site includes links to free services offered to internationally trained professionals (HealthForce Ontario, 2010).

greater access to international travel means that travellers, refugees and immigrants are increasingly at risk of being exposed to food borne illnesses while abroad (World Health Organization, 2002). Meanwhile, modern advances in the integration and consolidation of food industries expose more people in more parts of the world to food from fewer sources than ever, leading to outbreaks of food borne illness of regional, national and international scale (World Health Organization 2002b).

While the rapidity and range of illnesses and disease with which health care professionals must contend grows, so too do the risks of their actions in response to the complex needs of patients. Health care providers who order CT scans must contend with the radiation risks to their patients (Nickoloff & Alderson 2001). Chiropractors and their patients must deal with the possibility of an increased risk of stroke from chiropractic manipulation (Norris, Beletsky & Nadareishvili, 2000), while physicians, nurses and pharmacists must consider the risk of adverse events stemming from the wrong medication or fluid being prescribed or administered while in hospital (Baker et al., 2004). Even properly prescribed medications can, over the long term, emerge as significant threats to patient health in the light of longitudinal studies. Two recent examples include the warnings issued by the U.S. Food and Drug Administration (2007) that certain antidepressants can increase the risks of suicide in younger patients, and the announcement of a voluntary recall by Merck of its arthritis pain reliever Vioxx over concerns that the drug increases the risk of heart attacks in patients (U.S. Food and Drug Administration, 2004). Similarly, when patients are hospitalized or placed in long-term

care facilities, they must live with the risk of infection from viruses and bacteria such as the norovirus<sup>35</sup> (Vogel, 2011) and C difficile (Gravel et al., 2009). The Office of the Auditor General of Ontario (2008) reports that there are, on average, 220,000 cases of hospital acquired infections in Canadian hospitals each year, resulting in 8,000 deaths (p. 5).

### **Tradition**

The risks that accrue from modern technology and systems become more apparent to the public and to health professionals in light of the “reflexive monitoring” (Giddens, 1991, p. 16) through which health and public health agencies and patient advocacy groups now continually assess the health outcomes and the broader social impacts of new diagnostic approaches, treatments, drugs and technologies. This continual monitoring contributes, in the words of Giddens, to “radical doubt” as the “chronic entry of knowledge into the circumstances of action it analyses or describes creates a set of uncertainties to add to the circular and fallible character or post-traditional claims to knowledge” (Giddens, 1991, p. 28). The traditional prestige and authority of health professionals can erode under the glare of reflexive monitoring, with the result that traditional systems of technical knowledge are open to questioning and individuals increasingly choose between competing technical systems. Individuals can choose

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<sup>35</sup> Interestingly, Vance (2009) reported on how an interdisciplinary approach was successful in containing an outbreak of norovirus infection at a North Carolina hospital, pointing to the link between the growing complexity of health care in late modernity and the need for greater interprofessional collaboration involving health care professionals, management and the public.

between western bio-medicine and alternative therapies and Fraser Institute data suggests 76% of Canadians have done so at one point in their lives (Esmail, 2007).<sup>36</sup>

For health professions in particular, the questioning of traditional roles has also included the rethinking of traditional gender roles and a greater participation of women in the professions. In 2010, women represented 35.1% of all practicing physicians in Canada. Among physicians aged 35 or younger, that share climbs to 59.5% of physicians (Canadian Medical Association, 2010). The profession of pharmacy has seen a similar shift to the point at which women now make up the majority of practicing pharmacists in Canada and in many other developed countries (Hawthorne & Anderson, 2009). The implications of the feminization of health professions are varied. Women physicians tend to work fewer hours each week than their male counterparts (Sibbald, 2002); women are more likely to practice as general practitioners or family physicians than medical specialists (Dollin, 2001; Phillips & Austin, 2009); and women physicians spend more time consulting with patients and, as a result, see fewer patients each day (McKinstry & Dacre, 2008; Phillips & Austin, 2009). Similarly, women pharmacists are more likely to work part-time and in hospital settings, accentuating current shortages in the community pharmacy sector (Hawthorne & Anderson, 2009).

In his chapter “The reinvention of politics: Towards a theory of reflexive modernization,” Ulrich Beck points specifically to the greater participation of women in the workforce and in the professions, suggesting that, quite apart from the important

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<sup>36</sup> Giddens points to just such an example: “Someone might turn to holistic medicine after becoming disenchanted with the orthodox medical profession, but of course this is a transfer of faith” (1991, pp. 22-23).

changes to work patterns and lifestyles, this significant demographic and political shift leads to upheaval and “cuts up the nervous system of the everyday order of society” (1994, p. 27). His sentiments are echoed by a number of studies on this demographic shift in the health professions. Some researchers argue, for example, that health care professions may decline in status as a result of greater participation by women (Sibbald, 2002; Levinson & Lurie, 2004; Hawthorne & Anderson, 2009). Particularly relevant to this paper is the finding that “women empower other team members to develop their potential, act as role models by gaining the trust and confidence of colleagues, and take an interest in the personal needs of their staff” – all qualities that lend themselves to effective interprofessional collaboration (Levinson & Lurie, 2004, p. 472).

### **Public Faith & Democratic Participation**

These important shifts in traditional knowledge and traditional gender roles in health care not only invite people to choose from between different technical systems and different roles within health care, they may also invite patients to rely more on their own habits (Giddens, 1991), advice from friends and family, or information gleaned from the internet (Ahmed et al., 2006; Murray et al., 2003). Coupled with this move by patients to secure health information from other less professional sources is a demand by patients and health care funding agencies for greater influence over how resources are allocated – the demand for democratization, to use Giddens’ terminology. Beck sees this demand for greater say as an inherent part of late modern society. For Beck, “risk society is by tendency also a self-critical society... Experts are undercut or deposed by opposing

experts. Politicians encounter the resistance of citizens' groups... Administrators are criticized by self-help groups" (Beck, 1994, p. 11).

One of the visible indicators of this shift in power relations within health care is a move to patient-centered care.<sup>37</sup> The movement towards patient-centered care has been acknowledged and endorsed by the principal health care professions in Canada (CMA, 2007; Task Force on a Blueprint for Pharmacy, 2008; Canadian Nurses Association, 2009). Another indication of a shift in power relations is the increasing influence of lay individuals and patient advocacy groups in health care. Batt describes how "Canadian consumer, health and patient groups testify regularly at public hearings on pharmaceutical issues, sit on policy committees where drug policy decisions are made, attend workshops and consultations, and meet with health department decision-makers to discuss changes to drug policy"<sup>38</sup> (2005, p. 5). Although they acknowledge that the level of influence of patient advocacy groups is historically variable, Abelson and Eyles (2002) argue that citizens in Canada have had considerable influence on health policy and care in Canada through hospital advisory committees, boards of regulatory bodies, consultation

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<sup>37</sup> The Institute for Health Care Improvement defines patient-centered care as follows: "Care that is truly patient-centered considers patients' cultural traditions, their personal preferences and values, their family situations, and their lifestyles. It makes patients and their loved ones an integral part of the care team who collaborate with health care professionals in making clinical decisions. Patient-centered care puts responsibility for important aspects of self-care and monitoring in patients' hands – along with the tools and support they need to carry out that responsibility. Patient-centered care ensures that transitions between providers, departments, and health care settings are respectful, coordinated, and efficient" (Institute for Health Care Improvement, 2010).

<sup>38</sup> This influential role for individual citizens and health advocacy groups has been institutionalized to a point, with the Government of Canada's Health Protection and Food Branch establishing the Office of Consumer and Public Involvement in an effort to provide "information and opportunities for Canadians - and especially consumers of the products we regulate - to become meaningfully involved in the decision-making processes" (Health Canada, 2010).

processes and public opinion polls. The authors note, in keeping with Giddens, that the move to greater public involvement has often come at the expense of more traditional, professional influence.<sup>39</sup>

## **Conclusion**

It is in this solvent social setting<sup>40</sup> that the movement to greater interprofessional collaboration has emerged. Interprofessional collaboration is seen by many as a possible solution to new risks, as a new way for increasingly diverse health care professionals to work together, and as a reordering of the traditional power relations in health care in recognition of new demands for democratization. At the same time, the pace and profound nature of changes affecting health care may make interprofessional collaboration more challenging as health care professionals seek out a solid sense of professional identity.

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<sup>39</sup> The point is illustrated well by the current debate over self-monitoring of blood sugar levels by people with type 2 diabetes. Medical experts disagree on the impact of self-monitoring on actual patient outcomes (Bélanger, et al., 2009), while health administrators who consider reducing the insurance coverage for test strips face often stiff opposition from patient advocacy groups such as the Canadian Diabetes Association (Canadian Diabetes Association, 2010).

<sup>40</sup> I borrow this wonderful alliteration from Jackson Lears (1994, p. 75) and his description of early modernity in the mid-nineteenth century.

## Chapter Three – Literature Review

The questions surrounding collaboration between members of different professions are, ultimately, questions related to communication across cultural boundaries. They are questions of identity, anxiety and trust, meaning, and the influence of messages in the mass media. These are questions which have occupied communication scholars since the earliest decades of the discipline. This literature review will consider seven schools of thought within communication studies – seven moments where and when communication scholars paid particular attention to the challenges of intercultural communication. The review proceeds in roughly chronological order, though many schools of thought overlap in terms of time. Following the lead of Rogers (1999)<sup>41</sup>, the first such moment I consider is the work of the Chicago School and, in particular, the influence that Georg Simmel of the University of Berlin had on Chicago scholars such as Dewey and Lasswell. From Chicago, the review will move to Columbia University in New York and Paul F. Lazarsfeld’s influential notion of difference between sender and receiver as a key independent variable to consider when exploring influence and public opinion. Lazarsfeld’s focus and methodologies would profoundly influence the third moment this chapter will consider: the work of modernization scholars such as Daniel Lerner and Wilbur Schramm and their efforts to measure and understand the traditional

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41 Rogers (1999) links Simmel not only to the Chicago School but also to the field of intercultural communications as a whole, noting how Simmel influenced the work of Gudykunst, whom we will discuss in more detail later in this paper. Rothenbuhler (2003) similarly links Simmel to the Chicago School and notes that Park had studied with Simmel and that much of Simmel’s work was included in the University of Chicago department of sociology’s “Green Bible.”

culture of individuals in developing countries as a barrier to modernization. The fourth moment is centered on Palo Alto, California and marks an important shift in intercultural communications studies, away from mass media and towards interaction between individuals, as evidenced in the work of Erving Goffman and Edward T. Hall. From these four largely American schools of thought, the review will next consider the British cultural studies tradition and its understanding of culture as a resource, and of distinct cultural identities as a quality to be fostered and protected. The sixth moment considered, the interpretive tradition, features the work of scholars from many nationalities who assumed an active audience that actively and purposively makes choices with regards to the media and texts they engage and the manner in which they interpret those texts. Finally, the review will cover the more contemporary work of scholars in the intercultural communication research tradition and their particular methodological and theoretical approaches to understanding how to overcome cultural barriers in the interest of intercultural and inter-group communications.

The same questions of identity, anxiety and trust, meaning, and communication that have occupied communication scholars since the end of the 19<sup>th</sup> century have also, more recently, occupied scholars from a variety of disciplines who have studied interprofessional collaboration in health care. Their perspectives and contributions will be considered and compared with those from communication studies to close out the review.

As we shall see, these very diverse scholars have approached intercultural communication (and in some instances interprofessional collaboration) from a variety of methodological, epistemological and ontological perspectives. This chapter, then, will not

only summarize the relevant literature but assess the relative advantages and disadvantages of each for the study of interprofessional collaboration.

### **The Chicago School: Association, Disassociation and the Great Society**

The intellectual roots of the Chicago School lie both in Chicago and in Berlin – two cities that grew rapidly with the Industrial Revolution and that were the site of rapid urbanization, diversification and population growth. Though not exclusively focused on intercultural communication, the time and place of the Chicago School’s intellectual effort and their interest in consensus and the elusive “we feeling” made instances of contact and friction between cultural groups central to the research work of many of its most noted scholars.<sup>42</sup> The early efforts by Chicago scholars to explore and understand intercultural communication were very much focused on building “the capacity for empathy,” “participation in community and the acquisition of shared symbols” (Delia, 1987, p. 24).

One of the key concepts related to intercultural communication offered by the Chicago School was first articulated by Georg Simmel at the University of Berlin when he observed that both association and disassociation occur when members of two different cultural groups come together for interaction. The presence of strangers draws

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<sup>42</sup> Consider, for example: Cooley’s discussion of the need to forge a “we feeling” among people of different ethnicities and classes in *Social Organization* (1924); Thomas and Znaniecki’s (1918) exploration of the impact of modern media (especially newspapers) on Polish peasants in Europe and America and the need to use the press to “create a new secondary group from a plurality of primary groups” (1918, p. 242); or Jane Addams’ discussion of “The many foreign colonies which are found in all American cities” and how these bring with them “an enormous reserve” of traditions they can use to celebrate their homelands and America” (1909/2004, p. 29).

members of a group closer together such that the negation of the stranger provides structure and an “essential life-process” (1903, p. 491) to society. Dewey, who studied with Simmel in Berlin, later echoed the paradox, describing how contact between different cultural groups can lead to both exclusion and cohesion: “...the belief about superiority or being ‘as good as other people’, the intention to hold one’s own are naturally *our* feeling and idea of *our* treatment and position” (1922, p. 59). Harold D. Lasswell carried the idea to his study of wartime propaganda, describing propaganda as an instrument to “weld thousands and even millions of human beings into one amalgamated mass of hate and will and hope” (1927, p. 227).

The Chicago School generally took an optimistic view of communication and saw in the mass media important instruments of progress. Simmel, Dewey and Lasswell all saw in communication the seeds of a great and cohesive society. Simmel pointed to “the power of intellectual and educational interests to bring together in a new community like-minded people from a large variety of different groups” (Simmel, 1922/1955, p. 135). Dewey’s faith in a great society rested on enhancing education such that “intelligent direction may modulate the harshness of conflict, and turn the elements of disintegration into a constructive synthesis” (1922, pp. 121 – 122). Lasswell saw the positive potential of communication to bring disparate people together, praising, for example U.S. President Woodrow Wilson’s propaganda achievements in World War One: “one hundred million people, sprung from many alien and antagonistic stocks, was welded into a fighting whole, to make the world safe for democracy” (1927, p. 225).

Though they often invoked positive images of the benevolent potential of the mass media and described communication in near-magical terms<sup>43</sup>, many Chicago School scholars were also mindful of the disintegration, conflict and violence that modern conditions (including the mass media ill-used) could bring. Lasswell in particular observed the potential for the mass media to also sow the seeds of mistrust and hate. In his 1935 book *World Politics and Personal Insecurity*, he linked individual insecurities, cultural patterns and global politics on the eve of World War Two. He described how symbols in mass media propaganda campaigns were “eliciting fresh acts of identification from some, and provoking decisive acts of rejection from others” (1935, p. 33) – Simmel’s association/disassociation dynamic linked to the mass media. Lasswell paid particular attention to the role of anxiety in these processes, arguing that media representations of one cultural group could arouse “insecurity reactions” (1935, p. 155) among members of a second cultural group, and suggesting that group leaders could thus profit from generating insecurity. This observation that mass media messages can be used to elicit acts of identification from the in-group and acts of rejection from others is foundational to this study. It is precisely the potential for this dual process that will be explored in the context of different health care professions.

Drawing on the interactionist perspective of the Chicago School, Lasswell observed that existing stereotypes and preconceptions within one cultural group can

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<sup>43</sup> Dewey wrote simply and provocatively: “Of all affairs, communication is the most wonderful” (1925, p. 35).

define a second group and shape the expectations of the first.<sup>44</sup> He also noted that “the newcomer tends to respond to the attitude taken toward him by the native inhabitants” (1935, p. 128). If the attitude of the natives is negative, that response can take the form of a negative identification, which Lasswell warned, could be potent in “stimulating the elaboration of rival symbols” (1935, p. 128).<sup>45</sup>

Culture, for many of the scholars in this tradition, was not *necessarily* a barrier to community, nor was cultural homogeneity a desired end of communication. Simmel, for example, understood that modern, urban life brought with it opportunities for multiple group affiliations.<sup>46</sup> Multiple affiliations, he wrote, could lead to “psychological tensions” and, at the same time, could serve to “strengthen the individual and reinforce the integration of his personality” (Simmel, 1922/1955, pp. 141-142). Dewey also saw in modern life the opportunity for “interminglings of customs,” giving individuals the choice of selecting among the different cultural identities that surround them (Dewey, 1922, p. 70). Lasswell similarly understood cultural diversity as a resource and accused those who harbour negative stereotypes of immigrants of having “no glimmer of the cultural richness of the civilization in which these immigrants originated” (Lasswell,

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<sup>44</sup> “Fairy tales and folk lore, funny stories and derisive epithets,” Lasswell wrote, “all organize attitudes toward people who are black, dwarfed, foreign, strange, Chinese, German, Irish” (Lasswell, 1935, p. 126).

<sup>45</sup> Lasswell cites the example of Italian immigrants who were stung by epithets such as “wop” and provoked into identifying with Italian fascism.

<sup>46</sup> Simmel looks beyond nationality, ethnicity or race here, and considers affiliations based on family, occupational groups, interest groups, citizenship, social class, military affiliations and social clubs (Simmel, 1922/1955, p. 138).

1935, p. 135).<sup>47</sup> As we shall see later in the chapter, the Chicago School's fluid notion of culture may provide insight for those seeking to foster interprofessional collaboration.

The Chicago School pioneered and embraced a wide variety of empirical techniques, including a documentary approach to richly describing social life in the city, detailed content analyses of contemporary and historical media, surveys and the interpretation of census data (Delia, 1987). One of the defining features of Chicago School sociology was the emphasis on the community outside the university and the lived reality of diverse peoples there. Delia describes how "Park"<sup>48</sup>, in particular, insisted that his students get out into the city itself. Thus he fostered the development of methods of systematic observation and of participant observation" (1987, p. 32).

### **The Columbia School: Difference as a Dependent Variable**

There is also within the early history of American research into intercultural communication another trajectory with important links to the research into interprofessional collaboration. With its origins at Columbia University and the work of Paul F. Lazarsfeld, the Columbia School tradition draws particular attention through

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<sup>47</sup> In a 1957 essay, Lasswell similarly noted that "cultural diversity is itself a positive value in a free society" (p. 351) and, later added that "the change in Western arrogance owes something to the knowledge that has been accumulated of alien cultures and to the discovery that folk societies have in some instances done a better job of implementing basic human values than we have" (p. 353). Later, in his final publication (1980), Lasswell continued to caution against cultural homogenization, calling instead for a world zone of identity within a pluralizing world – a zone that would include "persons who possess an active sense of belonging to the 'nation of man' without losing their attachment to lesser identities within the whole" (pp. 520 – 521).

<sup>48</sup> Robert Ezra Park (1864 – 1944) studied with John Dewey and heard lectures from Georg Simmel while studying in Berlin. He spent 20 years in the sociology department at the University of Chicago, where he taught many of the leading sociologists of the subsequent generation, including Harold Lasswell (Peters & Simonson, 2004).

precise methods to the impact of *difference* on media consumption and effects.<sup>49</sup> Early in his American academic career, Lazarsfeld recognized and measured the extent to which different segments of the population consumed media from different sources (Lazarsfeld & Wyant, 1937).<sup>50</sup> Other researchers would follow in these methodological footsteps and focus on cultural difference, including Jeanette Sayre Smith's (1942) research into how the social and political attitudes of Italian immigrants in Boston correlated to consumption of ethnic media and whether this consumption pattern served to "hinder or further the Americanization process in the community?" (p. 590). The seeds for modernization research were sown.

Lazarsfeld returned to the question of difference and its impact on media consumption and effects in two of his most influential works (Lazarsfeld, Berelson & Gaudet, 1948; Berelson, Lazarsfeld & McPhee, 1954) in which the authors drew attention to the ways "exposure is conditioned by many personal and social characteristics – membership in community organizations, education, class, sex and – crudely – freedom from certain personality disorders" (Berelson, Lazarsfeld & McPhee, 1954, p. 241). While none of these studies was necessarily focused on culture or moments of intercultural communication, they were focused on difference as an independent variable that affects both media consumption and effects. To the extent, then, that people of a

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<sup>49</sup> Delia writes of the Columbia School's approach to communication and difference: "At the theoretical level, thinking shifted toward approaches such as that of Franklin H. Giddings, who argued for analyzing alternative response patterns in different social aggregates (political party, sex, social class, etc.) (Delia, 1987, p. 35).

<sup>50</sup> The article in *Public Opinion Quarterly* was appropriately titled "Magazines in 90 Cities – Who reads what?"

particular gender, economic status, race, and membership in a community group share a particular culture and cultural identity, cultural differences could serve as a barrier to reaching and motivating a mass audience.

Lazarsfeld's collaboration with Elihu Katz on *Personal Influence* (Katz & Lazarsfeld, 1955) confirmed culture and cultural identity as independent variables and potential barriers to effect. Their discussion of psychological predisposition specifically addressed prejudice and group membership and echoed the findings of Simmel, Dewey and Lasswell on association and disassociation: "... a prejudiced person whose attitude toward an out-group is strongly entrenched may actively resist a message of tolerance in such a way that the message may be perceived as a defense or as irrelevant to the subject of prejudice entirely" (Katz & Lazarsfeld, 1955, p. 361).

What perhaps most sets the Columbia School apart from the Chicago School is its emphasis on communication as persuasion<sup>51</sup> and its effort, through rigorous quantitative methodology, to isolate those dependent variables which most limited or fostered the persuasive effects of communication. Difference emerged as a key variable and, in the context of intercultural communication, cultural differences related to language, values, predispositions and media consumption habits were seen as barriers to be overcome.

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<sup>51</sup> Elihu Katz and David Foulkes noted this tendency in a 1962 article in *Public Opinion Quarterly*: "It is a most intriguing fact in the intellectual history of social research that the choice was made to study the mass media as agents of persuasion rather than as agents of entertainment" (Katz & Foulkes, 1962, p. 377).

## **Modernization Research: Culture as Barrier**

The modernization research project was, from its inception, a political one. Growing out of wartime propaganda studies and featuring many of the same scholars, modernization research sought to find ways to exchange traditional attitudes and relationships in underdeveloped countries with more modern ones as part of a cold-war effort to stop the spread of communism (Mattelart & Mattelart, 1992; Simpson, 1994).

The work of modernization scholars was in many ways situated at the crossroads of the Chicago and Columbia Schools within communication studies. Harold D. Lasswell's work in propaganda studies was foundational to the study of modernization and Lasswell became a leading figure in modernization research. Much of modernization research, however, followed in the methodological footsteps of Lazarsfeld and carried on the Columbia School's commitment to greater cultural alignment between sender and receivers in the interest of persuasion. A publication which captured this intersection of Chicago and Columbia is a three-volume series edited by three leading figures in propaganda studies: Harold Lasswell, Daniel Lerner and Hans Speier: *Propaganda and Communication in World History*. In their introduction, the editors contrasted traditional societies and their rigid hierarchies to modern societies and their "values of *freedom* and *equality*, which provide opportunities for any and all (in principle) to rise to positions of achieved superiority" (Lasswell, Lerner & Speier, 1980, p. xii).

Lasswell continued to see a role for efforts – especially by the scientific community – to forge consensus as a way to preserve democracy. He called for "world communication" leading to "world public order" and a shared identification with the

“nation of man without losing their attachment to lesser identities within the whole” (Lasswell, 1980, pp. 520-521). Lasswell’s roots in the Chicago School are evident here. Daniel Lerner’s methods, on the other hand, fell squarely into the realm of the Columbia School. Culture, for Lerner, is an independent variable – a potential barrier or short-cut to the effectiveness of campaigns. Lerner pointed to “the prevailing system of *values and goals* which compose the social myth; the structure and stability of political *institutions*; the pattern of *educational practices*; the condition of *technology*, and particularly of communications industries” as “limiting conditions” (Lerner, 1951, p. 1 – italics mine) to the effectiveness of propaganda.

Lerner’s *The Passing of Traditional Society* (1958) is consistent with much of his work in propaganda studies and continues to capture the spirit of Paul Lazarsfeld and the Columbia School.<sup>52</sup> He positioned culture (in this case the traditional cultures of the Middle East) as a barrier to modernization, lamenting the desire on the part of locals to modernize in their own way, and arguing that Middle Eastern “ethnocentrism... sows hatred and complicates the modernization process in the region” (1958, p. 47). Lerner carried forward Lasswell’s blend of interactionism and psychoanalysis in the concept of “empathy,” which he defined as “a high capacity for rearranging the self-system on short notice” (p. 51). He contrasted traditional and modern society by suggesting that modern audiences are more capable of empathy and, as such, demonstrate more widespread participation and “an expansive and adaptive self-system, ready to incorporate new roles

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<sup>52</sup> Indeed, the data upon which Lerner’s analysis was drawn was gathered by Columbia’s Bureau of Applied Social Research, and Lerner described his methodology as “a Lazarsfeldian latent structure analysis” (1958, p. 45).

and to identify personal values with public issues” (p. 51). Traditional culture, for Lerner, is a barrier to empathy and to modernization.

Wilbur Schramm is another leading figure in modernization research who shared with Lerner a conviction that members of traditional cultural groups had to change<sup>53</sup> and shared with Lasswell the confidence that the mass media were equal to the task. In *Mass Media and National Development*, Schramm linked change and modernization to broad, intercultural consensus. He called for a “nation-wide dialogue” to “weld together isolated communities, disparate sub-cultures, self-centered individuals and groups” (1964, p. 44). Schramm differed from Lasswell, however, in his belief that success in this endeavour might have to come at the expense of local culture, as “communication must bring about the transition to new customs and practices and, in some cases, to different social relationships” (1964, p. 114). Schramm reminded the reader of the “essential need to be ‘local’ in using the media – to be aware of local culture and symbol systems” (1964, p. 51). Rather than a celebration of the local and hybrid cultural identity, Schramm promoted a strategic understanding of local cultures as a means to construct more effective messages and select media channels for maximum effect. From there, the flow of messages that cut across cultures and weld cultural groups together could have their

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<sup>53</sup> “Unless they change,” he wrote, “they will have to watch technological growth from the sidelines; social change will happen to them, rather than their playing an active part in bringing it about” (Schramm, 1964, p. 19).

effect.<sup>54</sup> Culture, for Schramm as for Lerner, is a potential barrier<sup>55</sup> to effective modernization and the source of possible strategic advantage.

The parallels between the work of modernization scholars within communication studies and efforts to promote greater interprofessional collaboration are evident. Consider, for example, the call by the Royal College of Physicians and Surgeons of Canada for efforts to promote “the cultural and attitudinal shifts needed in order to realize and support collaboration both between specialties and between specialties and other health providers” (Office of Health Policy and Governance Support, 2009, p. 4). The call echoes in many ways the efforts by modernization scholars to remove cultural barriers, weld together disparate groups, develop new practices and foster new relationships. Like modernization scholars, those advocating for greater interprofessional collaboration in health care are split on the question of lesser cultural identities. While some scholars insist that professional identities serve only as barriers to collaboration, others – including the Office of Health Policy and Governance Support – are concerned that with the move to greater interprofessional collaboration: “the blurring of roles among health

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<sup>54</sup> Schramm’s research with Hideya Kumata suggested that common frames of reference may indeed exist and allow communicators to overcome “problems of meaning” (Kumata & Schramm, 1956, p. 229) and semantic frames of reference. By having American, Japanese and Korean students assess various concepts (i.e. communism, atomic warfare) using the same semantic differential scales (i.e. good – bad, thick – thin, sharp – dull), the researchers used sophisticated statistical analysis to conclude, with caution: “The remarkable correspondence across cultures tempts one to say that perhaps there is a semantic frame of references used by humans” (p. 238).

<sup>55</sup> Schramm pointed out that cultural traditions surrounding agriculture can present an important barrier, as agriculture involves “personal emotional expression, family ties, religious sentiment, social intercourse, and firmly established habits of behaviour” (1964, p. 116). The stronger the link between an activity and cultural identity, the bigger the barrier.

professionals have led to issues and questions regarding the appropriateness, clarity, and acceptance of these roles” (2009, p. 5).

### **Palo Alto: Culture as a Complex and Silent Language**

While the flow from Chicago and Columbia through to modernization studies is continuous, there is also a second trajectory in communication studies that had its roots in Chicago and that would go on to consider intercultural communication in some depth. The Palo Alto School<sup>56</sup> brought very different methodologies and assumptions to the study of intercultural communication, as evidenced by two scholars who paid particular attention to moments of intercultural communication: Erving Goffman and Edward T. Hall.

Goffman’s interest in intercultural moments of communication began with his dissertation research in the Shetland Islands, where he drew from the interactionist work of George Herbert Mead to study how the hotel staff interacted with outsiders, including Goffman himself.<sup>57</sup> Focused as it was on moments of interpersonal interaction, Goffman’s *The Presentation of Self in Everyday Life* (1959) was a clear departure from the focus on mass media of much of the research from the Chicago School, the Columbia School and modernization researchers. The work, however, retained important links to the Chicago School, especially to Mead’s work on symbolic interaction (Mead, 1934) and Simmel’s ideas on the stranger (Simmel, 1908/1950). Goffman also expanded the idea of

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<sup>56</sup> The school is named for the Palo Alto Veteran’s Administration Hospital where a leading figure from the group, Gregory Bateson, conducted research (Chriss, 1993).

<sup>57</sup> Charles Lemert provided a full account of this in his introductory essay to *The Goffman Reader* (1997).

communication to include not only spoken and written words but also the communicative potential of the human body. He noted that members of a society learn a shared understanding of body symbols<sup>58</sup> – a common body idiom. Similarly, he offered a more complete list of communicative stimuli that comprise the “personal front,” including “insignia of office or rank; clothing; sex, age and racial characteristics; size and looks; posture; speech patterns; facial expressions; bodily gestures; and the like (1959, pp. 14 – 15).

In *Behaviour in Public Places* (1963), Goffman argued that intercultural interaction involves complex rules of engagement that participants learn and then adhere to and evade in culturally-specific patterns.<sup>59</sup> He also – in a manner reminiscent of Lasswell – called attention to how successful interaction in which rules are mutually understood and expectations around adherence to those rules are clear, can lead to “a group atmosphere”<sup>60</sup> whereas attempts to interact with those who do not their share idioms, rules and expectations may have the opposite effects.

Edward T. Hall is perhaps most closely associated with intercultural communication, thanks in large part to *The Silent Language* (1959), which focused on the manner in which space and time communicate and how their meaning varies across

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<sup>58</sup> Goffman (1963) paid particular attention to the decision of whether or not to nod to strangers, noting that in smaller villages most everyone will warrant a nod, as compared to larger urban areas. “Thus, in Shetland Isle,” he writes, “there was a general feeling that strange seamen who sounded and looked British were to be brought within the circle of humanity, but not those from foreign ports.” (Goffman, 1959, p. 133).

<sup>59</sup> Goffman mentions as examples the differences in how women and men interact in traditional Hindu society, rural Paraguay and America (Goffman, 1963, p. 117).

<sup>60</sup> Goffman refers to this as a “we-rationale” – a more temporary and contained version, perhaps, of Cooley’s “we sensibility” (Goffman, 1963, p. 98).

cultures. Describing the complex and largely unwritten rules that govern intercultural encounters, Hall concludes: “Anxiety, however, follows quickly when this tacit etiquette is breached” (1959, p. 74), echoing Lasswell’s emphasis on insecurity. Hall’s research was designed to help diplomats and business people<sup>61</sup> overcome these cultural barriers to communication, though his emphasis on negative outcomes is of particular importance to this study. Hall returned to questions of culture and intercultural communication in *Beyond Culture* (1976). The book featured a deeper and more urgent sense that culture and distinct cultural identities were barriers to be overcome or transcended in the interests of global peace. He continued in the Palo Alto tradition of defining communication broadly and exploring a wide range of different communication stimuli. Culture, for Hall, was a “total communication framework” that included words, actions, postures, gestures, tones of voice, facial expressions, the way we handle time, space, and materials and the way we work, play, and defend ourselves (Hall, E. T., 1976, p. 37). Communicating across culture involves understanding each of these facets of the other culture in their historical, social and cultural context.

The research of the Palo Alto School was richly diverse and is difficult to categorize. When researchers from the school focused on intercultural communications, it was often with a very broad perspective of what constitutes communication – one that went far beyond the mass media. Palo Alto scholars also developed a deep understanding

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<sup>61</sup> Hall served with the Foreign Service Institute from 1951 to 1955, training and retraining American diplomats (Rogers, 1999). He also published (Hall, 1960) a summary of *The Silent Language* in the form of an article (“The Silent Language in Overseas Business”) in the *Harvard Business Review*.

of the role differences in culture can play in shaping the meaning that emerges from the myriad channels of communication they explored.<sup>62</sup> And while Edward T. Hall's early work mirrored the pragmatic intent of some of the modernization research, his later work moved more in line with that of his colleagues in focusing less on predicting and perfecting persuasion and more on describing and understanding the myriad and often unconscious ways in which human beings communicate and interact in social settings.

### **Cultural Studies: Identity, Resistance and Resource**

The British cultural studies tradition that emerged out of the University of Birmingham in the late 1960s was, from the start, focused on moments of intercultural communication. Raymond Williams (1958, 1961) traced the evolution of the concept of culture and, with it, a new understanding of communication and intercultural communication. Williams saw the concept of culture as a response to the Industrial Revolution, market capitalism and to the new kinds of personal and social relationships these forces brought with them to Western Europe from the late 18<sup>th</sup> century onwards. His research was fundamentally political<sup>63</sup> and Williams proposed a new kind of social relations built on solidarity, a common culture, equality of being, effective participation and diversity without separation. By rejecting the mix of individualism and capitalism

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<sup>62</sup> Another example of this focus is found in Ray Birdwhistel's studies on differences in the frequency of smiling among residents of different regions of the United States (Birdwhistel, 1970).

<sup>63</sup> Grossberg, Nelson and Treichler made a similar point: "... its practitioners see cultural studies not simply as a chronicle of cultural change but as an intervention in it, and see themselves not simply as scholars providing an account but as politically engaged participants" (1992, p. 5).

that had shaped social relations since the Industrial Revolution,<sup>64</sup> Williams set cultural studies apart from much of the research into propaganda and modernization, as well as the work of the Palo Alto School. There are similarities, however, with the progressive project of much of the early Chicago School research.<sup>65</sup>

Much like the Chicago School and modernization scholars, Williams called for a common culture. Unlike modernization scholars, Williams focused less on persuasion and more on power relations, insisting that common culture had to be founded on “equality of being” (Williams, 1958, p. 317). Anything less than equality depersonalizes and degrades human beings, undermining efforts to create a common culture out of shared experience. Equality, for Williams, did not mean homogenization in any respect. In many ways echoing the sentiment of Lasswell, he wrote: “Inequality in the various aspects of man is inevitable and even welcome; it is the basis of any rich and complex life” (1958, p. 317). Cultural studies, from the moment of its founding, valued<sup>66</sup> cultural difference, rather than seeing it as a barrier to be overcome. In keeping with this, cultural studies called for two-way, accessible communication between people, and rejected the one-to-many concept of mass communication. Transmission of messages through

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<sup>64</sup> Williams rejected “the ladder version of society” because it “weakens the principle of common betterment” and “sweetens the poison of hierarchy” (1958, p. 331).

<sup>65</sup> Rogers suggested that, once Park took the helm of the sociology department at the University of Chicago, the focus shifted: “The proper role of the social researcher, Park felt, was to study and report research results, but not to engage in ameliorating the social problems that were studied. This task should be left to social workers and to other professionals” (1999, p. 61).

<sup>66</sup> Williams expresses the value of difference well in *The Long Revolution* as well: “With that basic inequality (ownership of capital) isolated, we could stop the irrelevant discussion of class, of which most of us are truly sick and tired, and let through the more interesting discussion of human differences, between real people and real communities living in their valuably various ways” (1961, p. 335). (Brackets mine).

whatever means must not be “an attempt to dominate, but to communicate, to achieve reception and response” (1958, p. 316).

Whereas Chicago School scholars often saw a common culture emerging inevitably out of interaction, Williams saw genuine interaction as possible when a common culture, based on shared experience and equality, is present. For communication to contribute to the formation of a common culture, it must be the *right* kind of communication in the *right* social conditions.<sup>67</sup> This more tenuous relationship between communication and intercultural relations is in keeping with the work of Lasswell. It understands that communication of the *wrong* kind may contribute to the *wrong* kind of social conditions – conditions not based on equality and trust – thus deepening cultural differences and rendering future communication and collaboration more challenging.

Williams saw communication as an interpretive process and understood that successful communication between individuals is only possible if the two “come to share the complex details and means of a learned communication system” (Williams, 1961, p. 35). He did not take success for granted, however, understanding that cultural groups develop “structures of feeling” that make it challenging to communicate across cultures: “In some cases we will be literally unable to receive what is offered; we simply cannot see the world, cannot respond to experience, in that way” (Williams, 1961, p. 35).

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<sup>67</sup> Though the difference in perspective of “cart and horse” is important, Williams’ understanding of the relationship between communication and community is nonetheless closely aligned with the thought of Dewey and Mead: “... any real theory of communication,” he writes in *Culture & Society*, “is a theory of community” (1958, p. 313).

Williams' understanding of intercultural communication includes the dominance of one cultural group over another. As a Welshman and Cambridge-educated scholar, he had a profound sense of the domination of English culture over his own.<sup>68</sup> He had a lived sense of the Welsh culture and its steady erosion under English-dominated capitalism.<sup>69</sup> He also argued that with such domination comes an inability to express and represent a community's unique voice and have it heard. This notion of cultural power would find its echoes in some of the research into interprofessional collaboration.

In terms of epistemology and methodology, Williams – a literary scholar – brought the focus of research away from the responses of research subjects and to the text and the “personally verifiable statements” of their authors (1958, p. xix). Focus on rigorous measurement and statistical analysis was replaced by close readings of a variety of texts.<sup>70</sup> Texts could be read to better understand the evolving structure of feeling within a given cultural group (as Williams did with Welsh novels or Hoggart (1957) did with working class magazines and songs), or to reveal (as Graeme Turner summarized in *British Cultural Studies*), “the political implications of the media messages” and “the part

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<sup>68</sup> Williams described his own experience in “The Importance of Community”: “... I found that in myself – and of course by this time I had been away and through a very different experience – in myself that most crucial form of imperialism had happened. That is to say, where parts of your mind are taken over by a system of ideas, a system of feelings, which really do emanate from the power centre” (2003, pp. 181 – 182).

<sup>69</sup> In his analysis of Welsh industrial novels, Williams summarized the condition of the Welsh, as described in Gwyn Thomas's *All Things Betray Thee*: “... that deep ambiguity of a subordinated people, a subordinated class, whose visions are larger not only than those of the alien system by which they are dominated but larger also than is tolerable, when you are that far down and still seeing that far up” (1980, p. 228).

<sup>70</sup> Hoggart specifically called for textual analysis over surveys: “The close reading of forms of mass art may seem too elaborate a process to be worth the effort. The sociologist might offer, instead, the useful alternative of asking people what mass amusements mean to them. This suggestion, however, does not provide an adequate substitute for experiencing things in themselves, since we cannot know what we respond to until we have explored both the objects and our responses to them” (1982, p. 132).

the media played in determining definitions of the normal, the acceptable and the deviant” (Turner, 1990, p. 82). Similar to scholars from the Palo Alto School, Hoggart brought to cultural studies a broad view of communication that went far beyond verbal systems of meaning. In *Uses of Literacy* (1957) he explored the communicative power of elements as diverse as speech, manners of speaking, dialects, accents, intonations, false teeth, clothing, cars, songs and the choice of whether to watch a football game from the terrace or the stands. Hoggart also echoed the ideas of Goffman, paying close attention to specific moments of interaction and deriving patterns of social relations from them.<sup>71</sup>

Cultural studies scholars have also considered in considerable detail the notion of identity. Much as the meaning of texts is negotiated, Stuart Hall argued individual identities are negotiated, “constructed within the play of power and exclusion” (1996, p. 5). In the face of globalization and postmodernism, identity becomes a “movable feast,” formed and transformed continuously in relation to the ways we are represented or addressed in the cultural systems which surround us (cited in Hall, Hell and McGrew, 1992, p. 277). Hall, like many in the Chicago School, understood that identities are often formed through exclusion – in opposition to the perceived identity of the other. “Throughout their careers, identities can function as points of identification and attachment only *because* of their capacity to exclude, to leave out, to render ‘outside’,

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<sup>71</sup> Consider how this passage from Hoggart (1982) echoes Goffman’s dramaturgical approach: “There is a rich and provocative field to be explored in the interplay between ideas on character, relationships, setting and the nature of the dramatic within literary criticism, and sociological literature on symbolic interaction, role-playing and the definition of the situation” (pp. 129 – 130).

abjected” (1996, p. 5).<sup>72</sup> This notion of identity through exclusion brings with it questions of cultural power as individuals are “hailed by discourse” (Hall, S., 1996, p. 6), called to specific cultural groups, often at the expense of other groups by institutions (whether military, political, religious, commercial, cultural, etc.).

Cultural studies, then, offers concepts and methodologies with which to understand the challenges of interprofessional collaboration. Cultural studies shares with the Chicago School a commitment to participation, democracy and difference as a source of vitality; both traditions understand the value of common culture while not at the expense of the local and traditional. Cultural studies also compels us to consider questions of power in intercultural encounters and to be mindful of the destructive power of cultural domination. Interprofessional communication and collaboration, for scholars in the cultural studies tradition, must be carried out by professionals of all kinds and patients with equal power and prestige – a significant challenge for health care, as argued by numerous researchers into interprofessional collaboration (see discussion below). Methodologically, cultural studies encourages us to focus not only on the responses of research subjects but on the texts that surround them and from which they derive meaning in their daily lives.

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<sup>72</sup> Williams made a similar point: “War stands out as one of the fundamentally unifying and generalizing experiences; the identification of an alien enemy, and with it of what is often real danger, powerfully promotes and often in effect completes a ‘national identity’” (2003, p. 192).

## The Interpretive Tradition: Meaning, Engagement and Defense

After collaborating with Lazarsfeld early in his career, Elihu Katz continued to conduct influential research into moments of intercultural communication, focusing first on how different audiences with differing needs consume and use the media differently and, more recently, on how different social and psychological predispositions can yield different engagements with, and interpretations of the same text. Katz and Gurevitch (1973), for example, mapped out how differences in needs influence the uses and gratifications which individuals derive from media consumption and, hence, affect their media consumption habits. Though this research was also not specifically focused on intercultural communication, it did set the stage for cross-cultural comparison<sup>73</sup> since research into uses and gratifications was conducted in a number of different countries.

Katz's research became more fully focused on intercultural moments of communication when he and Tamar Liebes explored the way different cultural groups within Israel interpreted and engaged an episode of the American night-time soap opera, *Dallas*. The authors did find significant differences in the ways members of different cultural groups were involved in the program, in the ways they interpreted and made sense of the story, and in the way they applied their own narrative forms to retell the story in a group setting.<sup>74</sup> What is particularly interesting for this paper is that Liebes and Katz

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<sup>73</sup> Indeed, Katz and Gurevitch make the point that while their research was conducted in Israel, the BBC conducted similar research in England and Kaarle Nordenstreng studied the consumption of the mass media in Finland (Katz & Gurevitch, 1973, p. 164).

<sup>74</sup> Though Katz has longstanding connections to the Columbia School and its methods, the book often goes beyond differences in how a foreign program is interpreted to explore the small group patterns of

found particularly significant differences in the interpretation and responses of more traditional cultural groups as compared to the two “Western” groups (Americans and kibbutzniks). Their discussion of the efforts by members of more traditional groups to “mobilize values to defend themselves against the program” (1990, p. 153) were in many ways similar (if antithetic) to discussions by Daniel Lerner of the passing of a traditional society and reminiscent of the language of the very cultural studies scholars they had distanced themselves from in their introduction. This finding suggests that messages designed to forge association among members of one group could bring about a defensive reaction among members of another group, further defining and deepening the boundary between them.

The study of how international audiences interpret an episode of *Dallas* was, to use the language of Katz, a study of the ways media images *of* a majority, *by* a majority and *for* a majority were then interpreted by a minority.<sup>75</sup> Though they studied how the text of a dominant group was engaged and interpreted by others, Liebes and Katz did not share the same position on cultural imperialism as those in the cultural studies tradition. They set themselves clearly apart from those who, in their estimation “have labeled the process ‘cultural imperialism’ as if there were no questions but that the hegemonic message

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interaction within cultural communities – a description which is often more reminiscent of Goffman than of Lazarsfeld. Consider, for example: “Each consensus that arises from the process of mutual aid... takes on a new life as a conversational resource. The group makes use of these shared concepts and values. The group adopts into its culture the array of words, characters, metaphors, ideas, and attitudes which were verbalized as mutual aid and uses them as a symbolic vocabulary to enter even deeper into relevant issues and problems” (Liebes & Katz, 1990, pp. 91 – 92).

<sup>75</sup> Katz’s scheme was presented by Larry Gross in his contribution to Liebes and Curran’s *Media, Ritual and Identity* (1998, p. 89).

the analyst discerns in the text is transferred to the defenseless minds of viewers the world over for the self-serving interests of the economy and ideology of the exporting country” (1990, p. 4). They concluded: “Such programs may beam a homogeneous message to the global village, but our study argues that there is pluralism in the decoding” (1990, pp. 151 – 152). In the interpretive tradition, then, Liebes and Katz left open the question of whether and how members of different cultural groups will engage with, and make sense of the same texts.

Liebes expressed a unique position on cultural homogeneity in her 2003 book, *Americans Dreams, Hebrew Subtitles: Globalization from the Receiving End*. On the one hand, she offered an impassioned account about the Americanization of the media and its implications for Israeli society and culture, acknowledging cultural imperialism. On the other hand, she remained wary of particularism and the cultural and ethnic enclaves within Israeli society. Echoing the interests of the Chicago School, Liebes lamented the “emaciated ‘consensus’ in which government and media hold a tattered umbrella over a society segmented into a variety of cultures openly competing for political domination, with the ethos of the secular, Western-style democracy wearing thin” (Liebes, 2003, p. 18).<sup>76</sup>

In terms of methodology, Liebes and Katz also differed from the cultural studies tradition in arguing that close analysis of television programming was not enough and

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<sup>76</sup> Liebes reiterated her lament, bringing to mind the Chicago School’s concern for democracy and participation later in the book: “... we are now much more aware of the human tragedy surrounding us, on our side as well as the other. Yet, although we have gained in information and in empathy, we have lost the sense of membership and the potential for deliberation. Israeli media model 2000 continues to speak to viewers as individuals, not as part of a collective in trouble” (Liebes, 2003, p. 193).

that researchers needed to study the “actual interaction between the program and its viewers” (1990, p. 4) if they hoped to understand the way meaning emerges from interpretation and negotiation by individuals from particular ethnic and cultural communities (in this case, Israel, Japan and the U.S.). They pointed out that this qualitative methodology enabled them to study broad themes and patterns of response to the program by viewers, rather than using quantitative methods and focusing on “microscopic units” (1990, p. 9).

### **Intercultural Communication Research: Theoretical Precision**

As cultural studies and its critical stance expanded, a more empirical and less political approach to intercultural communication was emerging in the U.S. The field of intercultural communication research has only limited intellectual links with the broader field of communication studies. Fully 80 years after the publication of Simmel’s influential research, scholars in the intercultural communication tradition still referred to themselves as “youthful field” still needing to “cultivate methodological tools that are adequate for pursuing our inquiries” (Gudykunst & Kim, 1984, pp. 13 – 14).<sup>77</sup> References to pioneering scholars in communication studies are few and often absent.<sup>78</sup> Similarly, Min-Sun Kim and Amy S. Ebesu Hubbard (2007) suggest that “communications scholars

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<sup>77</sup> Gudykunst’s (2005) detailed essay on “the development of theories of intercultural communication in the United States,” for example, (p. 61) includes 110 references, of which only six date from before 1970, whereas 55 date from 1990 or later.

<sup>78</sup> In addition to the reference noted above, the other exceptions include two references to Wilber Schramm (Samovar and Porter, 1976; Starosta, 1984); one reference to Edward T. Hall (Gudykunst, 1994); one to Stuart Hall (Kim, 2007); one to Simmel (Kim and Gudykunst, 1988); one to Goffman (Kim, 2001); and one to Lasswell (Kim, 2001).

have long ignored 'culture' as a source of influence on human communication behavior” (Kim & Hubbard, 2007, p. 224), which, in light of the 20 or so preceding pages, seems incomplete as an assessment.

In formulating his approach to intercultural communication research, Gudykunst did look back further and drew from the work of Simmel<sup>79</sup> and Edward T. Hall<sup>80</sup>, among others, to elaborate a theory of communication with strangers he dubbed Anxiety and Uncertainty Management (AUM). “When anxiety and uncertainty are above our maximum thresholds,” Gudykunst wrote, “we are unable to communicate effectively (e.g., because we are focused on the anxiety or we cannot predict strangers’ behavior)” (Gudykunst, 2005, p. 70). Carrying on the optimism and progressivism of the Chicago School, Gudykunst wrote that “The extent to which individuals are mindful of their behavior moderates the influence of their anxiety and uncertainty management on their communication effectiveness” (2005, p. 70). He also suggested a role for the mass media in helping to reduce uncertainty about members of other groups’ behavior (Gudykunst, 1988).

Intercultural communication researchers generally view culture as a barrier. “Culture,” write Samovar and Porter “is a communication problem because it is not a constant; it is a variable. And as cultural variance increases, so do the problems of

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<sup>79</sup> Note the use of “the stranger” in the following quote, along with the use of the term “inter-group,” as if to stress the broad application of the concept: “To understand intergroup behavior it is necessary to recognize that at least one of the individuals involved is a ‘stranger’ ... strangers are physically present and participating in a situation (i.e. interacting with the ingroup), but at the same time are outside the situation because they are from a different place (i.e. an outgroup) (Gudykunst, 1988, p. 125)

<sup>80</sup> See Rogers (1999) for a detailed account of the trajectory from Simmel and Hall to Gudykunst.

communication” (Samovar & Porter, 1976, p. 6). The authors link the “problem” of intercultural communication to cultural variances in the perception of social objects and events” and much like Dewey and Edward T. Hall, propose that these barriers “can best be lowered by a knowledge and understanding of cultural factors that are subject to variance, coupled with an honest and sincere desire to communicate successfully across cultural boundaries” (Samovar & Porter, 1976, p. 9).

In contrast to much of the work from the Chicago School and cultural studies, Kim suggests that each individual must decide whether or not to maintain his or her original cultural attributes when faced with assimilation. She acknowledges that preserving one’s cultural identity “may serve many useful purposes for individuals and groups who value and desire cultural preservation. For the purposes of cross-cultural adaptation, however, it delays the acquisition of host communication competence and meaningful engagement in host communication processes” (Kim, 2001, p. 144). Echoing the thoughts of Lerner on ethnocentrism and empathy, Samovar and Porter (1976) write of the drive to maintain one’s cultural identity: “When we allow ethnocentrism to interfere with our social perception, the effectiveness of intercultural communication is reduced because we are unable to view aspects of another culture that differ from our own in an objective manner” (p. 11). Unlike Lerner, however, Samovar and Porter understand that either party to intercultural communication can display ethnocentrism, not only members of the traditional society.

Many scholars in the field of intercultural communication research share with cultural studies a strong sense of fluid and voluntary cultural identity in the era of globalization. Kim wrote of cultural identity for strangers in a new host society: “The

*choice* remains one that each individual can and must make” (Kim, 2001, p. 145 – italics mine). Similarly, Rich and Ogawa (1972) suggested that members of a minority can *choose* to move within the community of assimilated members of the minority or stay within their original community. Kim and Hubbard also suggested that “by maintaining control of *choice* and construction of boundaries, people may become ‘constructive’ marginals” who can “consciously create their own identity” (Italics mine – Kim & Hubbard, 2007, p. 229).

Given its more pragmatic and less political orientation, many intercultural communication researchers have only a limited conception of power. Kim, for example noted that individuals in host societies can use “disassociative communication behaviors” to erect and maintain “psychological barriers between interactants” while stopping short of exploring the power relations between these interactants (2001, p. 151). It would be wrong, however, to suggest that notions of power are completely absent from the field. Rich and Ogawa (1976), for example, note that power relations often exist between cultures and that where one group dominated the other, a third space exists where members of the dominated group can leave their cultural group, come close to the dominant cultural group but never quite join. Kim and Hubbard, for their part, write about “how to understand ‘the other’” and the dominance of modern Western ideas in shaping the discipline of intercultural communication research, calling on colleagues to “explore different ideologies that may reflect other cultures and populations and may offer additional revelations about our own familiar ideologies” (2007, p. 227).

Methodologically, intercultural communication research is characterized by a strong emphasis on quantitative research evidence and rigorous theory development.<sup>81</sup> The empirical evidence gathered by intercultural communications researchers yields both complex theories and, more pragmatically, assists researchers in “understanding, predicting, and controlling the phenomena of intercultural communication” (Kim, 1984, p. 27). This places the field squarely within the Columbia School tradition – research for the sake of understanding and controlling independent variables.<sup>82</sup> Intercultural communication researchers tend to take a broad and comprehensive view of what constitutes moments of intercultural communication. Kim’s (2001) integrative theory of intercultural communication, for example, looks at a multitude of variables and instances and forges them into a coherent theoretical model. She considers a wide range of moments of intercultural communication, including encounters between individuals of two different cultural groups, interaction within the host culture, interaction within the stranger’s cultural group, consumption of host mass media and consumption of ethnic media. The view of what constitutes intercultural communications is also wide in that it often considers cultural groups based on commonality other than nationality.<sup>83</sup> Samovar

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<sup>81</sup> The emphasis on theory development is so fundamental to the field that Young Yun Kim sets the field apart by noting that “(d)espite the rather substantial number of writings that stress the importance of interpersonal communication skills in intercultural ‘success,’ there has been relatively little effort directed to establishing the systematic, empirical validity of the assertions being made” (Kim, 1984, p. 23). One wonders, however, why the systematic and empirical work of Lasswell, Lazarsfeld, Katz, Hall, Birdwhistell and others is left out of Kim’s discussion.

<sup>82</sup> Gudykunst illustrates this tradition nicely in his *Bridging Differences: Effective Intergroup Communication* (1994) where he writes for his lay audience: “I translate the theory so that you can use it to improve your abilities to communicate effectively and manage conflict with strangers” (p. 6).

<sup>83</sup> Rogers (1999) credits Gudykunst for the broadening of the perspective to include differences that are neither ethnic nor racial.

and Porter look beyond racial and ethnic differences to consider cultural differences stemming from “gross socio-cultural differences without accompanying racial or ethnic differences” (1976, p. 1).

Intercultural communication research carries on in many ways the work of the Columbia School and modernization research. Culture operates as a barrier and rigorous research can help identify dependent variables so as to create conditions that maximize the effectiveness of intercultural communications. There is also, though, some alignment with cultural studies and the interpretive tradition in the notion of individual choice that is evident in intercultural communication research: the choice of whether and when to interact with members of another group, and the choice of identity the individual will construct and adopt.

### **Interprofessional Collaboration**

In this section, we turn our attention to a field of research which is different in many ways from communication studies. Researchers who focus on interprofessional collaboration are drawn from a variety of disciplines, including nursing, medicine, social work, sociology and health administration. Few researchers in interprofessional collaboration cite communication scholars – and in particular any of the communication scholars who focus on intercultural communication. This section will attempt, then, to identify important parallels between the work of researchers in interprofessional collaboration and the theoretical concepts developed by communication scholars and discussed in the preceding pages of this chapter. The goal is to show that these parallels

exist and to explore their implications for this study and future studies in interprofessional collaboration.

### **Distinct Professional Cultures**

As suggested in the first chapter, the possibility of distinct professional cultures and professional identities is recognized in much of the literature on interprofessional collaboration in health care. Consider, for example, Roberts' (1989) study into the challenges of fostering collaboration between social workers and physicians in light of the distinct occupational cultures that are manifested in physicians' preference for hard data as compared to social workers' preference for soft, qualitative data. Similarly, argues Roberts, physicians are oriented to saving lives, whereas social workers are more oriented to quality of life. Degeling, Kennedy and Hill also pay attention to the role of different professional cultures (in this case medicine, nursing and management) in resisting the move to replace profession-based structures (e.g., a nursing division) with clinical directorates (e.g., cancer care clinic) in hospitals. The authors explore how nursing and medical managers mediate the cultural boundaries between their profession and managerial roles. Using a quantitative survey of clinicians and managers, the authors point to the "resilience of professional subcultures compared to the fragility of management in clinical settings" (Degeling, Kennedy & Hill, 2001, p. 44). Simply put, even once promoted to management, nurses and physicians retained many features of their professional culture and differed significantly from their lay management counterparts. The findings also point to important differences between nurses and physicians: the former have a more care-oriented, collective approach while the latter

display a more cure-oriented, individual approach to care. The authors conclude that a move to multi-disciplinary clinical pathways in hospitals will require “negotiating a balance between the discursive domains of all stakeholders” (2001, p. 47). What is not clear is whether this negotiation will mean the erosion of cultural boundaries between nurses, physicians and managers or simply finding a way forward that all can agree to.

Much like Roberts and Degeling et al., Dombeck (2007) sees distinct professional cultures as barriers to collaboration. She links membership in a profession to a sense of personhood and makes the case that successful interprofessional collaboration requires a process of cultural sensitization similar to facilitating cross-cultural communication in other social groups. Dombeck’s understanding of culture is broad and reminiscent of the definition offered by John R. Hall and the work of Erving Goffman and Edward T. Hall. She maps out the symbols of professions (e.g., white coat, stethoscope), the rites of passage for each, and the specific ethical dilemmas faced by physicians, nurses, clergy and counselors. Atkins (1998) similarly compares membership in a profession to tribalism and adopts the position that “we have deep-rooted needs for attachment and continuity” (p. 304), echoing in part the Chicago School and cultural studies position on culture.

Adopting a Goffmanian interactionist perspective on culture, Wackerhausen (2009) writes that a member of a profession must “acquire and behave according to the (tacit) ‘cultural dimension’ of the professions... ‘good manners’, the unarticulated etiquette or customs of a profession” (p. 459). Professional culture, for Wackerhausen, compels members to “talk like we do,” ask “the type of questions we do,” respect certain “criteria of relevance” and “tell the type of narratives we typically tell” (p. 460).

The notion of what constitutes culture may vary from one researcher to another but the idea that members of a profession share a common professional culture is evident in these studies, with most sharing the belief that distinct professional cultures and cultural identities serve as barriers to interprofessional collaboration in health care.

### **Association and Disassociation**

The concept of association and disassociation proposed by Simmel and explored by the Chicago School finds its echo in the work of many interprofessional collaboration scholars. Irvine, Kerridge, McPhee and Freeman (2002) note, for example, that “interprofessional relationships continue to be characterized by conflict rather than cooperation and are frequently distorted by mutual suspicions, hostility and disparities between the way that a particular profession views itself and how it is viewed by other occupations” (p. 199). The authors list a number of factors that contribute to cultural barriers, including different interpretive frames, languages, stereotypes, training and identity. With the latter, they again echo Simmel and his understanding of how association can be generated through disassociation: “... intergroup competition can arise as each group strives to acquire or maintain its own social identity” (2002, p. 206).

Citing the work of Gieryn (1983), Pippa Hall (2005) introduces a concept that aligns well with the Chicago School and the association/disassociation dynamic. “Boundary-work,” she writes, “heightens the contrast between rival professions or occupations in ways flattering to the ideologists’ convictions” and “fosters the exclusion of rivals by labeling them as frauds, amateurs or incompetents” (p. 189). The emphasis on

heightened contrast and exclusion will be important to the analysis of messages in professional channels of communication that will follow in subsequent chapters.

Austin, Gregory and Martin (2007) draw from Tajfel's (1981) social identity theory to guide their analysis of findings from semi-structured interviews with pharmacists who become physicians. Echoing the notion of boundary-work proposed by Pippa Hall (2005), whom they cite, the authors explain that social identity theory suggests that individuals will – in a manner very similar to the dynamics described by Simmel – identify groups of others similar to them (“us”) and protect the status of their group through “out-group derogation and in-group favouritism” (p. 86).

Pecukonis, Doyle and Bliss arrive at similar conclusions in their exploration of the barriers to interprofessional education. They point to diverse cultural structures and profession-specific cultural frames as the principal reasons why educators avoid training students across disciplines. In keeping with concepts such as boundary-work and social identity, the authors cite sociologist William Graham Sumner as he describes a similar dynamic as that described by Simmel: “Each group nourishes its own pride and vanity, boasts itself superior, exalts its own divinities and looks with contempt on outsiders (Sumner, 1906, pp. 12 – 13 as cited in Pecukonis et al., 2008, p. 420).

Wackerhausen stresses, in a manner reminiscent of Dewey, that the narratives told by members of a profession to one another “are often rather ‘biased’ in the sense of accentuating *our* virtues, victories or unjust suffering and *their* (the other professions’) vices, failures and undeserved victories (2009, p. 460). It is precisely these kinds of narratives that can be told through the channels of communication of a profession and which the textual analysis portion of this study will explore.

## **Modernization and Empathy**

As suggested earlier in this chapter, the work of a number of researchers in interprofessional collaboration in many ways aligns with modernization research. Many researchers call for a new perspective that echoes the notion of empathy at the heart of much modernization research. Moreover, many of these studies resemble modernization research in that they fall short of arguing for the value of distinct professional cultures, seeing this first and foremost as barriers to collaboration. Pippa Hall, for example, points to the different training and socialization offered by each health profession as impediments to collaboration:

Profession-specific world-views merely prepare individuals to work within their own profession, not to communicate with individuals from another profession. They begin their careers with interprofessional barriers of unfamiliar vocabulary, different approaches to problem-solving, and a lack of common understanding of issues and values (P. Hall, 2005, p. 193).

Like Irvine et al., Hall also points to different interpretive frames as contributing to cultural barriers, pointing to a professions' unique world views and citing Petrie's (1976) research into the unique cognitive maps of different academic disciplines. She concludes by calling for the identification of clear and common goals by team members such that members can shift their own professional focus to one that considers the interpretations of others – a solution which brings to mind the concept of empathy that is at the heart of much modernization research (notably Lerner).

Similarly, Horsburgh, Perkins, Coyle, and Degeling surveyed incoming students for medicine, nursing and pharmacy programs at the University of Auckland and found significant differences in the attitudes and perceptions of entrants that were in keeping with the defining features of the professional sub-cultures revealed by the research undertaken by Degeling and his colleagues with practicing professionals. The authors carry on the assumption that is so prevalent in this literature, stating: “There is a major challenge to overcome if students enter programmes with values already formed” (2006, p. 430). They conclude by calling for “adaptable, flexible health professionals” (again echoing the notion of empathy) and for “challenging the underlying beliefs, values and assumptions of health care professionals” (2006, p. 430) – professional culture as a barrier to be overcome and perhaps eliminated.

Wackerhausen (expanding upon Donald Schon’s influential book *The Reflective Practitioner* (1983)) calls for “second-order reflection” that goes beyond a practitioner’s habitual cultural frame. This reflection from a new cognitive space is only possible, writes Wackerhausen “with a partial reversion of the process of socialization on the cognitive level... breaking the profession’s ‘colonization’ of and control over the practitioner’s reflection” (2009, p. 466) through “intentional and conscious re-education” (p. 470). In calling for new processes of socialization and new modes of reflection by practitioners, Wackerhausen’s work aligns with that of Lerner and others in the modernization tradition.

Björke and Haavie (2006) report on an effort to create a learning module that would be taken by students in eight different health care programs<sup>84</sup> and, in so doing, “challenged the boundaries of the traditional uniprofessional programmes” (p. 641). The effort was designed to foster the “widening professional perspectives by including and emphasizing the common foundation of the professional programmes” (p. 642) such that students would grow to identify “with the more general status of ‘health worker’” (p. 650). Here again, the emphasis on wider perspectives that incorporate a common perspective aligns this work with that of modernization research.

### **Uncertainty and Anxiety**

The notion that intercultural communication can be both prompted by, and a product of uncertainty and anxiety has been present in the work of many scholars, from Simmel and Lasswell, to Edward T. Hall and Gudykunst. It is also present in the work of several interprofessional collaboration scholars. Wackerhausen invokes the notion of uncertainty and anxiety when he notes that second-order reflection by practitioners may bring about a loss of identity, which he acknowledges can be unpleasant, destabilizing and traumatic. He similarly cautions that those who engage in second-order reflection may lose the “inclusion and rewards” of membership in a profession and face, instead, “punishment and exclusion” (2009, p. 467).

Social psychologist Gui-Young Hong (2001) explored the challenges of intercultural exchanges in health care and echoed the concern with anxiety of Edward T.

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<sup>84</sup> It is perhaps telling that the group of eight academic programs did not include medicine.

Hall and Gudykunst when he wrote of the misunderstanding and frustrations that arise from unsuccessful intercultural encounters in health care. Similarly, Pecukonis, Doyle and Bliss (2008) specifically refer to the role of uncertainty in social interactions. They suggest that stereotypes are often invoked to quell uncertainty about interaction with those different from us, and call for “interprofessional cultural competence” (p. 422) as an alternative, helping to reduce the defensiveness and confusion that come from profession-centric training.

A case study and theoretical model<sup>85</sup> reported on by San Martin-Rodriguez, D’Amour and Leduc (2008) incorporates both notions of professional identity and uncertainty. The study is based on a review of interprofessional collaboration in health care facilities that offer perinatal services in four different regions of the province of Quebec. In its 2005 form, the model includes four factors or dimensions that can contribute to collaboration (governance, formalization, shared goals and vision, and internalization). Of particular interest to this study are the dimensions of shared goals and vision, and internalization. In their discussion of shared goals and vision, the authors characterize professional allegiance as an example of “other allegiances” and see it as a barrier to a client-centric orientation and interprofessional collaboration. In their discussion of internalization, the authors point to mutual acquaintanceship and trust as important indicators and contributors to interprofessional collaboration. In this model, mutual acquaintanceship is built on a sense of belonging to a group with common

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<sup>85</sup> The theoretical model of interprofessional collaboration was originally proposed by D’Amour (1997) and later tested and refined (D’Amour, Ferrada-Videla, San Martin-Rodriguez and Beaulieu, 2005).

objectives, and in which members know each other's values, level of competence, disciplinary frames of reference, approach to care, and scope of practice. Trust among collaborating professionals is also an indicator and contributor, specifically trust in each other's competencies and ability to assume responsibilities. What is of particular importance for this dissertation is how the authors counterpose trust and uncertainty, suggesting an opportunity to link this model to the concepts of uncertainty and anxiety offered by Lasswell, Edward T. Hall and Gudykunst. The absence of trust creates uncertainty among professionals who must work together; uncertainty makes professionals more likely to work independently and erodes a sense of belonging to a team. When professions engage in boundary-work and negative narratives through their channels of mass communication, they perhaps have a negative impact on different professionals' knowledge of one another and on their sense of belonging to an interprofessional group. Further, these negative messages may provoke anxiety at the expense of trust. These are some of the effects that will be explored in the focus groups, interviews and textual analysis that will be discussed in subsequent chapters.

### **Cultural Hybridity**

Many of the researchers whose work has been reviewed for this section share a complex notion of cultural identity that is in many respects aligned with that of cultural studies. Dombeck (1997), for example, writes of constructed identity and argues that professional personhood is "a process that a particular individual experiences and integrates into other personal processes and experiences" (p. 11). Austin, Gregory and Martin (2007) also adopt a flexible, negotiated understanding of identity, suggesting that

participants are “professionally ‘bicultural’” and also “negotiating numerous other identities ranging from sex to age to linguistic background to sexual orientation” (p. 92). They conclude that cultural differences between professions are real, characterizing these as cultural baggage and an issue which educators, regulators and practitioners need to understand. Hong’s understanding of culture also includes hybridity, as he describes how the “interfaces between two cultures constantly revolve and evolve” (2001, para. 4). He makes clear that professional cultures are not fixed and that, as they come into contact with patients or other professionals from different cultural groups, members of a profession “interact and acquire elements of the professional cultures of members of other professional groups” (para. 24).

This study also draws from such constructed and fluid notion of professional culture, exploring how certain texts by health professions serve to prompt members of the profession to either acquire elements of a common culture or heighten the perceived contrast between their profession and others.

### **Power**

Questions of power (cultural, economic and political) do enter into some research into interprofessional collaboration and, in so doing, align these researchers with this aspect of the cultural studies tradition. Pippa Hall (2005), for example, writes that longstanding gender and social class divisions between professions and between professions and the lay population still contribute to the “friction and conflict” (p. 189) between professions. “Conflict and strain between professions,” she writes, “still rise to the surface today, triggering gender and social class issues, as well as invoking the

processes of closure and boundary-work” (p. 190). Atkins (1998) similarly echoes the work of Raymond Williams on Welsh culture when she acknowledges the anxiety professionals may feel as boundaries between professions are redrawn. She calls for concerted efforts to help members manage their sentiments and “bring these affective effects out into the open” (p. 304). Unlike Williams, however, Atkins issues a clear call for transition, and not preservation of distinct cultural identities.

Irvine, Kerridge, McPhee and Freeman (2002) adopt a more critical stance than others presented above, problematizing the rhetorical strategy behind interprofessional collaboration and noting that this new approach to practice was presented as “a panacea” (p. 201) for funding agencies, patients and subordinated care providers alike: “The ‘team’ has thus become a discursive and practical instrument of deciding the question of the division of labour in the favour of non-medical workers” (p. 203). Physicians, for their part, embraced the concept of teamwork and claimed themselves as the natural leaders of the team.

### **Cultural Understanding and Acceptance**

Though many of the scholars reviewed in this section share a belief that distinct cultural identities are best overcome in the interest of collaboration, others adopt a stance more in keeping with the Chicago School, calling for education, sensitization but not at the expense of lesser identities. Building on Sumner’s concept of ethnocentrism, Pecukonis, Doyle and Bliss (2008) write: “... if we are to be successful in promoting interprofessional education, we need to develop ways to challenge and dispel the notion of profession-centrism... to understand and embrace the professional cultures of our

colleagues” (p. 421). The notion of “embracing” rather than eliminating the culture of others aligns this position closely to cultural studies and the Chicago School. Echoing the sentiments of Dewey and the Chicago School, Pecukonis et al. conclude: “Perhaps the first and most important step in developing interprofessional cultural competence is a willingness to enter into a dialogue with another professional” (p. 424). Roberts (1989) strikes a similar position when he argues that success comes when members of both professions work in an atmosphere of mutual respect, identify conflicts, and build “understanding and nonjudgmental acceptance of each other’s values” (p. 217). There is a faith in communication evident in these citations that is very much in keeping with the Chicago School.

In general, then, research into interprofessional collaboration is methodologically diverse and is conducted by members of a variety of disciplines. Many researchers into interprofessional collaboration accept that distinct professional identities exist. While many of these see distinct professional identities as barriers to collaboration (calling for empathy in a manner reminiscent of modernization researchers), others are more inclined to celebrate these cultural differences. Researchers in interprofessional collaboration observe the same association/disassociation dynamic that Simmel described in the early 20<sup>th</sup> century, yet many also embrace a notion of cultural identity that is fluid, constructed and complex, in keeping with contemporary research in the cultural studies tradition. That these points of alignment between communication studies and research into interprofessional collaboration exist is encouraging and points the way for integrating the findings from this study into existing streams of research and theoretical models.

The work of Katz and the interpretive tradition is noticeably absent from this discussion, owing perhaps to the fact that none of the literature reviewed deals specifically with the narratives or texts in the communication channels of professions and in the mass media, and none explores the manner in which members of a profession engage and interpret these texts. This study, then, will be a small contribution to filling this gap and drawing attention to the possible role of these texts and these channels in shaping the communication and collaboration between members of different professions.

## **Conclusion**

This study builds on the work of a wide variety of scholars in a number of different disciplines and fields. The work of Simmel and the Chicago School on association and disassociation in a dynamic social setting is foundational to this discussion and the focus groups in particular aims to determine whether and when such a dynamic is invoked in the context of health professions. The notion of intercultural communication as a source of and product of anxiety and uncertainty – so central to the work of Lasswell, Edward T. Hall and Gudykunst – is also influential to this dissertation. The focus groups discussed in succeeding chapters pointed to the kinds of texts and channels which most contribute to or ease uncertainty and anxiety among health professionals. The textual analysis that follows will explore the prevalence of these ideas within both the specialized channels of communication used by professions and the mass media. These texts can educate members, foster intelligent direction and promote mindfulness, or they can heighten the anxiety that stems from “perceived cultural dissimilarities” (Gudykunst, 1988, p. 134) between members of different cultural groups,

thus rendering communication between those groups more difficult. The methodology and approach of Liebes and Katz have also influenced this study. The focus groups shed light on whether members of a profession engage the texts created by their or another, more dominant, professional group, and how various kinds of texts are interpreted and used by professionals. The focus on texts that characterized much of the research by Lasswell and Williams will also be evident in the textual analysis that will form a core component of this study. Close analysis of the journals, websites and other channels of professional associations shed light on the persuasive strategies these organizations employ as they seek to strengthen the professional identity of members. The individual interviews with key decision makers within the organizations added to this understanding of strategies and goals.

Much like Lasswell and Williams, the research is shaped in part by a belief that cultural diversity – in the context of health professions – is not simply a barrier but a resource – a richness that can contribute to the experience of professionals and to the care received by patients. A health care team composed of individuals who each approach health, wellness and illness in different ways is perhaps better able to grasp and address the complexity of that patient’s experience and more likely to assemble a blend of therapies and coping strategies that is equal to the challenge at hand. Furthermore, if those individuals derive personal satisfaction from their professional identity and feel strongly about their professional commitments, perhaps the quality and quantity of care they are willing and able to offer will also be enhanced and their membership in the profession will be more enduring – no small accomplishment in an era of acute shortages for many health professions.

## Chapter Four – Focus Group Findings:

### Engagement & Interpretation

The next four chapters will present the findings of this study. The order of the chapters will mirror the order in which the research was conducted, beginning with the focus groups (this chapter and the subsequent chapter), followed by the interviews and ending with the findings from the textual analysis. More than simply mirroring the chronology of the study, this structure helps ensure that the origins and precise meaning of the thematic categories used in the textual analysis are clear.

This chapter presents the first half of the findings from a qualitative content analysis undertaken on the transcripts from eight focus groups with nurse practitioners and pharmacists in Ontario. Specifically, the focus is on an analysis of the comments by participants that dealt with the texts presented in the groups, as well as on communication by professional organizations more broadly. The comments reveal the extent to which members of the two health care professions were drawn to and engaged the texts, and how they interpreted them. The comments also reveal the particular roles and functions that participants assign to communication efforts by their professional organizations. In the following chapter, the comments by participants around their sense of professional identity, and their interaction with members of other health professions will be analysed.

## **How the focus groups proceeded**

The focus groups began with the selection of sample texts to be presented to focus groups participants. A small number of texts related to Bill 179 and interprofessional collaboration were selected. Care was taken to ensure a blend of perspectives on Bill 179 and interprofessional collaboration. These included texts published by the medical profession (notably the Canadian Medical Association, the Ontario Medical Association and the Section on General and Family Practice) as well as texts created by professional organizations representing nurse practitioners (Canadian Nurses Association, Registered Nurses Association of Ontario and Nurse Practitioners Association of Ontario) and pharmacists (Canadian Pharmacists Association and Ontario Pharmacists' Association). Participants were shown an equal number of texts from the medical profession and those from their own profession. There was also an effort to use a balanced set of texts, including some that were critical of interprofessional collaboration and others that were more favourable. See Appendices 1.1 through 1.12 for excerpts of the texts that were used in the focus groups.<sup>86</sup>

The moderator's guide (see Appendix 2.1) included open-ended questions on four principal topics: (1) the participant's membership in their profession and their sense of professional identity; (2) Bill 179 and how members of the profession responded to and participated in the debate over the passage of the bill; (3) how participants engage and

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<sup>86</sup> All participants were shown four texts by the medical profession found in appendices 1.1 through 1.4. In addition to these four, nurse practitioners were shown four texts by their own profession, found in appendices 1.5 through 1.8. Pharmacists were similarly shown four texts by their own profession found in appendices 1.9 through 1.12.

interpret the sample texts presented to them; and (4) the influence, if any, the texts participants reviewed might have on real interaction with members of other health professions in the workplace. The questions were open-ended and non-directional to ensure that participants' own experiences, observations and priorities were expressed and that these could then serve to provide the categories and themes for the textual analysis portion of this study that followed. The moderator's guide featured only a small number of questions, allowing participants more time to reflect and comment on each, and creating more opportunities for participants to converse among themselves rather than merely replying to the moderator's questions (as discussed in Kitzinger, 1994).

The professional associations representing nurse practitioners (the Nurse Practitioners Association of Ontario or NPAO) and pharmacists (the Ontario Pharmacists' Association or OPA) were approached by the author and both organizations agreed to distribute recruitment appeals via email to their members, promoting the study and inviting members to contact the author to express interest in participating in focus groups. This indirect approach was complemented by direct recruiting efforts using a script and information sheet approved by the Carleton University Research Ethics Board (see appendices 2.2 and 2.3). In particular, the author visited community pharmacies in the Ottawa area and attended the annual conference of NPAO, greeting delegates in an area of the conference space set aside for researchers looking to recruit participants. No matter how they were first identified, potential recruits were all given the same information letter and consent form and asked to confirm their informed consent via email. Potential participants were offered a monetary incentive of \$50 to recognize the time required for their participation.

The Ottawa focus groups were held in the boardroom of the Carleton University Survey Centre in room 312 of the St. Patrick's Building on the campus of the university. Focus groups in Kingston, Mississauga, Toronto and Scarborough were held in hotel meeting rooms selected for their close proximity to major hospitals and clinics in each of those cities. All locations were neutral and featured comfortable boardroom tables for the participants and moderator. The conversations were audio recorded but no outside observers were present at any focus group.

The focus groups took place in November and December of 2010 and all were moderated by the author. Once the eight focus groups were completed, the audio recordings were transcribed by the author. Care was taken to extract every word, however audio quality or the participation of many participants at once (part of a free-flowing conversation) meant that a small number of words or phrases could only be rendered as "inaudible."

The transcripts were then analyzed using a qualitative content analysis approach. The analysis was less focused on documenting how many participants answered in a particular way to particular questions and, rather, looked for themes and patterns that cut across the questions. Guided by Krueger's five-step process for focus group analysis,<sup>87</sup> the analysis yielded a series of important themes that help us understand the kinds of messages that participants engaged with most and how these same participants interpreted those messages.

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<sup>87</sup> (a) Consider the words; (b) Consider the context; (c) Consider the internal consistency of the responses; (d) Consider the specificity of the responses; and (e) Find the big ideas (Krueger, 1988, pp. 120-121).

The excerpts from transcripts that are included in this chapter retain the exact wording used by each participant. In addition, where participants placed heavy emphasis on a particular word or phrase, the text was italicized. Any behaviour by the group (e.g., OTHERS AGREE) or sounds made by participants (e.g., GASP) are rendered in upper case text. Finally, when specific names of individuals, cities or institutions were used by the participant, these have been deleted and replaced by an indicator of the type of information deleted in square brackets (e.g., [name of institution]). This was done to help protect the identity of participants.

### **Findings from the Analysis of Transcripts**

This chapter will now proceed to answer two fundamental questions that Liebes and Katz (1990) suggest: what texts engage the audience most and how are these texts interpreted by the audience? An element of choice was built into the focus groups, with participants able to choose from among eight texts those that they would discuss. In addition, open questions with ample time to answer allowed participants to provide a glimpse into how they interpreted the messages they selected.

#### **What texts engage the audience?**

Elihu Katz's classification scheme for media images, described by Larry Gross (1998), provides a useful starting point for addressing the first question.

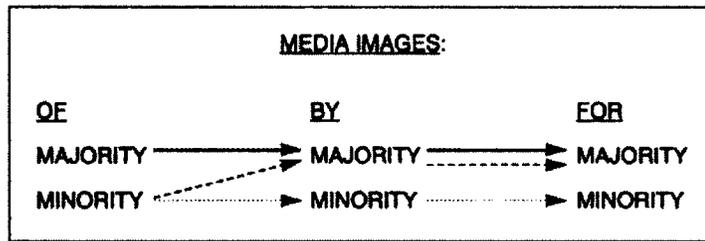


Figure 1 Katz's Classification Scheme for Messages (Gross, 1998, p. 89)

In Katz's model, media images can be images *of* a majority or a minority, *by* a majority or a minority, and *for* a majority or minority audience<sup>88</sup>. While Katz intended the scheme to classify images related to groups based on gender, culture, language, religion, ethnicity or sexual orientation, where there is often within a society one group in the majority and another in a minority position, the scheme can also be applied in the context of different healthcare professions. Though physicians do not constitute the majority of healthcare professionals in Canada, it has been argued (notably by Hall, P., 2005 and Freidson, 2001) that the medical profession wields greater cultural, political and economic power than other health professions. Indeed, many focus group participants made the same point as they interpreted the texts. They echoed the sentiment of Gross (1989) that "minorities share a common media fate of relative invisibility and demeaning stereotypes" (p. 89). As such, then, the subject of the text (i.e., whether the text primarily presents images of the medical profession or of the participant's own profession), the source (i.e., whether the text is by the medical profession or by the participant's own

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<sup>88</sup> It is possible that images of a majority would be created by a minority. In the specific case for this study, pharmacy and nurse practitioner associations created numerous images of the medical profession in many of their journals and websites. It is also possible that images by a majority could be intended for a minority audience, as when the medical profession creates texts (e.g., speeches at conferences, letters to journal editors, statements welcoming new association leaders) destined for the nurse practitioner or pharmacy profession. The idea of expanding Katz's model this way was first proposed to me by Prof. Karim H. Karim.

profession) and intended audiences of the texts (i.e., whether texts are intended for the public, the medical profession or the participant's own profession) are useful starting points for analyzing which texts drew the most attention and comments from participants.

Participants were given eight texts to review, including texts originally published in the mass media and others published in professional journals and newsletters. Four of the texts were *by* the medical profession, and four were *by* the participants' own profession. Two of the medical texts principally presented images *of* the medical profession, whereas the remaining two were principally focused on the pharmacy and nurse practitioner professions. Notwithstanding the limitations of a qualitative study with a small sample and limited number of texts, the three texts which were selected for discussion most often by participants and which, as a result, generated the most comments, share two important features: they were texts *by* the medical profession that presented images *of* the pharmacy and nurse practitioner professions.

The text which drew the most attention and commentary was an article entitled "Collaborative Care: A necessary evolution" (see fig. 4.3 above) from a publication of the Canadian Medical Association entitled *MD Pulse* (Fletcher, 2008) published to summarize the findings from the 2007 edition of the National Physician Survey (NPS Technical Advisory Team, 2011). The article draws on National Physician Survey data to outline the growing prevalence of interprofessional collaboration among physicians in

Canada. While ostensibly a positive article on the benefits of collaboration<sup>89</sup>, some pharmacists interpreted the article negatively. MA, in the first group with pharmacists, pointed out the contrast between the appeal to fear in some messages, all while physicians and pharmacists appear to be collaborating on a regular basis:

Well the thing that was interesting is that 78% of all physicians collaborate with other health care professionals and when you turn to this one (pointing to bar chart) the second biggest group is the pharmacists here. So who the heck are they talking about when they say that we're going to be working on our own?

Nurse practitioners were more consistent in how they interpreted this article, with nearly all pointing out that the article rarely mentions their profession. In particular, participants who selected this article noted that a chart showing those professions with whom physicians most regularly collaborate mentioned registered nurses, licensed practical nurses, and registered practical nurses. That chart, however, made no mention of nurse practitioners specifically. Others did note that a paragraph on the final page of the article mentioned a pilot project in Nova Scotia that brings the services of nurse practitioners to underserved areas. Most found this reference to be short of expectations and SH lamented the fact that too often nurse practitioners are seen as a solution for underserved areas:

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<sup>89</sup> The article, for example, states that "Among those who collaborate, 93% believe this working relationship improves the care their patients receive and 92% feel it enhances the care they deliver" (Fletcher, 2008, p. 40).

... this paragraph on the last page around one Nova Scotia clinic that they were talking about and how nurse practitioners are the primary collaborators, again, whenever there is mention of the nurse practitioner's role there is talk of... I always feel like it is brought into being for the underserved areas, where the physicians do not want to go (SH, Nurse practitioner group 5).

A newspaper article (Leslie, 2009) that was carried by the Canadian Press, with the headline: "Letting pharmacists prescribe drugs like letting flight attendant fly plane: OMA" drew the second highest number of comments (see Appendix 1.2). Dr. David Bridgeo, Chair of the SGFP lamented the move by the provincial government to let nurse practitioners lead local clinics and allow pharmacists to prescribe medications: "This is a decision which may have unintended consequences and has the potential to affect patient safety." The analogy of pharmacists and flight attendants and the unflattering comparison of education levels were seized upon by a number of participants in all groups. JO in the second group with pharmacist summed up the reaction:

...we're not uneducated. Like we're looking at five plus years, now six years of school and they're looking at eight years of school, so you know it's pretty comparable. Like we're not uneducated people who would be just sort of saying, "Oh I think you should be on this or you should be on that."

The text which drew the third highest number of comments is the ad by the Section on General and Family Practice (SGFP) of the Ontario Medical Association

(OMA) (see Appendix 1.4). The headline asks readers: “With today’s healthcare, is an apple a day your safest bet?” The ad goes on to explain that physicians have the most education of any healthcare profession and that, “When nurses, pharmacists and family doctors work as a team, patients benefit. However, when healthcare professionals work without the involvement of a physician, patient care and patient safety could suffer.” Both nurse practitioners and pharmacists saw themselves addressed in the advertisement and in a way that called into question their education and the safety of the care they provide. The reactions to the ad were consistently negative and featured in all but one of the groups. RO from the third group with nurse practitioners expressed a sentiment that was echoed by many of her colleagues:

Well, it makes me *mad* cause that’s my first emotion, right, I get angry, I guess. And, ah, you know, just that they continue to perpetuate that myth, right, that, you know, anybody other than a physician is providing unsafe care, uhm, isn’t educated to do it, and then again it’s that they *own* it, right? That it’s theirs.

These three texts were singled out for discussion by some two-thirds of participants, suggesting that participants are most engaged by texts which either exclude or call into question their credentials and capabilities. All three texts emanate from a profession other than the participant’s own – and one which is felt to have considerable power in the Canadian healthcare system. These twin characteristics, then, would seem to answer the first of two questions we set out to answer.

In terms of whether texts were *for* a particular audience, participants seemed less focused on this dimension as they made their top three selections. The three texts that

most engaged participants included one directed primarily to the medical profession and health policymakers (see Appendix 1.1) and two directed primarily to the general public and policymakers (see appendices 1.2 and 1.3). Those texts clearly directed to the participant's own profession (e.g., articles in professional journals or on professional organization websites) also generated some important discussion, in particular when these referenced the relations between the participant's own profession and the medical profession.

### **How Texts Are Interpreted**

The focus groups presented participants with a number of opportunities to discuss their interpretation of the messages put before them with one another and with the moderator. A qualitative content analysis of the findings was used to explore and classify into categories of similar meaning data gathered through the moderator's questions and the subsequent conversations (a process described in Hsieh & Shannon, 2005).

In all, four broad themes or categories of meaning were identified in the transcripts:

**Anxiety:** Many participants interpreted the texts by focusing a great deal on the strong, negative emotions they evoked as well as on the strong emotions participants feared the texts would elicit among the public and among members of the medical profession.

**Communication practices of professional associations:** Participants often reflected on the importance of communication by professional organizations. They focused on communication directed to the public, to members, to other health

professions, and to governments. Here too, comments included both positive and negative assessments of the communication practices of different organizations and professions.

**Professional identity:** The texts and the discussion within the groups gave rise to numerous comments and conversations on the topic of professional identity. Identity was expressed in a range of ways, including positive statements on the unique role and world view of the profession, statements on elements of professional identity that are shared by different professions, and differentiating statements on the positive attributes of a profession that other professions lack.

**Interprofessional interaction and trust:** The third theme focused on interaction in the workplace between members of different health professions and the role played by trust in the effectiveness of that interaction. Interaction and trust between professionals and the public was also discussed. Interaction was described in positive and negative ways, while some also lamented the absence of interaction in the workplace.

This chapter will present the findings related to the first two themes, while the third and fourth themes will be covered in the next chapter.

## **Theme 1 - Anxiety**

Participants expressed the anxiety<sup>90</sup> they felt as they interpreted the texts and discussed their concern that the texts would also generate anxiety among others.

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<sup>90</sup> Gudykunst (1994) defines anxiety in the context of intercultural communication as follows: “Anxiety is the feeling of being uneasy, tense, worried, or apprehensive about what might happen. It is an affective (i.e. emotional) response, not a cognitive or behavioral response like uncertainty” (p. 21).

## **Fear mongering, fostering division and anger**

Participants most often interpreted the texts as efforts by the medical profession to sow fear among the public. DE, a participant in the second group with nurse practitioners described her interpretation of the article by Keith Leslie (Appendix 1.2):

So I just thought this is really fear mongering. It's a tactic that's trying to grab people and get them worked up: "Oh my gosh! What's happening? Of course, that's right!" So it's written in a way to really rile people up.

SH, in the third group with pharmacists had a similar concern about impact on the public:

... you know what's the impact of all this on the public? Because, you know, just as *we're* influenced by reading this, you know if I was the public and I read *this* (pointing to the OMA's letter to the editor in the *National Post* – Appendix 1.11) I'd feel like, "oh yeah, my pharmacist is completely capable." But if I read *this* (pointing to the Keith Leslie article – Appendix 1.2), I'd feel like "(GASP) oh no way!"

Participants also interpreted many of the texts as efforts by the medical profession to foster division between physicians and members of their own profession. For example, when SH in the fifth group of nurse practitioners was asked if negative portrayals of the nurse practitioner profession in advertising and the news media could affect relationships between nurse practitioners and physicians, she answered:

I think before I saw them I would have said it made no difference because I would have reflected on my own personal interaction with my colleagues

and said, “Well, they’re fine with me and I’m fine with them.” But now that I see this kind of stream underneath – what’s coming from *their* professional organization – I suddenly feel, yeah, a little bit threatened by it, that this is what they’re hearing from people they probably trust and I don’t know how much weight they put to it, I really don’t. I don’t think it’s helping nurse practitioners and physicians to work well together, for sure it’s not. As I said, I agree with much of what’s been said. It’s... ah... it is us versus them kind of mentality.

Many pharmacists interpreted the texts in a similar way. HE, a participant in the first pharmacist group, suggested the texts create negative stereotypes that can adversely affect relationships:

I think it most definitely does affect what happens with the relationship. I think it creates stereotypes, first of all. If a pharmacist is portrayed in a negative way, I think that a group of physicians that, you know, really doesn’t know pharmacists or pharmacy, I think for them it creates a stereotype and it’s just *that* much harder to break the barrier. I think that if you – and now with the inter-collaborative classes taking place – I think that if you *do* form those relationships, especially early on, I think that there is more of a chance of their being interprofessional collaboration later on. But if those stereotypes are formed, I think that it’s just that much harder to break the barriers and to create those kinds of rifts among the different groups.

SH (in pharmacist group 3) expressed the idea of fostering division succinctly: “I guess they’re sort of putting down our profession and our abilities, and I guess creating discord too between us.” In the same group, PA reflected on his own uncertainty over relations with physicians in light of the negative messages in advertising and the news media: “If you’re bombarded by the negative stuff a few times in a row, you start to feel a little gun shy, like ‘ah geeze, you know, every time I call a doctor am I going to have to justify what I’m saying?’”

All of these comments suggest how participants worry that negative messages in the mass media can erode the willingness of both physicians and members of the participant’s profession to work together.

#### **A defensive stance**

Participants often adopted a more defensive stance when interpreting the messages, in a manner reminiscent of what Liebes and Katz (1990) observed as they invited members of different cultural groups to interpret an episode of *Dallas*. Participants interpreted the texts by the medical profession as evidence of fear among physicians themselves. EL in the second group of nurse practitioners saw “desperation” in the ads and media coverage: “Because they feel so attacked and so stressed that they’re gonna lose this... ah... *they* are the doctor.” When asked if she remembered any of the ads in the campaign surrounding Bill 179, DI (a participant in the fifth group of nurse practitioners) vividly recalled the SGFP advertisement and linked the message directly to what she perceived as fear felt by physicians: “It was very damning. And, uhm, you

know, it was really about family physicians feeling threatened and wanting to create their boundaries and saying, ‘No this is not your area. You shouldn’t be in it.’”

Pharmacists arrived at a similar interpretation. Though she struggled to express the exact source of the fear, RA in the first pharmacist group clearly linked the negative messages to fear among the physician profession that the role of pharmacists had advanced too far: “... are we really that far along that you need to be scared that we don’t have your patients’ safety at heart? Like, we’re all working for the same goal so what makes you think that we’re not qualified? It just seems like it looks that they’re scared to... I don’t know. I just don’t like that picture.”

### **Anger**

Finally, numerous participants simply expressed how angry they felt upon reading the messages in many of the ads and articles. In the second group with nurse practitioners, AN was blunt in her assessment of the SGFP ad’s effectiveness and impact: “This one is, I think they did a *great* job of getting me to read it and then they did a great job of making me angry at the end.” In a conversation with the moderator during the fourth nurse practitioner group, AB revealed her anger in reaction to the Keith Leslie article:

**AB:** Uhm because it says, “Having those roles filled by non-medical personnel is like having a member of a flight crew flying a plane.” I thought that was very inflammatory, uhm, derogatory, condescending and extremely childish.

**Moderator:** How did you feel then? As an NP as you read that, how do you feel?

**AB:** My blood is boiling!

Many pharmacists responded similarly. In the second pharmacist group, SA reflected on how her clinical skills were belittled by the article:

Maybe it's biased because they're selecting what they put in here for attention and all that kind of stuff but... I don't know, it makes me angry, I guess. Because I *know* I'm capable of doing a lot of the things that they're saying I can't do so I guess *that* makes me angry.

Later in the third group with pharmacists, PA summed up all three interpretations – fear mongering, fostering division and anger – in a single quote: “They’re trying to scare the public and they’re just using... creating a mud fight for no reason. So that’s why *that’s* incorrect... Well, I feel insulted, frankly. I feel very angry.”

Many of these comments by participants reveal what Lasswell termed an insecurity reaction to a text. The advertisements and articles were often interpreted in ways that generated anxiety and insecurity among participants. This interpretation served to deepen the perceived boundaries between medicine and the professions of nurse practitioner and pharmacist. The reactions of participants are often the “decisive acts of rejection” (1935, p. 33) that Lasswell described as members of one group come into contact with the messages of another. These deeper boundaries, many participants feared, make collaboration and communication between professions more challenging.

## **Excluding or including other professions**

In a manner reminiscent of much cultural studies research<sup>91</sup>, many participants focused their interpretations of the text on the extent to which their profession was included or excluded from the public discourse by the medical profession. The interpretations often differed depending on which profession was included in a particular text.

A number of nurse practitioners lamented, for example, the absence or relatively low profile of their profession in a CMA article on collaboration (Appendix 1.1). In the fourth group of nurse practitioners, CH drew a connection between the low profile of her profession in the article and the diminished sense of professional identity she and her colleagues feel:

... because I agree with you guys about this article – about the fact that it really makes a question mark: Where do NPs fit in? Who are we? How do we describe ourselves? How do people see us? And there isn't a designation because people don't know where to put us.

Many pharmacists, on the other hand, noted that their profession *had* been included in the article's main table, emerging as one of the professions with whom physicians are most likely to collaborate. This inclusion was a point of pride or satisfaction for some pharmacists, including JO in the second group of pharmacists, who noted: "I don't know 'cause it said that, who doctors are working with, so we're up there.

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<sup>91</sup> See for example the chapter by Larry Gross in *Media, Ritual and Identity* (Gross, 1998).

And it sort of was a little more positive on the fact that they *do* need to collaborate with other health care professionals so it was highlighting that.”

The same focus on inclusion or exclusion emerged as participants spoke of a campaign<sup>92</sup> by the Ontario Government to promote the various choices that Ontarians have when faced with an illness or injury. In this case, participants in the third group with pharmacists lamented their exclusion from one particular advertisement, while participants in the fifth group of nurse practitioners praised the same ad for including nurse practitioners as an option and “equalizing” the roles, in a manner that brings to mind Raymond Williams’ suggestion that equality is fundamental to effective intercultural communication:

It’s interesting now on when you see these commercials where they’re *equalizing* the roles in the sense you can call your doctor, call your NP or call your... yeah, they’re sort of giving *that* now as equal, not, ah, the one is over the other. So it’s interesting to see that now (BR – Nurse practitioner group 5).

The power to include or exclude members of a profession from a particular narrative drew the attention of many participants. Inclusion is validation and recognition of a profession, whereas to exclude a group is often interpreted as a slight or belittling of

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<sup>92</sup> It is interesting to note that this campaign was not included in the texts presented to any of the focus groups. That participants in a number of groups commented on the campaign suggests how much attention the ads received from the health professions they represented and from those they excluded. The particular television commercial referenced by the participant (and others in the campaign) can be seen at: <http://www.youtube.com/playlist?list=PLEDB0FDC3C0674C65>

that profession. Either way, the power of the source of these messages – in this case the CMA and the Ontario Government – was recognized and drew a number of comments.

## **Theme 2 – Communication practices of professional organizations**

A second prevalent theme to emerge from the analysis of the focus group transcripts was the communication practices of professional organizations. The notion that professions communicate was widely accepted and indeed praised as appropriate and important by participants. Many praised the particular efforts of their own professional association, whereas others were more critical of these efforts and their results. Similarly, while some critiqued the efforts of the medical profession to communicate around Bill 179, others praised the effort and envied the boldness of the message and the resources behind it. In praising professional communication, many participants drew attention to the unifying effect of these messages and how they foster participation, cohesion, conversation and sharing.

### **Assessing the practices of participants' own professional organizations**

Participants were nearly unanimous in their acceptance of communication as a key role for professional organizations. Many, including JU in the first group with nurse practitioners, urged the organizations to continue their efforts in this regard:

We've gotta ignore this crap and we've gotta do our *own* good storytelling to the government. That's... they've got the *ultimate* power and we've just gotta get the public on our side and get these stories out to the government.

Similarly, DO in the first group with pharmacists suggested the competition for health care funding makes it essential that professional organizations communicate:

I think that other organizations do it. Everybody's trying to sell themselves these days. It's competitive and, ah, there's only so much money in the health budget so you're fighting for every penny that you get, specialty fees and stuff like that.

Many nurse practitioner participants recognized the contributions of their own associations and praised the texts distributed for the focus group and the effort in general by their profession to reach out to the public, the media and governments. BR, in the fifth group with nurse practitioners, sums up her positive assessment of the efforts by RNAO and NPAO:

I think it's fantastic and I think the RNAO is doing a great job and NPAO, in reaching out and trying to educate the public, because we have more momentum now in terms of the public acceptance of the role of nurse practitioner. I think they do a great job of reaching out and they actually do a good job of reaching our members as well with information.

Pharmacist participants were less positive in their assessment of their professional organizations' efforts to communicate. While there was some praise for specific texts such as appendices 1.11 and 1.12 ("And then I liked this article here from the OPA, ah, because I felt like it made a good defense for us and our capabilities" SH – Pharmacist group 3), there were also several calls for more efforts by pharmacy organizations, as explained by RA in the first group with pharmacists:

People don't really know what our true potential is and we've never realized that because we don't say like "hey we can do that, we can do this." People don't even know what we can do because we don't really broadcast.

Nurse practitioners also critiqued the efforts by their professional associations and colleges but focused their critiques more on specific texts than the overall effort. The messages presented to the groups were described as "wordy" (DE – nurse practitioner group 2), "cluttered" (AN – Nurse practitioner group 2), "cloudy" (PA – nurse practitioner group 3) and "divisive" (JU – nurse practitioner group 1).

### **Assessing the practices of medical organizations**

Participants also assessed the various texts and campaigns by medical organizations, offering both praise and criticisms for these messages. As we saw in the earlier section on the theme of Anxiety, participants were often offended by the messages of the SGFP campaign and by their exclusion from the CMA publication on collaboration. The messages of the medical profession were also described as "strange," (SA – Pharmacist group 2), "trying too hard," (JU – Nurse practitioner group 1), "guarding turf" (DE – Nurse practitioner group 2) and the work of a group that was out of touch with its members and not quite "level-headed" (SH – Pharmacist group 3).

On the other hand, participants also expressed some praise and envy for the efforts and resources of the medical profession. DE, in the second group of nurse practitioners, for example, recognized the qualities of the OMA campaign designed to promote its members (see Appendix 1.3):

I think that that's effective for the public. It's not too wordy. The public doesn't want it. And yet, it's nice, it's got a nice picture, there's a good relationship between the two of them and it says something. So to me it's very positive for the medical association.

CH, in the second group of pharmacists, recognized the effectiveness of the media relations strategy employed by the SGFP and evidenced in Appendix 1.2:

My comments around that I guess are just that the comments by Dr. Bridgeo almost seem inflammatory. I think that the impetus behind that is, well BR said one thing: it sells papers. But what it does is it draws attention to the article. Comments like that are what's gonna generate media attention and coverage and attract attention towards the OMA's point of view or their perspective on the issue.

Similarly, DO – in the first group of pharmacists – was somewhat envious of the effectiveness of the medical profession's media relations efforts and their ability to generate positive news stories:

But there never seems to be positive articles about pharmacists in the newspapers. It always the negative stuff. And you *will* get positive articles about doctors. You'll see enough of those in the papers, with what they're doing or what they've discovered, and what's going on...

Participating in the same group, JO summed up the position well: "Doctors have gained power through marketing, through public perception."

## Impact of Communication on Members

In discussing the texts and communication efforts of their professional organizations, participants pointed to the impact of these on their fellow members' sense of cohesiveness. Participants pointed to the role of these efforts in forging and fostering cohesiveness, conversation, sharing and participation.<sup>93</sup> LY, in the fifth group with nurse practitioners, described the importance of cohesiveness and the role professional organizations play in fostering it:

I think that it's *empowering* for nurse practitioners because we realize that we have a solid group of *facts* behind us and we're united and we are going to carry on with this and there's political action. And like the very last statement in this *Registered Nurses Journal*: "RNAO will be there to make sure parties' political choice is a decision that reflects the public good." So they're gonna be there and we are part of that. We're part of the RNAO and we're gonna be there and we're gonna make sure that the political parties do this.

Professional organizations also used communication to foster a conversation by members on the issues raised by Bill 179. PA, in the third group of pharmacists, described conversations with her pharmacist colleagues on this topic:

Not on a *personal* basis. On a *professional* basis, through the association, yes. It was something that was certainly talked about: how are we going to

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<sup>93</sup> The description brings to mind Freidson's (2001) discussion of professions as consciousness communities.

move forward; this is gonna be the new reality and we need to pull up our socks and increase our knowledge base to meet the standards that are going to be expected if you want to jump into these new areas.

Finally, professional organizations also fostered sharing among members by passing along information and inviting members to pass it along to others. The process was recalled by MA, in the first group with nurse practitioners:

And I didn't even hear about it until our pharmacist on our team sent me, forwarded me the email of the response from the head of OHA, who just *slammed* the OMA for the ad... She was like, "Wait till you read this. This is gonna *make your day!*" And it did. And I forwarded it to a whole bunch of people.

Finally, the participation fostered by the communication practices of professional organizations often came in the form of rallying members to write letters of support for Bill 179 to their representative in the provincial legislature. This was reported by a number of nurse practitioners, including MA in the fourth group with nurse practitioners: "Groups of us got together and wrote papers to send in and a lot of nurse practitioners played an important role, including the professional association – NPAO – to really lobby for some of those changes."

## **Conclusion**

The analysis of the focus group transcripts suggests that members of health professions often turn to texts in professional journals and in the mainstream media that represent them as professionals. The findings also suggest that nurse practitioners and

pharmacists are aware of the role that communication by professional organizations can play in educating and persuading the public, the news media and governments. They are also aware of the role of such practices in forging a sense of community among members. Participants not only agreed on the range of roles such messages can play but were generally supportive of the efforts of their professional organizations to engage in such practices.

In the following chapter, we continue with the analysis of focus group transcripts to explore the impact such practices might have on interprofessional interaction and trust, as well as on members' sense of professional identity.

# Chapter Five – Focus Group Findings: Identity and Interaction

The analysis of focus group findings continues in this chapter and moves away from the texts surrounding Bill 179 and the communication practices of professional organizations, to consider the impact these might have. In particular, this chapter explores the two remaining themes that emerged from a qualitative analysis of the focus group transcripts: participants' sense of professional identity and the nature of their interaction with members of other health professions.

## **Theme 3 – Professional Identity**

The sentiments expressed around professional identity were wide ranging, often linked to the text being discussed and to the participant's own experiences. The sense of professional identity was often expressed in a positive way, including expressions of pride and a clear sense of the unique role of the profession within health care. Some participants were more ambivalent in their identity, expressing a sense of hybrid identity and mixed emotions. Finally, a number of participants expressed their identity by reflecting on ways their profession *differs* from others, displaying the association/disassociation dynamic. The points of differentiation were varied, including remuneration, patient orientation and the rhetoric used by the associations representing the profession.

### **Positive identity: Professional role and knowledge**

Participants described a confident sense of identity principally drawn from what they described as their unique knowledge and unique role in health care. Nurse practitioners positively described their profession as holistic, focused on the whole patient and on the social setting in which they live. RO, in the first group of nurse practitioners, summed up this paradigm nicely: “I think we look at things from a completely holistic and a wellness point of view... it doesn’t matter how critical the issue is, you’re looking at. It’s all about restoration of health, it’s not about treatment of illness.”

Many participating nurse practitioners also pointed to their role in empowering patients as one of the defining features of the profession. In the second group with nurse practitioners, AN pointed to this role in empowering patients as one of the features that drew her to the profession:

Well I think it’s that whole sense of feeling that I can empower my patients. And knowing that I have a particular skill set and certain gifts in this field that allow me to empower my patients with knowledge, with the ability to plan for making change, uhm, the ability to support them while they make that change.

Pharmacists also expressed a positive sense of professional identity by focusing on the defining features that make their profession unique. Central to this definition was the notion of a profession based in science but oriented to helping people and with a strong service ethic that stems from the retail orientation of many pharmacists. In the

third group with pharmacists, for example, SH explained her career choice by explaining how the pharmacy profession is both based in scientific knowledge and oriented to helping others: “I liked sciences and I wanted to do something meaningful with that so I felt that this was more meaningful than going into the computer field or something like that because I could actually *help* people.” In the first group with pharmacists, DO summed up “the kind of person who gets into pharmacy” as “a type of person that has compassion and caring – not a lot of being pushy.”

Pharmacists also expressed pride in their role in as the “last line of defense” (SH, pharmacist group 3) before the patient takes a particular medication. This focus on patient safety was echoed by TI in the second group of pharmacists: “So I have to do it because I’m the last man standing before it goes to the patient.”

The positive sense of professional identity for many stemmed from their pride in the specialized knowledge they share with colleagues. Nurse practitioners often expressed pride in the higher level of more complex, medical knowledge that allows them to think critically. In the third group of nurse practitioners, PA linked professional knowledge to the autonomy that is also central to the professional identity of many participants: “You are valued for your experience and your expertise and you are expected to be a critical thinker and to have evidence to support what you’re doing, *not* that someone’s told you to do it.” Pharmacists similarly discussed their specialized knowledge. In the first group with pharmacists, RA recounted a conversation she had with her physiotherapist, explaining how a pharmacist’s knowledge goes beyond dispensing prescription drugs, and linking this knowledge to the role of the profession:

I went to my physiotherapist today and I told her I was coming here tonight and like “oh the jobs that pharmacists are most involved in are giving the medication and watching for drug interactions.” But I said, “Do you know how many people we keep out of doctors’ offices and out of emergency rooms with certain triage care within the pharmacy, like recommend first aid, recommend eye drops?” We can help people with lots of different things other than just a prescription you can get from the doctor.

### **Hybridity and ambivalence**

Both nurse practitioners and pharmacists also expressed some ambivalence towards their professional identity, however. Many nurse practitioners expressed more of a hybrid identity, drawing from both their medical knowledge and status as nurse practitioners and from their prior role as nurses. As JU expressed in the first group of nurse practitioners, “Well you know what a family doctor is? Yes. You know what a registered nurse is? Yes. Well I’m right smack there in the middle. I’m blending those two.” Some participants were less at ease with the hybridity of their role and their professional identity. In the first group of nurse practitioners, MA summed up her ambivalence: “I think I feel sometimes like I’m not part of either group of people or profession. It’s lonely a little bit out there sometimes too. Like, you’re not really part of the nursing profession some days and you’re not part of the medical profession.” Members of a third group were clear that their identity as nurses remains strong, even after they become nurse practitioners: “One of my NP colleagues and I always say,

“We’re nurse practitioners but we’re nurses. We are *still* nurses.” (BE, Nurse practitioner group 4).

The ambivalence that many pharmacists expressed was based on their dual role as retailers and health care professionals. Many saw a tension between these two roles and called for colleagues to focus more on their duties as health care professionals. In the first group of pharmacists, DO contrasted the retail and professional orientations and suggested participation in the focus group was an example of a more professional orientation: “It’s interesting the people that you have here tonight. A lot of the pharmacists that I know are completely retail-oriented. That’s what they do. They are in the profession to make money and to run a business. It’s interesting that not many of them have signed up for this. Probably because a lot of the people that you have here are more interested in the profession.”

In the second group of pharmacists, BR lamented the retail orientation and called for pharmacists to move away from a retail setting and into a care setting: “A major chain is not your primary sellable feature of your business, it’s that you’ve got good relationships. I mean, I don’t know, I still hold the vision that that’s where our profession can go, to these smaller setting where we’re adjacent to a clinic cause this is in the best interests of the patient if you really want to think about it.”

#### **Professional identity in contrast: Money**

In addition to positive expressions of professional identity and concerns about a more hybrid identity, a number of participants expressed their sense of professional identity by focusing on the contrast between their profession and others (notably

medicine). In doing so, participants expressed their identity by using the association/disassociation dynamic. They focussed their attention on numerous points of differentiation, most of them linked to the notion of professionalism they expressed.

The most common approach was to contrast the emphasis on money participants perceive among physicians to their own more selfless orientation. In the fifth group with nurse practitioners, SH contrasted her approach to remuneration to that of physicians by recounting her experience at a professional development seminar:

It was nice to attend the course with family physicians but, at the same time, I was really *uncomfortable* when many-a-time the physician who was delivering the course would bring to the attention of the physicians that, “OK you go for the family visit... you go for the home visit of the palliative patient, this is the code that you’re gonna be using and *this* code will give you *more* money than what you used to get before. *This* medication is what you will be ordering for this particular scenario and if you use *this* code you’re gonna be getting *more* money.” So it’s always physicians and money and that makes me uncomfortable. If *I’m* doing the same role in the community, prescribing the same medications, doing the same things, I am not gonna get any extra money. Which is probably OK with me but makes me a little uncomfortable with the fact that doing the same role when a physician does it, you will get *more* money.

Pharmacists drew a similar distinction. In the first group of pharmacists, for example, JO called into question the financial, rather than professional orientation of physicians:

And what also bothers me is that doctors are just as much a corporation and a business as pharmacists are yet, because they don't have cash registers in their offices it's not seen that way. They're seen as the epitome of health care. What kind of health care is it when I wait an hour and a half at a clinic to see a doctor for five minutes? That's *less* time than it would take my pharmacist to fill that prescription. So they've gotten very good at milking the system and, you know, getting money as effectively and efficiently as possible, while maintaining this clean, Teflon, white-coat persona of "we're giving you the best health care and everybody else will kill you."

#### **Professional identity in contrast: Patient orientation**

Language around patient orientation was also used to differentiate the participant's profession from the medical profession and express a sense of professional identity. Participants felt the efforts to protect scope of practice on the part of the physicians was unprofessional since these did not have the patients' best interests at heart. In the third group of nurse practitioners, PA contrasted the willingness of her colleagues to collaborate, as compared to physicians: "Because if the NPs are, ah, willing to help the profession, uhm, you know they're not looking at it from the point of view of the patient, clearly. They're looking at it as a territorial..." Pharmacists similarly suggested that the medical profession is more interested in protecting scope of practice than in the advancing the interests of patients. In the second group with pharmacists, CH

summarized the intent of the SGFP's campaign: "Uhm, I guess similarly to KE, it doesn't really surprise me a whole lot. It's a turf war."

In the second group with pharmacists, KR questioned the commitment to patients that is evident in the SGFP's response to the move to greater collaboration:

I think if they had actually taken a step back and looked at it as how it could *benefit* people instead of how maybe they were getting leadership taken away from them or getting finances taken away from them, then they probably would have agreed that it might have been more beneficial.

#### **Professional identity in contrast: Time**

Interestingly, time spent with patients was also used as a differentiator. This ties back closely to the discussion of both money and patient orientation. Nurse practitioners, for example, frequently pointed out that their profession is in part defined by the ability to take the time to educate and empower patients, rather than keeping appointments as short as possible so as to maximize revenues. DE summed this approach up well in the second group with nurse practitioners:

Well I think for me it's that you get to spend time with the client, really making sure they understand. Like, it's education and health promotion so it's *all* the components, it's not – you know – "this is what you got and you take this." It's like looking at the whole picture and there's a lot of time in trying to see if there's interest into buying into that to help them take control a little bit. But it's that whole padding around it, which in our

fee-for-service, which a lot of doctors function in, they just don't have the time for it.

RA, participating in the first group of pharmacists, made a similar point about the time with patients taken by pharmacists:

Like they come and talk to us more than they talk to their doctor. They come in for their refill four times a year and they talk to their doctor once for the refill for five minutes. But they talk to us at least four times a year and every time they come into the store we say, "How are you doing Mr. Smith, so nice to see you, how are the kids, did you go away on the trip that time?"...we have more relationship with the patients than their doctors.

#### **Professional identity in contrast: Professional rhetoric**

The highly charged rhetoric of the SGFP campaign was often contrasted with the less emotional and less negative rhetoric used by associations representing pharmacists and nurse practitioners. The rhetoric of fear and anxiety was seen by many as inherently less professional than the more stoic approach of their respective professions. This preference for logic over emotion, this concern for the plight of the fellow human being over oneself, and this ability to endure criticism while restraining one's response can perhaps best be summed up as a stoic<sup>94</sup> position. John Durham Peters (2005) specifically

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<sup>94</sup> The notion of emotional detachment and objectivity, for example, was a central part of the stoic philosophy. R. W. Sharples (2005) writes of the stoic approach to emotions that they are to be "interpreted

explored the links between the professions and the stoic attitude: “This is the attitude of doctors, soldiers, reporters, judges and social scientists” (p. 108).<sup>95</sup> In this way, the rhetorical strategy of focusing on ethical appeals based on the knowledge and competence of the profession, combined with the logical appeal of science serve to demonstrate the stoic dignity of professions.

Participants echoed this position in numerous comments. MU, a participant in the fourth group of nurse practitioners, specifically set out to contrast the rhetoric of the SGFP in the Keith Leslie article and that of the Nurse Practitioners Association of Ontario in their media release:

... the media advisory actually talks about nurse practitioners providing safe... research showing that they provide safe, effective care, there is... it's not inflammatory and it provides some... hopefully they do provide some factual stuff – their research that they are quoting on. Whereas this one is just, you know, what am I gonna say that's going to get you really worked up? This one (pointing to the advisory) is more professional.

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in intellectual terms; those such as distress, pity (which is a species of distress), and fear, which reflects a false judgment about what is evil, are to be avoided (as also are those which reflect a false judgment about what is good, such as love of honours or riches)” (p. 896).

<sup>95</sup> Quoting Cicero and suggesting the link between an ideology of professionalism (and the claims it renders possible) and stoicism, Peters writes: “Again, we must keep ourselves free from every disturbing emotion, not only from desire and fear, but also from excessive pain and pleasure, and from anger, so that we may enjoy that calm of soul and freedom from care which bring both moral stability and dignity of character” (p. 109).

Pharmacists drew a similar contrast between their own association's rhetorical approach and that of the SGFP. In the second group of pharmacists, KR called for a more careful and less derogatory approach than that displayed by the SGFP:

"I don't like it because this ad is not really advertising for you as a physician primarily. It's advertising to put down, to make you think something about the other health care professionals. I think you really need to be careful and more politically correct when you're advertising to a big group. Especially if you're advertising like *you* as a professional. It's not a very professional way to advertise. You have to be careful.

#### **Professional identity in contrast: Knowledge**

Professional knowledge was used both as a source of positive identity (as was noted earlier in this section) and as the basis for identity in contrast. JO, participating in the second group of pharmacists, described how her learning in pharmacology exceeded that of the medical students with whom she interacted:

... the people that I went to school with, the medical students, they *do* realize that their learning in pharmacology is *very* limited and so when they get out of school, like they are not... they are much more willing to call you up and ask you than maybe the doctors that have been around for a while and have never had maybe some of that.

Given the role of professional knowledge in participants' professional identity, it is not surprising to find that many criticized the SGFP campaign specifically for its challenge to their level of knowledge. These were often the most emphatic comments of

the focus groups. In the first group with nurse practitioners, RO summed up the defense of that profession's knowledge base:

... *less* educated – which isn't true. By the time you get to be a nurse practitioner you have quite a few years of university education under your belt. And experience. So when they say, in a number of places here: "less educated," "less trained or educated individuals not make significant mistakes." It is offensive... and... untrue.<sup>96</sup>

Finally, we saw examples of nurse practitioners and pharmacists engaged in much the same process of questioning others' knowledge base as they compared themselves to physicians, nurses, physicians' assistants and pharmacy technicians. For example, in the third group with nurse practitioners, SH questioned the pharmacist's capacity to diagnose conjunctivitis or pink eye properly:

You go ask the pharmacist and they give you advice but one of the things they don't do is they don't examine you. And so you may complain of any other symptoms that you have and they could ask you questions to further understand the issue. But they don't necessarily whip out a stethoscope or an otoscope of any other kind of scope or ask you to undress, you know, or look at your contact dermatitis or anything else you've got.

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<sup>96</sup> The actual quote from Leslie (2009) reads: "Even as the most trained and educated primary care providers, we make mistakes, so how can lesser-trained or educated individuals not make significant mistakes," wondered Stewart."

Similarly, in the first group of pharmacists, TI questioned the capacity of other health professionals (including nurse practitioners) to initiate blood pressure medications:

For example, if someone has high blood pressure that's almost always a chronic situation so you will need a new prescription every so often. So if a nurse practitioner wants to extend it, that's allowed. However the nurse practitioner cannot always initiate because some drugs are not allowed with certain other medical conditions or in combination with other drugs. Pharmacists *know* that. Nurses probably do but may not because the pharmacology training is not as extensive as ours. And *even* the physicians have less pharmacology training than us. So *we* are more appropriate in this kind of situation, like starting blood pressure medication, for example, than a nurse practitioner and *probably*, sometimes, even than a doctor.

These comments were perhaps paradoxical in light of the criticism of the SGFP campaign, yet they revealed once again how important knowledge is to the participants' sense of professional identity. The comparison of levels of knowledge and the defense of one's own professional knowledge base seem to be important forms of boundary work that the texts presented to participants helped to initiate.

### **Professional identity in contrast: Power**

In a manner anticipated by Raymond Williams (1958) and his emphasis on equality of being, differing levels of power were also used to contrast different professions and, in so doing, to deepen many participants' sense of identity. Many NPs, for example, pointed to autonomy as a driving force for the decision to become an NP

and a key differentiator between nurse practitioners and nurses. As VA expressed in the first group with nurse practitioners:

I decided to practice, to go into NP, I guess in my undergrad I kind of knew that I wanted to do that to have more autonomy and to be more of my own practitioner as opposed to, uhm, working shift work and working under someone else. Having more independence and having a larger scope of practice and able to do more things.

Similarly, in the first group with pharmacists, DO celebrated the increased power which pharmacists currently enjoy as compared to when he began his career:

In 35 years I've seen it go from doctors being in complete control when I first started working. When I started as a pharmacist in [name of province], pharmacists used to buy gifts and the doctors used to reject the gifts. They'd send it back if they didn't like it and ask for something else. I'm at the end of my career and I regret that I won't have the opportunity to get involved in this collaboration. I think that it's a really exciting time.

Power was also used as a differentiator by nurse practitioners and pharmacists who contrasted their level of power to the more substantial power of members of the medical profession, be it in the form of formal power (i.e., rules and committees), traditional power relations or gender power. In the second group with pharmacists, KR pointed to the formal powers physicians enjoy as prescribers of medications:

When it comes down to it, though, they *do* have the control. If we start saying "OK then be the leader, do your thing. We're not gonna fix any

prescriptions you write...” We’re not gonna play dirty with them, right?

But they can... in a way like do whatever they can to limit...

A number of participants also pointed to the power that physicians derive from traditionally having been in a position of authority over other health professions. The power relations linger even while formal power structures change, leading to frustration but also a heightened sense of differentiation between “us” and “them.” In the fourth group with nurse practitioners, MA noted the symbolic capital that physicians enjoy, especially among members of the general public:

... it seems that physicians still have an awful lot of symbolic capital in our society. They are very influential. They actually think they’ve *lost* a lot of that; I don’t really believe that. The public really does believe that... it’s like your question, CH, “Well are you my doctor?” Well, who’s my doctor? They believe that that’s how the system works. They also see physicians at the top of the hierarchy. So I... I just think that’s our reality right now.

Finally, it should be noted that a number of nurse practitioners pointed to how the power of physicians is perhaps rooted in the traditionally male profile of the profession, as compared to the female profile of nursing. As much of the profile of both professions is changing and becoming more balanced (in particular that of medicine), the traditional power relations linger and help deepen the sense of identity of nurse practitioners. Responding to the SGFP advertisement, CA (a participant in the first group of nurse practitioners) noted the link between a female subject for the illustration and her

profession: “It’s so *obviously* a female face there. And female is the face of nursing, right? That’s no guy’s eye.”

#### **Theme 4 – Interprofessional Interaction and Trust**

The fourth principal theme addressed by participants was the interaction between them and colleagues from different professions and the role that trust plays in fostering effective interaction. While all agreed that effective interprofessional interaction and trust are important to the quality of health care delivered, participants reported on a wide range of experiences, including positive interaction, negative interaction and the barriers that prevent interaction.

##### **Negative interaction**

In a small number of instances, participants recounted examples of negative interactions they had with physician colleagues in the workplace. For example, MA recounted in the first nurse practitioner group how a fellow nurse practitioner was greeted at her new clinic:

So this guy was just down the hall or across the hall, and she went over on day one to chat with him and introduce herself – you know, get to know you sort of visit – and he said, “Listen, your office is over there; my office is over here. The less I see of you, the better.”

TI, a participant in the second group of pharmacist shared a story of his interaction with physicians:

So I've made mention to some doctors that they need to correct some of the prescriptions. Sometimes they say, "yes," sometimes "no" out of stubbornness. There's no good reason given, just, "that's what I've written, you supply that."

### **Lack of interaction**

More often, however, participants described a lack of interaction and a lack of commitment to interprofessional collaboration in their work setting. As described by TI, participating in the second group with pharmacists, the barriers can include intimidation and a lack of opportunity for face-to-face that comes from working in separate physical locations:

Yeah, if I'm working in a hospital situation I can see it face-to-face with the doctors and it's to the point where other team members are afraid to *say* anything. Like, you will have the full consultation with the patient; you step outside the room and the physician says, "I see this, I see this or that, let's do this." OK, fine. And then we'll leave and some of the pharmacists will tell me, "Well he forgot about evidence for *this* and this is a concurrent condition the patient has so it might be a better idea to do this." I say, "Well why didn't you *say* anything?" "Well, the doctor's going to say 'no', we don't want to cause problems; we don't have time, we have to see the other patients and it's almost lunch" ...or whatever it is. Like, there's *numerous* reasons why they won't talk back. So *that's* the kind of personality that you're dealing with to start with. And, in a

community pharmacy, there's not much face-to-face with doctors obviously; there's basically zero face-to-face time with doctors; it's done mostly through fax or phone. You never, like it's very rare that you get a doctor calling in a prescription themselves. They will write it down and tell a secretary to call it in. And if the secretary makes a mistake or it sounds wrong, you can tell them "no, I mean this pill sounds funny for this weight of patient. So she'll say "well *that's* what the doctor wrote." "OK, well do you want me to write a note back telling you to talk to the doctor about it or do you just want to tell the doctor?" Like even the receptionists become this like extra barrier in the way of helping patients.

Participants suggested that the absence of interaction reflects a lack of willingness to collaborate on the part of physicians. CA, participating in the first group with nurse practitioners, described the situation in her workplace: "When I worked in long-term care we would have big family conferences and it would be everybody except the physician, you know. They couldn't be bothered." In the first group with pharmacist, MA described a similar scenario in a long-term care setting:

... when I worked in long-term care, that's what we did. We worked as a team. You know, the doctor showed up once a week for maybe half a day. Everybody else was there: the nurses and the dietitian and the social worker. They were the ones who were there every day, day in and day out. They were the ones that were doing the coordinating. They were the team that were taking care of the patients.

Other participants cautioned that such limited experience and interaction with pharmacists or nurse practitioners can make negative messages from a medical association to its members more potent. In the fifth group with nurse practitioners, DI recounted how fear and the absence of knowledge coupled with negative publicity affected how the Chief of Drugs and Therapeutics reacted to her requests for medical directives:

And he didn't really know what to do with us and we're sitting there saying, "Well I want to be able to initiate insulin. I want to do this and I want to do that." And he's got that whole issue of liability and fear in the organization. "What experience do you have to do this?" And it took a number of times to go through that committee to eventually end up with what I wanted. The first time was very negative and I think some of this information, uhm, in the media may have negatively impacted on us in the workplace. We couldn't progress at the rate we wanted to.

Speaking in the second group of pharmacists, BR made the same point about interaction and relationships as buffers to negative campaigns: "Whether this influences physicians, I think it depends on a physician who has a relationship with a pharmacist. If they don't, it might. Uhm, if they've had a bad experience with a pharmacist, it might. As to the percentages for that, they should do a study!"

### **Stories of positive interaction**

A large number of participants took time to point to specific instances where the positive interpersonal messages of colleagues contradicted the negative messages of texts

they reviewed and made them more optimistic about the prospects of effective interprofessional collaboration. RO, in the first group of nurse practitioners, pointed to how grateful the physicians with whom she works are to have her on staff, freeing them up to pursue research and teaching:

My role saves one FTE anesthesia guy every year. So the department can actually give some of my physician colleagues academic time, right? So because I'm there doing the work of a – you know – essentially an anesthesiologist without pokey stuff and the gas passing, they can actually get the academic time they would not already have and they're so grateful. So it's totally different. As long as you don't get into that fiscal stuff, it's a different world.

HE, a participant in the first group of pharmacists, described a similar example of being valued for her expertise in a hospital setting:

I am a [specific specialty] intensive care pharmacist and we are expected to go out on rounds and rounds include the docs, the attending physician, several residents, a dietician, the pharmacist, often the social worker is there and the chart nurse, and the nurse who's taking care of the patient. And every patient is discussed and everyone contributes. And often if there's a drug question that comes up, everyone will look at the pharmacist and say "What should we prescribe? What do you think the dose should be?" And half the time I'm sitting there calculating the doses and making sure that they get the drug right. So I mean in the hospital, we're already

doing so much collaboration that it's just interesting that retail has lagged so far behind.

### **Positive interaction and effects of media messages**

In recounting these instances of positive interactions, many participants expressed confidence that the experience of working alongside pharmacists or nurse practitioners can do more to shape attitudes among medical professionals than any campaign by any professional association. This parallels Gudykunst's (2005) notion of interaction as a means to reduce levels of anxiety and uncertainty. In the first group of pharmacists, LA explained the benefits of interacting and building relationships with physicians: "It's all about relationship building. Once you build that relationship, you're more on board with the doctors; you're more on board with the patients." EL, participating in the second group of nurse practitioners, acknowledged that negative messages in the media have an impact, while expressing confidence that the negative messages would be undone by the positive interactions in the workplace: "But when you talk to them, you are aware of what they were told by their association. So I guess when you approach them you try to make them see the other side of us and that picture is different than maybe what they are reading or being told. And, by working with us, they will see it for themselves."

Participants expressed similar confidence that the attitudes of the public were more influenced by real world interaction with pharmacists and nurse practitioners than ad campaigns and media relations. In the second group with pharmacists, DO contrasted the negative messages of the SGFP campaign with the positive relationships he enjoys with customers:

... I was in a store for 30 years; it was a [brand name] pharmacy. I'll tell you, a lot of the customers that I had there, if they saw those articles they would say, "Oh this isn't fair. You know you've been my pharmacist for 30 years and you guys are taking a bad rap." ... the people that you are associating with in your pharmacy or in the hospital, whatever you're doing, you get to feel that these people appreciate your value.

### **The OMA is *not* all physicians**

Many participants drew on similarly positive experiences working with physicians to make a clear distinction between the OMA's Section on General and Family Practice and the individual physicians with whom they work on a daily basis. PA (a participant in the third group of pharmacists) contrasted the media messages of the SGFP, while also pointing to instances where physician colleagues offered praise:

Well, I feel insulted, frankly. I feel very angry. But then I back up and realize this is the OMA speaking, this is not *doctors* speaking. I mean, it's certain doctors who are in charge of the OMA making these statements but I also know, as I mentioned, I talked to and worked with *several* doctors who are very happy to collaborate. They call me up and ask me, "What can I do with this patient? How can I get them off this drug and on to this *other* drug? What's the best drug to use if they're having these side effects?"

LY, a participant in the fifth group with nurse practitioners shared a similar observation about the OMA and physician collaborators:

... so maybe the OMA – and they are a huge, very powerful lobby group – but they don't own every physician. And *they*, you know, they still seem to be very happy to work with nurse practitioners, the ones that I've met anyways.

### **Changing professional cultures**

In addition to the positive experiences cited above, many participants also suggested that professional cultures are changing and that barriers to interprofessional communication and collaboration are slowly being lowered. Dewey's (1922) notion of "intelligent direction" as a means to "modulate the harshness of conflict, and turn the elements of disintegration into a constructive synthesis" (pp. 121-122) is useful for understanding these comments. Many participants pointed specifically to growing opportunities for interprofessional education as conducive to collaboration. In the fourth group with nurse practitioner, SA pointed to the influence of interprofessional education:

I think as doctors are growing up, the younger ones coming up are getting a lot more collaborative than the older ones because they're being educated in an interprofessional way. I see that a lot now in physicians. They often come now and *ask* your opinion. They *want* to be taught by you." Similarly, in the first group of nurse practitioners, HE described the impact of interprofessional classes at [name of university]: "I think it's changing now too because I think a lot of classes at [name of university] are inter-collaborative classes where they actually have doctor and nurses and pharmacists in one class.

Pharmacists echoed the sentiment. Three participants in the second group of pharmacists described a new attitude to collaboration among medical residents:

**JO:** I think newer doctors realize it a lot more than older doctors. Because now that... I just graduated recently and when I was in school we did do a lot of interprofessional meetings and like we discussed all this and you definitely get a lot of stereotypes and like anger come out in the other professions *but* the people that I went to school with, the medical students, they *do* realize that their learning in pharmacology is *very* limited and so when they get out of school, like they are not... they are much more willing to call you up and ask you than maybe the doctors that have been around for a while and have never had maybe some of that... I don't know.

**CH:** I'd agree. I have a younger brother who's a resident right here in [name of city] so I socialize with him and his doctor friends and they really rely upon the pharmacists. (INAUDIBLE) The first thing they want to know when they're on rotation is "who's the pharmacist?" I think that is a bit of a cultural difference or an age difference I guess in terms of, you know, how much reliance or how much exposure they had to different professions and what their capabilities are and how I can use them to my advantage.

**SA:** Definitely, out on rotations I would see that. They would come up and ask us, the residents would. It's definitely changing.

## **Differing perspectives on trust and collaboration**

The role of trust in interprofessional collaboration was described in d'Amour's (2005) model and explored by a number of participants in the comments cited above. It is worth noting that this topic is one where nurse practitioners and pharmacists differed in their experiences and comments. A number of nurse practitioners discussed trust in the context of how challenging it can be for a member of their profession to earn the trust of physicians. In the second group with nurse practitioners, EL contrasted the level of trust physicians have with one another as compared to trust with nurse practitioners:

... it seems like you always have to prove yourself first. They have to work with you first. They don't *need* to trust another physician. Really, they'll assume that they're good right off the bat. With us, it's, "Oh. OK." And then, "Ah, OK." They get warmed.

Pharmacists, on the other hand, shared few such stories. Those who did, such as PA in the third group of pharmacists, offered a more varied account:

Although there are also complete polar opposites. Either they're fully against this: "This is the worst thing that ever happened. You think you can tell me what to do." Or they're totally on board with it: "OK, yeah, I really didn't think about that." There doesn't seem to be a middle ground.

Pharmacists tended to consider their own role in limiting the extent to which physicians trust the pharmacist profession. Some, such as HE in the first group of pharmacists, considered the extent to which pharmacists isolate themselves in community pharmacies and limit their interaction with physicians:

I think it's the way the system... in hospitals, we work *with* each other, we're beside each other, we see each other all the time... and we get to know each other on a human level. Whereas, when you have pharmacists working in retail, in the pharmacy, and you never see the doctor, you don't get to know that physician and so it's harder *to* collaborate when you don't know these people on a personal level.

Others suggested that the reluctance of pharmacists to reach out and educate physicians on the full potential of the pharmacy profession was partly to blame. As RA described in the first group with pharmacists:

It's all like building a relationship so it seems like a lot of this stuff is that you don't really value a pharmacist until you get to know a pharmacist get to know what they do and it's *because* we don't really, uhm, stand on our soap box like other health professions might. People don't really know what our true potential is and we've never realized that because we don't say like, "Hey we can do that, we can do this." People don't even know what we *can* do. Because we don't really broadcast.

Both pharmacists and nurse practitioners agreed that earning the trust of physicians is essential to patient care and professional satisfaction. Pharmacists differed from nurse practitioners in sensing that they have perhaps less road to travel to earn the trust of physicians and in the recognition that their approach to their work may be hampering the formation of that trust.

## Conclusion

Overall, the comments offered by participants in the focus groups suggest important relationships between the texts that health professional associations circulate, the professional identity of health professionals (both those within and those outside the sending association's membership) and the prospects for communication and collaboration in the workplace. The contributions of scholars in intercultural communication shed light on a number of the findings from the groups. The expression of anxiety by participants – both their own and what they imagine others would feel – connects with much of the work of Simmel, Dewey, Lasswell and Gudykunst cited in chapter two. The strong reaction to being included or excluded in public discourse recalls the work of scholars in the cultural studies tradition, including Larry Gross and Raymond Williams.

The positive expressions of identity by pharmacists and nurse practitioners, even in the face of texts that would deny or diminish that identity, also align well with the work of cultural studies scholars, in particular Stuart Hall. Many of the comments illustrate the process Hall (1996) described of individuals being called to or “hailed” to specific cultural groups by messages in the media (p. 6). Hall's thoughts on cultural identity also shed light on the comments of participants who expressed their sense of professional identity as being in contrast to other professions. As Hall expresses unequivocally: “Throughout their careers, identities can function as points of identification and attachment only *because* of their capacity to exclude, to leave out, to render ‘outside’, abjected” (p. 5). I would add to Hall's suggestion that points of

identification can also serve to render other groups different enough to make the boundaries between members of the in-group and others sharper and deeper. It is an idea that was expressed by scholars in the Chicago School tradition (notably Simmel, Dewey and Lasswell) and by Liebes and Katz. The comments in the focus groups suggest that many nurse practitioners and pharmacists define their own sense of professional identity in similar ways.

Finally, the comments by participants relating to interprofessional interaction and trust called to mind much of the contemporary work of scholars in the intercultural communication research tradition. In particular, Gudykunst's work on anxiety and uncertainty helps to clarify the potential impact of negative campaigns that serve to limit the knowledge that members of one group have about members of another group, and that create an atmosphere of anxiety and mistrust in the workplace.

The number of participants who shared stories of positive and negative receptions by members of the medical profession aligns well with the work of Lasswell and, later, Kim. As Lasswell suggested, "the newcomer tends to respond to the attitude taken toward him by the native inhabitants" (Lasswell, 1935, p. 128). In 2001, Kim wrote of how participants in intercultural communication can use "dissociative communication behaviors" to erect and maintain "psychological barriers between interactants" (Kim, 2001, p. 151).

The more positive findings about the impact of interaction and efforts to foster interprofessional education and culture change fit well with the theoretical model proposed by d'Amour et al. with its emphasis on mutual acquaintanceship and trust as important indicators and contributors to interprofessional collaboration (D'Amour, 2005).

Indeed, the interpretation and comments of participants suggest that texts in the mass media can serve to foster either anxiety or mutual acquaintanceship and trust. The eventual outcome will depend in part on the intent and strategy of the author, a topic that will be explored in more detail in the subsequent chapters as we turn to interviews with professional organization executives and with reporters and editors, as well as to an analysis of the content of professional journals and mainstream media.

# Chapter Six – Findings from Individual

## Interviews

### Introduction

With this chapter, we move from exploring the manner in which the texts from professional publications and the news media are engaged and interpreted by health professionals, to explore the decision-making processes that led to the creation and dissemination of those texts. To borrow from Shannon and Weaver's (1949) mathematical model of communication, the focus in this chapter shifts from the receivers to the senders of messages about interprofessional communication and Bill 179 in Ontario. The data we analyse here stem from a qualitative content analysis of transcripts from 13 individual interviews undertaken with executives from health professional organizations and with reporters and editors who focus on health care (whether working for professional journals or the news media). See Table 1.2 in chapter one for a breakdown of interviewee profiles. Note that the identity of the organizations and professions these individuals represent have been omitted to help protect their confidentiality. Note also that, in contrast to the focus groups, the interviews did not feature the distribution and review of any advertisements, articles or other texts. Interviewees responded to questions only, though some did recall and discuss some of the same texts that had been distributed to focus group participants.

## **Findings**

Though the interview participants were quite diverse in their profession and roles within their respective organizations, the analysis of transcripts revealed considerable consistency in the broad themes touched on by all. Overall, four themes emerged from the analysis of transcripts, each of which is briefly defined below, in order of the prevalence of each theme within the transcripts.

**Theme 1 – Professional Identity:** The analysis of the interview transcripts suggests that an important goal for associations and regulatory colleges is the creation of a shared professional identity for members of a profession. In particular, we find statements related to the goal of creating cohesion and collective action among members. We also find statements related to the goal of making it clear to members and external audiences (i.e., governments, the public, professional and news media) how the roles and tools at the disposal of a profession are changing. If knowledge, recipes and tools, as Hall suggests (J. R. Hall, 1990), are indeed elements of a group's culture, then ensuring that both members of a profession and its external audiences are aware of the profession's knowledge, roles and tools is a key step in forging cultural identity. Finally, the interview transcripts make clear that there is the potential for negative identification, with several comments related the tensions that exist between professions and a smaller number that refer specifically to professional identity forged out of contrast to other professions. Simmel's notion of "association and disassociation" being required to achieve "a definite formation" (1903, p. 491) echoes in many of these passages.

**Theme 2 – Professional Angst<sup>97</sup>:** The conversations with association executives and members of the health media often turned to the anxiety that is felt by so many in the health care sector. Participants described uncertainty over future funding and models of health care delivery, rapidly changing roles, and tensions between different professions (both at the individual and organizational level). These can render interprofessional communication and collaboration both more challenging and more essential.

**Theme 3 – Interaction and Trust:** Many interview participants also discussed how the process of interacting across professional boundaries serves to foster greater trust and, as such, enhance interaction and collaboration between those professions. Two levels of interaction and trust were discussed: between individual practitioners and between professional organizations. At both levels, interview participants discussed events, programs and channels of communication that have been designed to cut across different professions and foster more effective interprofessional care.

**Theme 4 – Professional Organizations as Communicators:** With such emphasis on forging a shared cultural identity, addressing the professional angst of members, and fostering positive interaction and trust, it is perhaps not surprising to find that the role of professional organizations as communicators emerged as the fourth theme in the interview transcripts. Participants consistently pointed to the role that professional

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<sup>97</sup> The choice of words is inspired by an association executive who remarked about the current conditions: “You know, we did a membership survey a year ago and still, across the country, there is a real sense of angst about where the profession is going.”

associations and regulatory colleges play in reaching out and communicating with members of a profession, the public, the news media and governments. As they communicate, associations and regulatory colleges seek to inform and to influence members, governments, the public and media, as well as members of other professions. The communication strategies are often interwoven, engaging more than one of these audiences at a time.

### **Professional Identity**

The theme of professional identity often emerged from the analysis of the interview transcripts. Participants expressed how professional associations and regulatory colleges must forge a close sense of cohesion among members – what Freidson termed “community or solidarity” (2001, p. 101). Others specified how professional identity is forged from greater awareness of changes to the roles of their profession and the tools used by its practitioners. Finally, participants described the identity of their profession by contrasting theirs to other health professions, thus illustrating the association/disassociation dynamic suggested by Simmel and others in the Chicago School.

## Professional Identity and Cohesion

Interview participants often expressed the desire and need to forge a strong sense of professional identity among members as a means to forge cohesion<sup>98</sup> within the group that is manifested in both the attitudes of members to the profession and its institutions and in the behaviour of members, as they rally around a cause and participate in joint efforts.

The attitudes described by interview participants included pride in their chosen profession and a sense that positive change was possible and worth an investment of time and energy. One executive described the current state of professional identity among members in this way:

I think it's probably getting stronger that, with this recognition of expanded scope, *members* are feeling, you know, they're excited about this change and we saw that in our evidence – the research that we did. They're excited about the opportunity; they're excited about change.

Similarly, a different executive linked the group's sense of empowerment to the cohesion within the group:

I believe the members, the people who we have still as members, and those who stood there and said, "This, this is going to work and we have to go through a rough time first," now feel that they've worked hard and

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<sup>98</sup> This emphasis on both attitude and behaviour as components of group cohesion reflects Friedkin's useful description: "Groups are cohesive when they possess group-level structural conditions that produce positive membership attitudes and behaviors and when group members' interpersonal interactions maintain these group-level structural conditions" (2004, p. 421).

they've moved forward, and they're moving *the profession* forward and they're moving health care forward. So they feel like a more cohesive group.

Professional organization executives are also seeking a strong sense of professional identity as a means to foster collective action that will advance the profession. One executive described a moment of collective action – the merger of two small associations – as the moment at which members of the two groups came to the conclusion: “... you know we have some- a lot of things in common, let's try to move together.” Another executive described the goal of professional identity with a more colourful analogy: “As a leader, you want to keep the herd heading west, right?” The most commonly cited examples of collective action by members of a profession were efforts to secure feedback on plans from members and campaigns to lobby government officials. One association executive described how members are called upon to collectively review and provide feedback on proposed legislation: “The taskforce typically is solicited from membership: common members to anybody interested. And putting forth effort in looking at the proposed legislation and what feedback we want to provide back to government on those proposed changes.” Another described an annual campaign that invites individual members to reach out both to the public and to Members of Provincial Parliament (MPPs):

... the intentional communications strategy there would be to use it as an opportunity to increase the awareness of [*our members*], and part of it would be engaging [*our members*] to participate in Take Your MPP to Work Day... so that our MPPs become aware of the role, get some

personal time with a [*member*], to really increase their understanding of the possibilities for the role in the future.

Of course, as associations are voluntary organizations that professionals may choose to join, the decision to join and retain membership is itself an important example of collective action that makes the organization self-sustaining – a point not lost on one association executive who noted from a member survey that success in generating collective action tends to solidify membership: “So that may be telling me that there is growing support, and growing perception of the need to stay connected with [*the association*], because [*the association*] is the group that’s going to help us really create the contextual meaning for all of this in my particular situation.” The key point for this discussion is that executives from professional organizations are aware of their role in forging a sense of shared professional identity and cohesion among members. That identity is not solely an end in itself but also a means to achieving collective action and continued membership.

### **Knowledge, Roles & Tools**

As mentioned, a strong sense of professional identity also stems from recognition – both inside and outside the profession – of that profession’s knowledge, roles and tools. This is particularly true in an era in which all three elements – knowledge, roles and tools – are changing dramatically for several health professions. Pharmacists, for example, are relinquishing some of their traditional roles (e.g., counting, labeling and checking) to a new regulated health profession in Ontario: pharmacy technicians. The profession is moving away from counting and dispensing and towards a more patient-centered role

focused on education, counsel and, in some instances, writing prescriptions for patients. This is accompanied by significant changes to the pharmacy curriculum. All of these changes are neatly summed up by one executive:

The expanded scope of practice, we hope, will allow the pharmacists to move away from more of the distribution model to more of the clinical and cognitive practice, which hospitals practices have led for a number of years now and continue to do so. In fact, if you look at curriculum at the Faculty of Pharmacy at the University of Toronto, they're doing advanced degrees now where it's entry-level PharmD (Doctor of Pharmacy), instead of traditional Bachelor of Science in Pharmacy. So there is already a move in academia to acknowledge that pharmacy is cognitive; it's not a technical profession. It's not lick and stick and count and pour, which the media still holds to. Every time you see a new drug or a new service, you see the vignette of someone counting pills, right?

Note how, with the final comment, this executive draws a link between public and media recognition of new knowledge, roles and tools, and the members' sense of professional identity.

Similarly, the knowledge, roles and tools of nursing are changing, exemplified best by nurse practitioners in Ontario who undergo more extensive education and have assumed a number of new roles, including diagnosing certain conditions, writing prescriptions, ordering diagnostic tests, as well as running NP-led clinics, with only a link to a consulting physician who may not necessarily be housed in the clinic. This expanded scope of practice helps shape professional identity directly with nurse practitioners. The

new scope also shapes professional identity indirectly, by bringing with it greater public recognition of what nurses and nurse practitioners can do, as one association executive explained:

So removing that restriction and allowing open prescribing gave them an opportunity to do something they were already fully capable of doing. The public should know this because that helps them get better care and faster care. The nurse is happier because they're actually working to their full scope of practice. So it was an example of how we could both talk about how this is gonna benefit patients but how this was also a celebration for us, because it's been something we've been working toward as an association.

Interviewees also pointed out that widespread recognition of changing knowledge, roles and tools is important for ensuring effective interprofessional collaboration. As one professional organization executive explained:

I think that in order to collaborate appropriately and to communicate with your colleagues, you have to have a solid understanding of your *own* role, and your *own* obligations, and your professional requirements. So, that's the piece we need to communicate to people.

Similarly, the editor of a professional journal pointed to the importance of ensuring readers understand what models of interprofessional collaboration are working and what the roles of all professions are within that model:

We published a whole supplement on collaborative practice, for example. It was specifically around the topic of mental health but it also included other examples of interprofessional collaboration that people could say, “Here’s a situation where it works,” and how patients benefit, the professionals who work there find it very satisfying, everybody knows what their specific role is, and they all, you know, learn so much from each other.

Interviewees were clear, then, that building greater awareness of professionals’ knowledge, roles and tools is an important part of forging a strong sense of professional identity among members. Here again, though, the identity is not merely an end in itself. In this case, a strong professional identity among members can often be accompanied by greater recognition among the media, the public and members of other professions. This excerpt from an interview with a health reporter illustrates the relationship well, pointing out how claims to expanded scope in a news story will immediately be noticed and challenged by another profession:

The OMA, again, is *really* strong. Again, especially, I’ve talked to the pharmacists because the pharmacists say, “You know we could do this, we could expand. We could actually *prescribe* or change to a generic...” – all these sorts of things, the OMA will want to comment on that right away.

Widespread recognition and acceptance of a profession’s knowledge, roles and tools is an important goal of communication by professional organizations, linking together efforts in media relations, government advocacy and interprofessional relations.

## Identity in Contrast

Finally, the interviews yielded a number of instances in which participants defined their profession by contrasting it with another profession. Following many of the patterns we saw in the focus groups, interviewees most often differentiated their own profession from physicians, in terms of overall professional culture. One executive summed up the difference using an international analogy:

Zubin Austin<sup>99</sup> at the University of Toronto as well had done a lot of research on the culture and he does this... he's probably published on it, but he does this great, presentation on, "Pharmacists are like Canadians and Physicians are like Americans." They're cautious, they're not out there. They're not more risk-averse where physicians are far more... you know, they just exude confidence, right?

Interviewees also mentioned the same advertising and media relations campaign by the Section on General and Family Practice (SGFP) that called into question the safety of an expanded scope of practice for either nurse practitioners or pharmacists. Much like focus group participants, interviewees defined their profession by contrasting their own rhetorical strategy from that used by the SGFP:

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<sup>99</sup> Austin contributed to an article in the *Canadian Pharmacists Journal* that explores this same topic and ponders the extent to which this cautious culture of pharmacy is a limiting factor for the profession: "By acting on this lack of confidence, pharmacists are allowed to 'fly under the radar' of patients and other health care professionals, avoiding new responsibilities and accountability for patient outcomes. Many people, both in and outside of pharmacy, including patients, other health care professionals and pharmacists themselves, are often unable to clearly define the responsibilities of pharmacists" (Rosenthal, Austin & Tsuyuki, 2010, p. 38). Note too how the authors link professional identity within a profession to awareness of roles among those outside the profession.

They had pretty rogue groups within their association, like some of the family practitioners in their own section... They looked like they were protecting their turf, whereas we tried to take the high road. So our goal was to constantly take the high road: Hey, this is the right thing for the system; this is the right thing; [members of profession] are already willing and able to take on this additional responsibility; they've always collaborated with physicians.

The process of defining one profession by contrasting it to another went beyond contrasts with the medical profession. Interviewees contrasted hospital pharmacists from pharmacists practising in community pharmacies (“...their membership being more business-oriented”), and contrasted nurses from pharmacists:

Contrast that with the nurses who say, “We can do everything. Without us the system falls apart.” Pharmacists are more, you know, they're more the mother-may-I kind. You know, “If it doesn't bother the doctor could you please call me back, because I think there's a problem with this dosage.”

The association/disassociation dynamic is evident in these and other transcripts, and the contrast with the medical profession, as it was in the focus groups, is the most prevalent contrast. Regardless of which foil is called upon, the attempt is the same: to clearly define a professional group's identity to its members and to external audiences.

Overall, questions of professional identity generated nearly as many comments as questions about associations as communicators. Given the close link between both topics, this comes as little surprise. A dynamic professional environment challenges the cohesion

of a professional group and challenges the clear and stable sense of identity members of a profession might enjoy. Rapid change makes collective action to protect and promote the profession all the more important. The much needed professional identity can come from positive messages about new roles, knowledge and tools used by a profession; it can also come from negative messages that contrast one profession from another. As we saw with the findings from the focus groups, the choice of communication strategy can influence the extent to which members of different professions establish trust and collaborate effectively.

### **Professional Angst**

This concerted effort to forge a solid sense of professional identity came at a time of considerable tension in the health care sector, coupled with great and rapid change. In this sense, the interviewees confirm the description of the health care sector offered in the second chapter, in particular changes to the traditional roles of health care professions and changing expectations from the public and governments. Interviewees spoke of interprofessional tensions that exist both at the level of professional organizations and individual practitioners. They also spoke of a rapidly changing health care system that can prove frustrating and confusing for patients, funders and practitioners alike.

### **Interprofessional Tensions**

Participants pointed to tensions that stem from strained relations between members of different professions as they adjust to new ways of working, and from strained relations between different professional organizations as they seek to influence the outcome of the processes that were set into motion in 2009 when the Ontario

Government introduced Bill 179. The preponderance of statements by interview participants focused on tensions that exist between different health care organizations. For many, those tensions took the form of the medical profession being “very turf-protective.” Another suggested a medical association “did not believe that *our members* should have prescriptive authority and that they didn’t think that *our members* should be allowed to lead... interprofessional teams.” The tension runs both ways, of course, and one medical organization executive described how, “oftentimes, other disciplines, in moving forward through the HPRAC<sup>100</sup> process, were really looking much more at autonomy, rather than collaboration.” A health care reporter summed up the tension by recalling how he watched, “those who, in their own view, have the most to lose, be the most entrenched.”

Though most of this tension is kept inside meeting rooms and formal submissions to government<sup>101</sup>, a number of interviewees pointed to the very public advertising and media relations campaigns of professional associations as evidence of, and contributors to, the tension in health care. The SGFP campaign was described as “nasty,” “rogue,” and “almost shocking.” One executive commented that with so many conflicting perspectives competing for attention – through internal channels and more public channels – the situation can be both tense and confusing for practitioners: “I would say one of the biggest challenges, especially when things are happening so fast, is every organization is

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<sup>100</sup> The Health Professions Regulatory Advisory Council provides independent advice to Ontario’s Minister of Health and Long-Term Care on matters related to the regulation of health professions in the province.

<sup>101</sup> One health reporter reflected on how these tensions are most often kept out of the public arena: “What they do... what they do that’s brilliant is they agree on a few fundamental points and that’s their public life and they disagree about a thousand others and they just don’t talk about this publicly.”

communicating their own thing, and every organization may have their own agenda or objective, so sometimes the communications are spun a little differently depending on what you're trying to achieve.”

The tensions that interviewees described also occurred at the level of individuals working to collaborate across professional boundaries. Tension can start the moment a new member is introduced into an interprofessional team, as one health organization executive explained:

Some of them come in with their elbows up, ready to fight for what they think an NP should be doing. So that sets everybody's teeth off and they end up in conflict with the office staff, with the family practice nurses that are there, and with the docs.

Another executive described tensions created by having to learn new ways of providing care:

And now they're expected to still work in a busy dispensary, figure out how they're going to have a relationship and a workflow with regulated pharmacy technicians, getting pressure to do meds checks from head office, finding the time and do they have the skills for it?

A third health organization executive cited the tensions that accompany a lack of certainty around changing roles: “And so there's been some cases of doctors, not all doctors did, going up to the pharmacist and saying, ‘Why the hell you asking me? I thought you guys got this already, quit bugging me.’” Still another described tensions resulting from unequal access to patient information records and the limitations this

imposes on the recommendations made by pharmacists in the community, suggesting that physicians can be “annoyed at community pharmacists for making those suggestions.” These findings all suggest that tension between professionals and between professional associations are a challenge for practitioners, creating anxiety and making effective communication and collaboration more challenging at times.

### **Adapting to Change**

Interview participants also suggested that anxiety can stem from the wide array of major changes affecting the delivery of health care in Ontario. These changes can be economic in nature, including rapidly climbing costs and growing government deficits. One health care reporter explained: “Ontario’s is the biggest health care system and the biggest problem that it’s trying to deal with, because of the extent of the funding – you know it’s 44 cents of every dollar the government spends right now.” The same reporter continued by citing the need for rapid change in the face of this fiscal pressure: “And it has to happen fairly quickly as this province and all the others come to grips with all these changes that they have to make or they’ll go broke. They literally can’t afford to keep spending the way they are in health care...”

In addition to cost pressures, the health care system is becoming increasingly complex, causing growing frustration among patients, according to a public opinion poll discussed by a health organization executive:

...navigating the health care system is actually more devastating to them than the diseases that they actually have. And they talked a lot about

getting lost within teams. They talked quite openly about having to go from site, to site, to site to see different practitioners.

Another executive pointed to the wait times that persist in spite of substantial government investments in health care:

This was the first time in probably a generation that the government was looking at the scope of practice for members, combined with the fact that we were, at that time, if you go back a year or two ago, right in the center of what we would call a wait time slash access crisis.

Other health organization executives suggested that changing inter-professional relationships themselves can create questions and confusion: “They’re more focused on, ‘Oh we have a nurse practitioner or we have a pharmacist here on our team. How’s that working or how’s that gonna work?’” In the end, the leaders of health professional organizations agreed that, as one summarized it, “The status quo would not survive. It wouldn’t survive, it would be different, or had to be different.” Fostering positive interaction and trust between professions is all the more pressing and challenging in a tense and fluid environment.

## **Interaction and Trust**

The third theme that emerged from the analysis of interview transcripts focuses on interaction between members of different professions and how this affects the trust between them. As mentioned in the earlier review of intercultural communication literature, many scholars have observed how interaction between members of different groups can often serve to reduce anxiety and uncertainty (Gudykunst, 1988, 2005), build

trust (Kim, 2001) and foster further interaction and collaboration (the process of internalization described in San Martin-Rodriguez et al. (2008) and in D'Amour et al. (2005)). Interview participants explored this theme by discussing the bridges that facilitate interaction, both between individuals and between professional associations. Many also commented on the important differences between relations at the institutional level (i.e., between different professional associations) and the practitioner level. Finally, many interview comments focused specifically on the level of trust that exists between different professions.

### **Building Bridges at the Institutional Level**

Institutional bridges come in many forms, including informal discussions between institutions, formal programs, educational offerings that are interprofessional in nature and that support interprofessional collaboration, as well as efforts to collaborate on specific projects and share resources. Many health organization executives pointed to informal conversations and official meetings they and their colleagues have had with representatives of other professional associations and colleges. These conversations are often on the topic of interprofessional collaboration and how the challenges of this new way to deliver health care can be overcome. Interviewees described, for example, meetings to discuss electronic health records, the flow of communication between members of different professions and specific solutions to emerging issues. This ongoing series of discussions between health professional organizations was neatly summed up by one association executive:

... associations speak to each other all the time. They don't stop talking.

They're always speaking to each other about how we can work better with each other to deliver the best possible care. I don't think that aspect has changed.

Echoing the calls of some of the focus group participants, a number of interviewees described educational programs that are designed to bring together members of different professions and to educate practitioners on how to collaborate more effectively. One interviewee described the impact of undergraduate education that brings together different professions: "... medical students and pharmacy students and nursing students have more exposure to each other during their training, which helps reduce the hesitation about doing this when they get into practice because they're used to interaction during their university training." Interviewees also described professional development programs that teach practitioners how to collaborate more effectively, such as the Canadian Pharmacists Association's ADAPT<sup>102</sup> program and the College of Family Physicians of Canada's mentoring programs for physicians and nurse practitioners who work together. Similarly, participants described professional development programs that deliberately bring together members of different professions, including nursing professional development events being opened up to physiotherapists and pharmacists. Medical programs are similarly bringing together physicians and nurses who work in family health teams to learn about specific topics such as diabetes medication and

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<sup>102</sup> The program's web page is found at [www.pharmacists.ca/adapt](http://www.pharmacists.ca/adapt). Among the six major topics covered in the program, we find "Collaborating successfully with other health care providers."

memory assessment. Articles in professional journals are another way that interprofessional collaboration can be fostered through education. One interview participant pointed to a specific article<sup>103</sup> and summarized its key point: “A nurse practitioner and a family doctor – or any discipline – need to sit down, first and foremost, and think about what the patients actually need, and then have a really good look at what each of the partners bring to the table from a knowledge and skill set and what they like to do, and work it out together.”

Participants also described formal programs that bring different professions together to conduct research and deliver care. These included the IMPACT project<sup>104</sup> of the Canadian Pharmacists Association (Integrating Family Medicine and Pharmacy to Advance Primary Care Therapeutics), which led the way to placing more than 100 pharmacists in family health teams in the province. Articles about this program were published in professional journals and were often co-authored by physicians and pharmacists. Similarly, an executive described a Cancer Care Ontario program that brings together nurse practitioners and physicians to explore how to better collaborate and integrate their efforts in the care of patients living with cancer.

Finally, interviewees described efforts by professional associations and regulatory colleges to collaborate and share resources. Examples ranged from simple sharing of newsletter articles and information sheets on recent changes to legislation, to

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<sup>103</sup> The article is titled “Healthy workplaces and effective teamwork: Viewed through the lens of primary health care renewal” (Jones and Way, 2007).

<sup>104</sup> The stated goal of the IMPACT project was: “To improve patient outcomes by optimizing drug therapy through a community practice model that integrates pharmacists into family practices” (Goal of IMPACT, 2008).

collaborating on advocacy efforts by writing letters of support for other professions, collaborating on research to understand current attitudes on collaboration among members of different professions, and developing common standards around controlled acts relating to medication practices.

All of these efforts to communicate, educate, run joint programs, share resources and collaborate are bridges between professions in two important ways. First, they serve to open and strengthen channels of communication between professional organizations. Second, the act of bringing together individual members of different professions to learn, exchange and deliver care serves to build trust, create positive relationships and set the stage for more effective collaboration in the workplace. This relationship between bringing professionals together and building trust was effectively described by the editor of a professional journal:

These were pharmacists who had worked primarily in community-based retail settings and they had not worked in a physician's office before. And family physicians talk to pharmacists on the phone but they hadn't worked face-to-face and they hadn't shared their patient records and all that kind of stuff before. And once they got to know each other, and found out how much the other could benefit them, and how much the patients could benefit by them collaborating, they got along like a house on fire. And then they couldn't understand how they hadn't worked like this before.

## **Interaction and Trust on the Ground**

This brings us to the second aspect of interaction and trust that was discussed by many of the interviewees: that what happens on the ground is often a better measure of interprofessional collaboration and has more influence on levels of trust. The majority of these comments focused on how working relationships are positive, in spite of what the communication campaigns by professional organizations might suggest. As one executive summed up the disparity: “You know, this really isn’t an issue at the practice level; they just figure it all out. This is an issue that we at the national and provincial levels kind of create.” Another executive added that practitioners on the ground often have to ignore the political dealings of their organizations and focus on providing care: “And, at the ground level, where practitioners actually work together, they were having to kind of ignore what was happening at the provincial level, in order to make sure that they worked well together to deliver care. And, from *our organization’s* perspective, that’s what we wanted to have happen and continue to have happen.”

Generally, participants agreed with the assessment of the IMPACT program mentioned above: the act of working together builds trust and fosters more collaboration. One association executive drew a sharp contrast, for example, between physicians who had worked with nurse practitioners and those who had not:

We still have physicians who have never worked with nurse practitioners, who make comments without any personal context, and sometimes those are negative concepts or negative comments, and they just, they don’t have the lived experience of working with them. Although you can present data, you can present research, you can present stories, those all help, but...

from what I've observed, the biggest impact in the medical community is with those physicians who work with nurse practitioners on a daily basis.

Other executives were more cautious in their assessment of the results of working together. Some argued the results are not always positive:

There are a few doctors they have a great relationship with, they can call them up and have a conversation and it's very positive. And they have some that won't have anything to do with them. I think it's very much at the individual practice level.

Similarly, one interviewee suggested that some strategies for collaboration can build trust, whereas others can be "quite destructive." Citing the example of having nurse practitioners relegated to the routine task of taking PAP smears, the executive described the challenge of finding the right distribution of roles:

And so when you look at trust, it's how do you take individuals who have great knowledge and skills, areas where they like to work, and a patient population that has specific needs, and meld those ingredients into something that actually ends up being an interdisciplinary team?

Other interviewees cautioned that real issues still remain. Some pointed to the persistent hierarchy that exists in health care ("Even with the expanded scope of practice, that hierarchy is still going to be difficult to change now."). Others pointed to the complexity of determining fair remuneration when health care is delivered by an interprofessional team ("Those are very contentious issues that affect collaboration."). Finally, a health reporter, pointing to the debate on nurse-practitioner led clinics,

suggested that what professionals say to members of other professions and what they say within the medical community can be quite different: “There’s a lot of grand words about, ‘Oh yes, we want to work together... da, da, da.’ But there’s a big, big backroom fight over who’s going to be the boss.”

Navigating this complex terrain can be challenging for nurses, pharmacists and other non-medical health professionals.

## **Professional Organizations as Communicators**

### **A Key Role**

Interview participants were asked to reflect on why the organization had chosen to communicate with members, the public, the media and government on the move to greater interprofessional collaboration in health care and, more specifically, the provisions of Bill 179. Many answers started with a recognition of the importance of Bill 179 and the move to interprofessional care to the profession: “Oh, it’s absolutely huge in terms of *our members’* profession,” explained one executive. Other executives suggested that dramatically changing roles for practitioners are creating a need for more information on the part of practitioners:

So it is very important, and it’s going to be more important over the next little while, because the changes are starting to roll out and unfortunately government is doing it in dribs and drabs; it’s coming out slowly, incrementally, which means people need to understand certain things...certain things are different and have changed and from your perspective may have improved, and other things have not changed, and

you have to keep track of what I can do and what I can't do, and that's going to be even more important in the next little while.

Changes as fundamental as these create strong demand for information by members and an obligation for a regulatory body: "We have an obligation to communicate the legal requirements and the standards to our members."

Participants also pointed to the importance of communicating to influence the changes that are happening in health care, with one association executive summing it up simply, "Our job is to advocate. It's right in our boilerplate... you know the boilerplate description of our association – why we exist."

### **Reaching Multiple Audiences**

Participants expressed how the communicator role is not only vital but also complex. They spoke of diverse audiences that need to be reached and engaged. Chief among these was their own membership. Participants spoke of the need to ensure members understood the implications of the new legislation, as explained by one executive who described the association's effort:

So we tried to build knowledge of what it was and what it could be... we did teleconferences and said, you know, "Please join us on this teleconference and we'll talk about how it impacts you, how it affects you.

Interviewees also spoke of the importance of reaching out to external audiences. Generating media coverage, for example, was seen as an important way to exert influence: "The idea was to get favourable coverage in the media that would say... 'Hey you know what? This is, this is just good sense for our public healthcare system to have

*our members* do more.’” In the same way, building awareness among the public was seen as an important role for the profession. As one association executive explained: “What we just wanted to do was to say, ‘this is what we can do, this is what we believe’, and, you know, try to provide the public the knowledge, and other professionals the knowledge, the knowledge that we were trustworthy.” Many also spoke of communicating with governments and shaping legislation as key roles for associations and regulatory colleges. One executive described the process:

What has happened over a period of several years... is that *members* have communicated to [*name of the organization*] as well as others, governments and other stakeholders, their concerns with respect to the scope of practice for *members* and how that hinders their ability to provide appropriate patient care.

### **Interwoven Efforts**

Interview participants commented on how communication with members, the media, public and government can be interwoven and function synergistically. Member communication can serve to rally members and incite them to reach out and write letters to governments, for example. One association executive described the process:

We developed a tool kit... some very basic information on what they needed to know, what did they need to know about letter writing, really trying to not get them to focus on me-me-me but on “What will this do to make healthcare better, safer, better for the patient, improve access,” all of those things.

Similarly, communication with governments can generate opportunities for member communication and interest from the news media:

... my department was involved in writing the speaking notes for the submission that was made to the Commission members. At that point, we probably just did internal communication. As we became aware ... when the Commission actually released its finding – “Here’s what we’re recommending” – we started to become a little bit more outward with our own messaging. We also started receiving calls from reporters and so we knew we had to have specific examples: if in fact, this is going to change, this is what members will be able to do.

In much the same way, outreach to the media was seen by many executives of professional organizations as part of a larger process of shaping the legislation in the province: “So that’s where we were headed. And you know, we got good coverage and we had great coverage in media. We’d get op-eds in favour of, you know, expanding scope of practice.” Other executives noted how communication with the media and public also reaches other health professions and, as such, can affect relations between professions:

The last thing we would want to do would be to come out strongly against other disciplines having increased scopes of practice. I think the message that we continue to act to deliver is interdependent collaborative practices, and standing very strongly for amazing ways for good people to be able to work together. And so that’s the message we deliver to the public.

These myriad and often synergistic relationships between member, media, public and government communication activities render the process both vital and complex for associations and regulatory colleges. In keeping with this complexity, health organization executives described a wide range of communication tactics their organizations deployed as part of their efforts surrounding Bill 179 and the move to more interprofessional collaboration in health care. These included websites, emails, newsletters, professional journals, surveys, teleconferences, meetings, media releases, speeches, advertisements, submissions to government and letter-writing campaigns (to both newspapers and government officials). As one executive neatly summarized: “I think the complexity of communication cannot be understated... It requires constant attention and constant revisiting to see how you can do it better. It’s very complex, I believe.”

## **Conclusion: Parallels between Focus Groups and Interviews**

The findings from these executive interviews parallel those from the focus groups in a number of ways. As mentioned, this likely reflects the fact that many executives from associations and regulatory colleges are themselves practitioners or former practitioners. In addition, professional organizations strive to align their priorities with those of their members; through surveys and consultations, the organizations learn the attitudes and opinions of members and work to reflect these in their plans. It is appropriate, then, that leaders of these organizations would reflect, in many ways, the focus group comments of their members. Last and not least, the questionnaires for the focus groups and interviews had important parallels. Both included questions on the topic of interprofessional collaboration, Bill 179, communication campaigns on the topic of Bill 179, and the relationship between trust and interprofessional collaboration.

Notwithstanding the reasons cited above, the parallels between the findings from the focus groups and interviews are important and worthy of some analysis. The four broad themes that emerged from the data analysis (anxiety, professional identity, interaction and trust, and communication) are quite consistent. This consistency gives strength to these findings and points the way to four categories to guide the qualitative textual analysis that will be covered in the following chapter.

The table below summarizes these four themes and the sub-themes for each.

Focus Group Themes	Interview Themes
<p><b>1. Anxiety</b></p> <ul style="list-style-type: none"> <li>• Fear mongering, fostering division and anger</li> <li>• Fostering division</li> <li>• A defensive stance</li> <li>• Anger</li> <li>• Excluding other professions</li> </ul>	<p><b>Professional Angst</b></p> <ul style="list-style-type: none"> <li>• Interprofessional tensions (institutional and individual)</li> <li>• Adapting to change (costs, complexity, changing roles)</li> </ul>
<p><b>2. Professional Identity</b></p> <ul style="list-style-type: none"> <li>• Positive identity (professional roles and knowledge)</li> <li>• Hybridity and ambivalence</li> <li>• Identity in contrast (money, patient orientation, time, professional rhetoric, knowledge, role in health care, power)</li> </ul>	<p><b>Professional Identity</b></p> <ul style="list-style-type: none"> <li>• Cohesion</li> <li>• Knowledge, roles and tools</li> <li>• Identity in contrast</li> </ul>
<p><b>3. Interaction and Trust</b></p> <ul style="list-style-type: none"> <li>• Negative interaction</li> <li>• Lack of interaction</li> <li>• Positive interaction</li> <li>• OMA is not all physicians</li> <li>• Changing professional cultures</li> <li>• Differing experiences of NPs and pharmacists</li> </ul>	<p><b>Interaction and Trust</b></p> <ul style="list-style-type: none"> <li>• Institutional bridges</li> <li>• Interaction and trust on the ground</li> </ul>
<p><b>4. Communication Practices of Professional Associations</b></p> <ul style="list-style-type: none"> <li>• Influencing government</li> <li>• Educating the public</li> <li>• Generating media coverage</li> <li>• Forging cohesion among members</li> </ul>	<p><b>Professional Organizations as Communicators</b></p> <ul style="list-style-type: none"> <li>• A key role</li> <li>• Multiple audiences (members, media, public and governments)</li> <li>• Interwoven efforts</li> </ul>

**Table 4 Comparing Focus Group and Interview Themes**

The analysis of focus group and interview transcripts showed that both groups of participants expressed how anxiety is a factor in their work. Focus group and interview participants shared a concern over tensions between members of different professions. Focus group participants saw that tension primarily in the texts that were put before them. Interview participants were not shown any texts, though many remembered and referred to some of those same texts. More often, however, they referred to their daily dealings

with practitioners, the public, governments and leaders of other professional associations. As such, their notion of tension and anxiety included the effects of the fundamental changes in Ontario's health care system. Focus group participants, perhaps driven by the group setting and the sample texts presented to them, generally used stronger language and focused more on their own personal sentiment. They also expressed more the frustration of being excluded from texts – a topic which was never broached in any great depth in the interviews.

All participants spent considerable time discussing various elements of professional identity. Practitioners (in the focus groups) and executives (in the interviews) often used similar language to discuss and describe the importance of knowledge, roles and tools in defining professional identity. Both groups also used similar examples and language to define their own professional identity in contrast to other professions. Clearly, there are widely shared elements of a professional identity – stories that each profession tells its members and external audiences. Examples such as the more holistic approach of nurses, the more in-depth medication knowledge of pharmacists, and the greater diagnostic knowledge and skill of physicians come to mind. Some differences did emerge, including the emphasis among focus group participants on hybridity and the tensions in identity these can bring about, such as the tension between the retail and health care orientation of pharmacists, and the nursing and medicine elements of nurse practitioners.

Both groups of participants also spent considerable time discussing the role of interprofessional interaction in fostering greater trust and collaboration. The key difference here is that focus group participants spoke more about negative interaction and

the absence of interaction, whereas interview participants spoke much more about positive interaction; interview participants also distinguished and elaborated on interaction at the level of both practitioners and institutions.

Focus group and interview participants agreed that communication is a key role for professional organizations to play. They also agreed on the important goals to be addressed by communication, and on the four key audiences that professional organizations need to address: members, media, government and public. Focus group participants, being on the receiving end of much communication, were generally more critical in their assessment of the effectiveness of their profession's efforts.

These four themes: anxiety, identity, interaction and trust, and communication will serve as the broad categories for the textual analysis of the texts disseminated by professional associations and regulatory colleges in the four years before and after the passage of Bill 179.

# Chapter Seven – Findings from the Textual

## Analysis

In this chapter, we move from exploring the manner in which the texts from professional publications and the news media are created, disseminated, engaged and analysed, to focus on the texts themselves. Specifically, the chapter shares the results of a textual analysis of more than 200 articles, media releases, media interviews and advertisements created and disseminated by health professional organizations (notably those representing nursing, medicine and pharmacy) and by the news media. Thus, our analysis will have considered the audiences for the campaigns relating to Bill 179, the organizations that created and disseminated those texts, and the texts themselves. The period of time included in the analysis begins in 2008 and ends in 2011 – the years leading up to, including and following the debate and passage of Bill 179 in Ontario. The intent of the analysis is to explore the extent to which the four overarching themes that were identified in the focus group and interview transcripts are also present in the actual messages disseminated by professional organizations. Are the same themes that are present in the focus and interview transcripts (anxiety, interaction and trust, professional identity and communication) also present in the messages these professional organizations actually create and distribute? Do their messages serve to heighten or lower anxiety? Do they foster or hinder interaction and trust? Do they reflect and deepen professional identity and, if so, around what elements of professional identity? Finally, do professional organizations reflect upon and report on their role as communicators?

## **Four Themes**

The four themes that emerged deductively from the analysis of focus group and interview transcripts now serve as categories into which texts will be categorized.

**Category 1 – Interaction and Trust:** This category was created to capture texts that dealt with the interaction (or lack thereof) between practitioners of different health professions and/or between organizations representing different health professions. Specifically, the interaction and trust described related to interprofessional collaboration and/or to Bill 179.

**Category 2 – Professional Identity:** This category captures texts that discuss elements of a practitioner's professional identity. Based on focus group transcripts, the elements searched for included professional knowledge, autonomy, time spent with patients, holistic approach to health care, patient-centered approach to health care, role of money in the profession, and the specific roles and tools of the profession.

**Category 3 – Communication:** This category built on the content of both focus group and interview transcripts to capture examples and discussions of the role that professional associations and regulatory colleges play in communicating to members and external audiences. The goals of these efforts to communicate and the channels used (i.e., internal or external) were also noted.

**Category 4 – Anxiety:** This fourth category captures texts that discuss the uncertainty and anxiety that accompany the significant change in Ontario's health

care system and its impact on professional roles, tools, knowledge and relationships.

The author then carefully read each article or advertisement and, from these, extracted texts (i.e., paragraphs or sentences) that fit into one of the four categories. Each article or advertisement yielded multiple texts and, in some instances, texts were found to fit into more than one category. In this way, the 208 articles and advertisements yielded texts that were placed in categories 923 times.

These texts were then re-analysed and, where appropriate, re-sorted into a small number of sub-categories. Table 5 below summarizes these four categories and the resulting sub-categories that emerged from the analysis.

Categories	Sub-categories
<p style="text-align: center;"><b>Interaction and Trust</b></p>	<p>These texts are sub-divided based on the manner in which the interaction and trust is characterized:</p> <ul style="list-style-type: none"> <li>• <b>Bridges:</b> Messages that report on <i>existing</i> trust, successful collaboration and <i>successful programs or projects</i> designed to foster these</li> <li>• <b>Barriers:</b> Messages that report shortages of trust, unsuccessful collaboration and the absence or failure of <i>programs or projects</i> designed to foster these</li> </ul> <p>Bridges and barriers are further sub-divided based on the level at which the bridge or barrier primarily operates:</p> <ul style="list-style-type: none"> <li>○ <b>Individual</b> practitioners in the workplace</li> <li>○ <b>Professional associations and regulatory colleges</b></li> <li>○ <b>Governments</b> at the provincial or national level</li> </ul>
<p style="text-align: center;"><b>Professional Identity</b></p>	<p>Statements relating to these elements of professional identity are further subdivided based on the <i>type</i> of identification:</p> <ul style="list-style-type: none"> <li>• <b>Positive Identity:</b> Reasons why the profession is worthy of esteem</li> <li>• <b>Negative Identity:</b> Reasons why the profession is superior to other professions</li> <li>• <b>Shared Identity:</b> Elements of professional identity two or more professions have in common</li> </ul>

**Table 5, Continued**

Categories	Sub-categories
<p><b>Communication</b></p>	<p>Messages that highlight communication as an important role for associations and regulatory colleges are further subdivided based on the intent of the communication.</p> <ul style="list-style-type: none"> <li>• Messages intended to <b>advocate</b> on behalf of the profession to legislators and policymakers</li> <li>• Messages intended to <b>educate</b> members</li> <li>• Messages intended to <b>promote</b> the virtues and value of the profession</li> <li>• Messages intended to foster <b>participation</b> by members</li> </ul>
<p><b>Anxiety</b></p>	<p>Texts that fall into this category were further subdivided to identify the nature of the anxiety created, including:</p> <ul style="list-style-type: none"> <li>• Messages designed to evoke <b>fear</b> and highlight risks to a profession or to the public;</li> <li>• Messages designed to <b>differentiate</b> professions and call attention to points of disagreement between them;</li> <li>• Messages that are <b>rival symbols</b>, prompted by earlier messages by a different profession; and</li> <li>• Messages that evoke or reflect <b>anger</b> and other negative emotions.</li> </ul>

**Table 5 Categories for Qualitative Textual Analysis**

### **Interaction and Trust: Bridges and Barriers**

Texts that fall in the category labeled “Interaction and Trust” were the most prevalent in the analysis, representing 50% of the texts that were categorized. Of these, the majority (35%) were further categorized as bridges: texts that report on existing trust between different professions, successful collaboration and programs or projects designed to foster these. The balance of the texts reported on barriers to trust and collaboration.

Table six below summarizes the distribution of these texts between the categories and sub-categories.

Category	Medicine	Nursing	Pharmacy	Total
<b>Interaction and Trust: Bridges</b>				
Individual	50	39	59	148
Association	33	24	41	98
Government	40	5	25	70
Education	2	0	5	7
<b>Total – Bridge</b>	<b>125 (32%)</b>	<b>68 (29%)</b>	<b>130 (44%)</b>	<b>323 (35%)</b>
<b>Interaction and Trust: Barriers</b>				
Individual	23	4	27	84
Association	14	16	9	39
Government	4	1	4	9
Education	0	0	5	5
<b>Total – Barrier</b>	<b>41 (10%)</b>	<b>21 (9%)</b>	<b>45 (15%)</b>	<b>137 (15%)</b>

**Table 6: Textual Analysis: Bridges and Barriers**

### **Bridges**

As the table summarizes, much of the coverage in the professional journals, public relations campaigns and news coverage reviewed for this study focused on efforts to demonstrate how interprofessional collaboration can work in the context of Bill 179, or efforts to describe formal projects and initiatives designed to build bridges between professions. All three professional groups whose publications and websites were reviewed were more likely to feature texts pertaining to interprofessional bridges than any other category. The bridge texts are largely optimistic and pragmatic: a “how-to” guide for practitioners and a celebration of achievement. Titles of articles include: “Where do we go from here?: Planning for the future of pharmacy practice” (Darby, 2010, p. 6); “Advancing an interprofessional care culture within primary care” (Oandasan, 2009, p. 1173); and “Team Building 101” (Burke, 2009a, p. 22).

The bridges these texts describe and celebrate were led either by individuals, associations, governments or educational institutions. Texts that profile individual bridges were the most prevalent by a significant margin, drawing attention to the work of individual practitioners or teams in a specific setting. This article from the *Canadian Medical Association Journal*, for example, favourably describes the impact that individual pharmacists have had on physicians and interprofessional teams:

Every day, pharmacists help patients deal with drug-related problems, such as drug prescriptions with no clear indications, medical conditions for which the patient needs a prescription drug but has not yet received it, drug side effects, drug–drug or drug–food interactions, suboptimal dosing and poor drug selection. Once the problems have been assessed, the pharmacist formulates a plan to resolve them, usually by initiating, stopping or changing the drug therapy or changing the dosing (de Lemos, 2008, p. 65).

These kinds of bridge texts serve to foster both interaction and trust by indicating to readers that interprofessional collaboration is happening, trust is building between individual practitioners, and patients are benefiting. Many cited the results from specific published studies<sup>105</sup> on the improved health outcomes that accompany more collaborative practice.

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<sup>105</sup> Consider this excerpt from a letter to the editor of a daily newspaper, by the CNA: “For example, when the Winnipeg Regional Health Authority introduced a full-time nurse practitioner in one of its nursing

The second most prevalent category was for texts focusing on how health professional associations and regulatory colleges are building bridges – creating programs that bring members of different professions together to learn, share and collaborate. This article in the Ontario College of Pharmacists (OCP) publication (*Pharmacy Connection*) points to a successful collaboration by 14 regulatory colleges: “In 2010, representatives from fourteen health regulatory colleges (and one transitional Council) came together as an interprofessional working group to develop common principles to support patient care” (Cadotte & Lee, 2011, p. 28). Similarly, this text describes a collaborative program by the Ontario Pharmacists’ Association and the Ontario College of Family Physicians:

The Ontario Pharmacists’ Association and the Ontario College of Family Physicians (OCFP) recognized the importance of pharmacists’ services and partnered to develop the Pharmacist and Physician Mentorship Program in 2007. This program is an ongoing, interprofessional education program funded by HealthForceOntario and co-developed by OPA and OCFP to provide resources for the integration of pharmacist services and development of collaborative relationships within Family Health Teams (FHT) (Bokma, 2008, p. 26).

Finally, a smaller number of texts described efforts to build bridges in health education: “It’s equally important, notes Dr. Neville, to communicate well between peers,

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homes, transfers to hospital emergency rooms were reduced by 20% and drug costs went down 17% overall, according to a 2009 article in *Canadian Nurse*.” (Shamian, 2010, p.1).

and within and across teams. That's why McMaster includes a program on interprofessional communications, where medical students learn alongside students from other health-care disciplines, like nursing (Foxman, 2010, p. 32).

In pointing out specific examples of efforts by associations, regulatory colleges, governments and educators to foster greater collaboration and new roles for practitioners, this coverage serves to normalize the changes, educate readers on the new roles, and signal the willingness and the resolve of the organizations to move forward with these changes.

The third most prevalent type of text focuses on efforts by governments to build bridges, foster greater interprofessional collaboration, and expand scope of practice. These texts point overwhelmingly to Bill 179 and to the consultation process of the Health Professions Regulatory Advisory Council (HPRAC) to inform and guide the legislation. All three professions closely watched the process of the legislation and the specific regulations that flowed from it. They reported to their members and to the public on the progress, and they offered praise and or criticism of the legislation as it progressed. A media release by the RNAO, for example, celebrated the announcement by the Ontario Government of an expanded scope of practice for nurse practitioners:

The Premier was greeted with the longest standing ovation ever when he announced that nurse practitioners (NPs) will have their powers extended to admit and discharge patients in hospitals. "This is extremely important news for nurse practitioners and more importantly for patients in Ontario," says Doris Grinspun, RNAO's Executive Director (Zych, 2011).

Government bridges went beyond legislation to include coverage of government funding. References were made, for example, to Health Canada's Primary Health Care Transition Fund and how, "the 2-year project created research and working papers, toolkits, and the 'Canadian Collaborative Mental Health Charter'" (Canadian Collaborative Mental Health Charter, 2007, p. S12). Government-initiated pilot programs also created bridges, such as the TIPS<sup>106</sup> program that brought five different health care teams together for learning, shared decision-making and collaboration – a process described in a *Registered Nurse Journal* article: "Physician Elaine Parker says TIPS gave the team an opportunity to think about how they would share patients and programs and explore stereotypes they had about the various professions on the team" (Burke, 2009a, p. 23).

### **Barriers**

In contrast to these optimistic and positive texts, we also find a smaller but still important number of texts that focus on the failures of interprofessional collaboration and the barriers that prevent this model of care from being effective. Here again, we find that the barriers operate at the level of individual practitioners, associations and governments (though none pointed to barriers at the level of health educators). This article in the *Canadian Family Physician*, for example, points to a number of barriers that would prevent individual practitioners from collaborating effectively:

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<sup>106</sup> Though the acronym is TIPS, the program is formally named the Building Positive Interprofessional Relationships in Health Care: A Collaborative Initiative for Patient Safety and Quality Work Environments program.

If sharing care appears reasonable for limited therapeutic areas, such as smoking cessation or emergency contraception, or even collaborative follow-up of anticoagulation therapy according to an accepted protocol, it becomes completely wacky if it is generalized to all treatments. If all the professionals associated with provision of care had unlimited rights to prescribe, it would be a veritable Tower of Babel... I can hardly imagine the chaos if all and sundry can prescribe and change each other's prescriptions. It's a good bet that, at the end of the line, patients will pay the price and suffer the consequences (Ladouceur, 2009, p. 1169).

The logistical barriers are explicit here, while the lack of trust in non-physician prescribers is more implicit. For readers, this text serves to discourage and perhaps reduce interest in pursuing more interprofessional models of care.

Next, barriers that operate at the association level were also featured in a number of texts. The barriers included the very communication campaigns that associations engage in and that are the impetus for this dissertation. In a letter published in the *Registered Nurse Journal*, Dianne Martin, Executive Director of the Registered Practical Nurses Association of Ontario pointed to a previous column in the Journal that lamented the use of Registered Practical Nurses (RPNs) to replace Registered Nurses in Ontario hospitals<sup>107</sup>. The letter suggested that the column served as a barrier to building trust and

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<sup>107</sup> RPNs generally complete a two-year college diploma program, whereas RNs must complete a Bachelor of Nursing degree. RPNs command lower hourly rates than RNs, which is why hospitals are shifting some duties traditionally done by RNs to them in an effort to reduce expenditures (Roles in Nursing, 2012).

collaboration: “Building respectful, trusting and collaborative teams is always challenging during times of pressures or change. We all need to advocate for patients while ensuring we do not damage those teams in the process” (Martin, 2009, p. 7).

Finally, a smaller number of texts discussed barriers at the government level, including charges that legislation does not go far enough: “The OPA had proposed a minor ailments prescribing program, but the province hasn’t yet approved such a role for Ontario pharmacists” (Expanded pharmacist services will save health care dollars and reduce ER visits: Ontario study, 2009, p. 271). Other government barriers included charges that government legislation goes too far in changing the way care is delivered, such as this quote by Dr. Suzanne Strasberg, then President of the OMA, in a *Toronto Star* article on the government’s announcement of NP-led clinics: “What we don't want to see are silos of health care being provided such as nurse-led independent clinics” (Boyle, 2009, p. A18).

It is important to note that all three professions considered for the textual analysis were approximately three times more likely to discuss bridges than barriers.

## Communication

In parallel with the results of focus groups and interviews, the texts included numerous references to the professional organization's role as a communicator. Indeed, these texts were the second most prevalent in the textual analysis, representing approximately 1 in 5 of the texts categorized, as table 7 below illustrates.

Category	Medicine	Nursing	Pharmacy	Total
<b>Communication</b>				
Advocacy	38	28	24	90
Promotion	15	8	9	32
Education	3	5	23	31
Participation	9	9	7	25
Defense	4	4	1	9
Cohesion	1	1	2	4
<b>Total – Communication</b>	<b>70 (18%)</b>	<b>55 (24%)</b>	<b>66 (22%)</b>	<b>191 (21%)</b>

Table 7 Textual Analysis: Communication

Table 7 also shows how these texts described communication efforts as designed to principally achieve four communication goals:

1. Advocacy campaigns directed to governments to influence policy and legislation;
2. Education campaigns designed to help members and non-member practitioners prepare for new roles;
3. Promotion campaigns directed to the public and designed to influence public opinion on the profession and health care; and
4. Participation campaigns designed to generate feedback and involvement of members in advocacy and promotion campaigns.

A smaller number of texts seemed designed to rise to the defense of the professions against charges by other professions, the government, the public or media, while a very small number seemed principally geared to forging a greater sense of cohesiveness among members.

### **Communication and Advocacy**

Advocacy emerged as the top priority for medicine, nursing and pharmacy, as measured by the prevalence of these kinds of texts. Indeed, for both medicine and nursing, messages on the topic of advocacy efforts represent more than half of the texts in the category. Advocacy messages typically pointed to meetings or correspondence between an association or regulatory college, and an elected official or senior policymaker. For example, an article in the *Ontario Medical Review* described how “OMA will engage in ongoing consultation with HPRAC and other stakeholders as various means to facilitate the development of effective means of interprofessional care” (Health Professions Regulatory Advisory Council Consultations on Interprofessional Care, 2008, p. 58). Similarly, the CNA described its advocacy efforts at the federal level: “In Ottawa, CNA’s efforts are also geared toward lobbying the federal government to reduce the barriers that prevent NPs from practising to their fullest abilities. This includes the authority to prescribe narcotics and other controlled drugs” (Awareness Campaign Promotes NPs, 2011, p. 20). In addition to reports on past and planned efforts, some texts celebrated the accomplishments and pointed to advocacy as a priority for members and for the association: “I know there will be plenty of examples of advocacy right here at RNAO. There always are” (Kearsey, 2009, p. 4). Texts by the pharmacy profession also

focused on communication geared to advocacy (e.g., “As the plans for these changes have been developed and rolled out, OPA, as your professional association, has been in active discussions with government and other industry stakeholders, ensuring pharmacists’ voices were heard and the value that our profession offers was recognized” (Miller, 2009, p. 30)). These did not represent as great a share of the pharmacy texts as was the case for medicine and nursing, however.

### **Communication and Promotion**

To a lesser extent, professional associations and regulatory colleges also disseminated texts designed to promote their respective professions to the public. Texts dealing with promotion typically focused on formal campaigns by the organization to enhance public awareness of the profession and the role. This article, for example, describes the OMA’s 2008 advertising campaign: “The OMA recently launched the latest phase of the Campaign for Healthier Care with a series of engaging newspaper and radio advertisements that will run in major markets across the province for three weeks beginning the month of May” (Campaign for Healthier Care Update, 2008, p. 11). Similarly, the CNA described its advertising campaign designed to promote the role of nurse practitioners: “‘Although NPs have been around since the 1965, their role is not well known throughout Canada.’ said Nora Hammell, director of professional practice and regulation at CNA. ‘This campaign aims to change that’” (Awareness Campaign Promotes NPs, 2011, p. 20). As interview participants made clear, promotional campaigns are valued by many association members and associations are eager to promote the investment and the results to their members. All three professions used

advertising to promote themselves to the public. The efforts varied in scale, however, with the OMA (including the SGFP) creating and publishing the most advertisements, and the pharmacy organizations turning least to this tactic.

### **Communication and Education**

The pharmacy profession's texts were also distinct in the additional focus they placed on educating members. Indeed, more than a third of the pharmacy texts in the communication category paid particular attention to education. Many of these described how pharmacy organizations are educating and preparing members for a new, expanded scope of practice (e.g., "Elsewhere in this issue, you'll read about our Association's commitment to providing any additional tools and knowledge pharmacists need to ensure they are ready for an expanded scope of practice" (Perlman, 2009, p. 30)). Texts from medical<sup>108</sup> and nursing<sup>109</sup> organizations featured similar texts, though these represented a smaller share of texts relating to communicators.

### **Communication and Participation**

Finally, associations and regulatory colleges disseminated numerous articles designed to foster participation by members. These generally called for member feedback

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<sup>108</sup> The College of Physicians and Surgeons of Ontario's *Dialogue* newsletter, for example, described a learning program in the area of collaboration on mental health: "Over the last several months, more than 750 clinicians have attended workshops in Ottawa, Casselman, Peterborough, Barrie, Sudbury, Thunder Bay, Guelph, and Simcoe. Future workshops are in planning with leadership from the Centre for Addiction and Mental Health and university CME departments" (Maximizing Patient Safety Together, 2011, p. 20).

<sup>109</sup> The College of Nurses of Ontario similarly directed nurse practitioners to the learning that is required of them as their role expands: "As always, NPs are expected to follow the practice expectations set out in the Nurse Practitioners practice document. This document and the NP lists are available at [www.cno.org/np](http://www.cno.org/np)" (New authorities for NPs imminent, 2011, p. 9).

and for participation in consultation processes, as this quote from the Ontario College of Pharmacists' *Pharmacy Connection* illustrates:

We will be incorporating the feedback we have heard from you as we travelled the province this fall, to develop regulations supporting these new authorities. Once the regulations for all new activities have been developed and approved by Council, they will be circulated to the members for comment and feedback, and I ask that each of you read and familiarize yourself with what is being proposed (Clement, 2009, p. 4).

Interestingly, nearly half of the texts calling for participation called for member involvement in advocacy efforts, further adding to the weight of messages focused on advocacy. This quote from the *Registered Nurse Journal* (Grinspun, 2009, p. 6) illustrates a strong appeal for participation in advocacy:

In the 1990s, RNAO called on every member to stand up for our profession and talk about the evidence linking RNs to better outcomes for patients and budgets. The same action is needed today. Pressure your organizations and your MPPs. Share your stories with the media. Call RNAO – we will stand by you, and with you!

That the preponderance of texts related to both member communication (i.e., educating members, fostering participation) and external communication (i.e., advocacy communication and promotion of the profession) suggests that communication is one of the fundamental roles of professional associations and regulatory colleges. This confirms

the importance of carefully studying how associations undertake this role and the impact of the messages they disseminate.

Finally, a small number of texts in the communication category focused on efforts to defend the profession against charges by government or other professions, and on fostering cohesion among members of the profession.

## **Professional Identity**

The third most prevalent category of texts consisted of those dealing with elements of professional identity. Of these, the majority<sup>110</sup> fell into three sub-categories:

- Identity defined by a patient-centered orientation to health care;
- Identity defined by specialized knowledge; and
- Identity defined by the specific roles and tools of the profession.

Texts that defined the profession as patient-centered typically focused on the profession's concern for patient safety, the profession's wish to enhance access to care for patients, and the profession's efforts to improve health care for all rather than advancing solely the profession.<sup>111</sup> The specialized knowledge of the profession was often described in general terms and focused on years of post-secondary education. Many texts from the pharmacy profession did focus more specifically on medication

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<sup>110</sup> The small number of remaining texts referred to the holistic approach of the profession, the time spent with patients, the nature of the rhetoric used by the profession in its public campaigns and the role of money in the profession. Note that each of these generated considerable discussion in both focus groups and interviews and relatively little presence in the texts that were analysed.

<sup>111</sup> This is reminiscent of the notion of "devotion to the use of disciplined knowledge and skill for the public good" that Freidson (2001, p. 217) argues is part of the "soul of professionalism."

(“Pharmacists go to university for 5 or more years and are the experts in appropriate use of medications. That’s their job” (Ontario’s family doctors say pharmacist prescribing may affect patient safety and care, 2009, p. 270). Some texts from the medical and nursing profession focused on the knowledge to effectively diagnose illness and disease. Those that defined professional identity by the specific roles and tools the profession can deploy focused mostly on diagnosis, prescribing and, in the case of nursing, admitting and discharging hospital patients. These specific roles are all included in the changing scopes of practice for nurse practitioners and pharmacists, which may explain why so much attention was paid to them between 2008 and 2011.

Some interesting patterns emerged from an analysis of which profession disseminated the various texts related to professional identity. The texts disseminated by the nursing profession were the most likely to refer to elements of professional identity, with approximately one in four falling into this category. The majority of these dealt with the new array of roles and tools that nurse practitioners had acquired through Bill 179. These were communicated through professional journals (“NPs will be able to carry out a variety of previously unauthorized acts and treatment procedures such as setting or casting bone fractures, ordering bone density tests and MRIs, and dispensing certain drugs” (Grinspun, 2009, p. 6) and through more public channels such as this 2008 media release: “NPs are RNs with advanced education and decision-making skills in assessment, diagnosis and health-care management. They have legislative authority to treat common illnesses and injuries, write prescriptions, order lab tests, X-rays and other diagnostic tests” (Scarrow, 2008, p. 1). This focus on roles and tools is in keeping with the fact that the nurse practitioner role is relatively new in Ontario and the expansion of

the scope of practice for nurse practitioners is more substantial than expansion for pharmacists.

Approximately one in five of the texts disseminated by the medical profession dealt with elements of professional identity. The majority of these focused on how patient-centered the profession is, with particular emphasis on patient safety: “The number one priority for Ontario's doctors throughout this entire process has been and remains patient safety because the level and quality of care that a doctor can provide should not be substituted for expediency,’ said Dr. MacLeod” (Ontario's Doctors Support Collaboration Among Health Care Professionals, 2009). Many other texts in this category focus on how the profession is working to enhance patient access to a family physician: “All people in Canada will have access to a family practice/primary health care setting that offers each person the opportunity to have his/her care provided by each of the following: a personal family doctor and a registered nurse and/or nurse practitioner” (Interprofessional Teams: Who are FPs working with?, 2009, p. 385). The strategy suggested by the prevalence of these two themes is to position physicians as the safest choice of health care practitioner and discourage policymakers from shifting medical roles to non-physicians in an effort to address the shortage of physicians, especially in northern and rural communities.<sup>112</sup>

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<sup>112</sup> The point was articulated by Dr. Don Pugsley, a member of the CMA Board of Directors at the association's annual conference: “Collaborative care,” Pugsley told delegates, “should not be seen as an opportunity for governments and must not be permitted to substitute one care provider for another simply because [one] is more plentiful or less costly than the other.” (Kondro, 2007, p. 558)

Texts disseminated by the pharmacy profession were less likely to refer to professional identity<sup>113</sup>, with about one in eight texts falling into this sub-category. Those that did deal with professional identity were more likely to focus on the pharmacists' knowledge of medication, as illustrated by this column in *The Ontario Pharmacist*: "This is a truly exciting move forward in our efforts to demonstrate pharmacists' unique skills and value as medication management experts, and to enhance our collaboration with other healthcare professionals so that together we can provide the kind of care Ontarians need and expect" (Darby, 2008, p. 5). Texts by the pharmacy profession also focused a good deal on how patient-centered the profession is, with particular reference to working in the interest of patient health and protecting patient safety: "As health-care professionals, it is so important that we communicate regularly to ensure our patients are getting the best and safest possible health care" (Pharmacist-physician collaboration key to patient safety, 2009, p. 18). Other texts suggested that "pharmacists are one of the most accessible of healthcare providers," pointing to the number of locations and the hours many of these keep (Ontario pharmacists ready to provide additional safe, accessible services to patients in collaboration with other health professionals, 2009). Since the role of pharmacists is also changing to include diagnosis and prescription in specific cases, we find references to these changing roles in some of the texts as well, for example: "An expanded definition of pharmacy scope of practice to include: 'promotion of health, prevention and treatment of disease, disorders and dysfunctions through monitoring and

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<sup>113</sup> This is perhaps in keeping with the quiet prevailing culture of the profession that was described by both focus group participants and interview participants.

management of medication therapy” (OPA welcomes health professions bill as “groundbreaking” for Ontario pharmacists, 2009, p. 166).

The analysis of the texts relating to professional identity also considered the manner in which the element is presented. Some texts were categorized as instances of *shared* identity, where the text suggests that the particular quality is shared by two or more health professions (e.g., “After decades of working in silos, pharmacists, physicians, nurses, dietitians and other healthcare providers are realizing that they share a common goal: providing the best care possible for patients” (Felix, 2008, p. 22)). Others were categorized as instances of *positive* identity, where the quality is attributed solely to the author’s profession without any suggestion that other professions lack this quality, as illustrated by this editorial from CNA President Kaaren Neufeld:

What really struck me as the H1N1 response rolled out was nurses’ ability to communicate and adapt despite the differences in people, places and politics they encountered. It showed me the resilience of nurses and of the profession of nursing itself. So often, we dwell on the negative and on what could or did go wrong instead of asking, “why did that go right?” (Neufeld, 2010, p. 2).

The remaining texts were categorized as instances of *negative* identity,<sup>114</sup> where the quality is attributed solely to the author’s profession, with the suggestion that it is lacking or absent in other professions. In this column for a debate on pharmacist

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<sup>114</sup> This paraphrases Lasswell’s notion of “negative identification” which results from individuals seeing their cultural group disparaged in some way (1935, p. 128).

prescribing, Jacques Desroches argues that only the extensive training of physicians qualifies them to prescribe:

I am among those who consider medical training to be a unique field of expertise that brings with it the ability to make a diagnosis and to prescribe the appropriate medication... I remain firmly convinced that the practice of medicine is complex, with many subtleties and variations, and that the only training that develops the expertise required to correctly make a diagnosis and to adequately prescribe medication is medical training (Desroches, 2009, p. 1177).

The contention here is that instances of shared identity can help to foster collaboration by reducing anxiety, stressing collegiality across professional boundaries and building mutual trust. On the other hand, instances of negative identity can have the reverse effect, serving to heighten anxiety, stressing exclusivity and eroding mutual trust. These are all patterns of response seen in the focus groups with practitioners. The focus group transcripts also suggested that instances of positive identity are less likely to heighten anxiety among the author's own profession while possibly heightening anxiety among other professions who may feel excluded or question the claim made by a profession other than their own.

Table 8 below summarizes the distribution of texts focused on identity between positive, shared and negative identity, as well as the overall percentage of texts which fall into the Professional Identity category.

Category	Medicine	Nursing	Pharmacy	Total
<b>Professional Identity</b>				
Positive Identity	21	48	26	95
Shared Identity	23	5	9	37
Negative Identity	25	7	4	36
<b>Total - Identity</b>	<b>69 (18%)</b>	<b>60 (26%)</b>	<b>39 (13%)</b>	<b>168 (18%)</b>

**Table 8 Textual Analysis: Professional Identity**

The analysis reveals that instances of positive identity were most common overall in the articles and advertisements analysed. This is consistent with the findings from interviews with executives from professional organizations, which suggested that associations and regulatory colleges have an important role to play as communicators. These organizations work to forge cohesion among members, promote the profession and defend its reputation. These functions are well served by messages of positive identity, especially as professions celebrate newfound roles. Fittingly, then, nursing and pharmacy were most likely to disseminate messages featuring positive identity.

Instances of shared identity were the second most prevalent, though significantly less prevalent than instances of positive identity. Most of these focused on how all health professionals share a common concern for the health of the patient. Given the call by many focus group participants for inclusive displays of shared identity and commonality, it is disappointing to see relatively few messages of this kind.

Finally, instances of negative identity were as prevalent as instances of shared identity. These texts covered a wide range of topics, including the exclusive education

and clinical knowledge of physicians, the exclusive approach to patient care of nurse practitioners (i.e., more time with patients, more emphasis on education, more caring), and the particular medication expertise of pharmacists. While all three professions disseminated texts featuring negative identification, the texts from the medical profession were most likely to feature this approach, with instances found in professional journals, media interviews and advertisements. As the profession that risks losing exclusive claim to professional roles and tools, medicine is perhaps the most likely to adopt a more aggressive stance and seek to limit the gains in credibility and scope of practice of other professions.

These findings align well with findings from the focus groups in terms of the prevalence of texts dealing with patient-centeredness, professional roles and tools, and professional knowledge. All three elements of professional identity were the subject of much discussion. Other elements, including a holistic view of health, time spent with patients and whether a profession's rhetorical approach is professional or not, also featured prominently in the focus groups but were only minimally represented in the texts analysed.

## **Anxiety**

The final category into which texts were classified covers texts dealing with anxiety. Here we find messages that reflect and/or contribute to the anxiety that practitioners feel in a period of great change, new roles and relationships, and often public campaigns to influence that change. Based on the focus group findings, the Anxiety category features four sub-categories:

1. **Fear:** Texts that highlight the risks to patients and/or practitioners of the changes happening or proposed
2. **Division:** Texts that stress the differences and antagonisms between professions and practitioners from different professions
3. **Rival Symbols:** Texts that report on, or that themselves are disseminated in response to a challenging message by a rival profession
4. **Anger:** Texts that express the strong, negative emotions of a professional organization and/or practitioner, in the face of these changes

Table 9 below summarizes the distribution of texts among these sub-categories for each of the three professions. The table also shows the overall percentage of messages that fall into the Anxiety category, and suggest that medical publications, advertisements and websites were more likely to communicate messages dealing with anxiety during the period of the campaign, as compared to nursing and pharmacy.

Category	Medicine	Nursing	Pharmacy	Total
<b>Anxiety</b>				
Fear	38	14	9	61
Division	32	8	6	46
Rival	7	2	3	12
Exclusion	7	1	0	8
Anger	4	2	0	6
<b>Total - Anxiety</b>	<b>88 (22%)</b>	<b>27 (12%)</b>	<b>18 (6%)</b>	<b>133 (14%)</b>

**Table 9 Textual Analysis: Anxiety**

The analysis of the texts in this category considered the specific nature of the paragraph or sentence, placing each into one or more sub-categories. The analysis also considered whether the texts were disseminated using more internal channels (i.e.,

professional journals, member newsletters), as opposed to more external channels such as media releases, media interviews, letters to the editor and advertisements.<sup>115</sup>

### **Anxiety and Fear**

The most prevalent sub-category across all three professions was Fear. While all three professions disseminated texts featuring or evoking fear, these were more prevalent among texts from medical sources. The medical profession was also more likely to disseminate texts that invoke fear using external channels such as media releases, advertisements and letters to the editor. These texts focus largely on the risks to patients of proposed changes in the delivery of health care. The words “patient safety” were called upon multiple times, as this Canadian Press article illustrates well: “The Liberal government is putting patient safety at risk by letting non-physicians do some of the work doctors currently perform, the Family and General Practice section of the Ontario Medical Association warned Wednesday” (Leslie, 2009). Similar arguments were also disseminated through internal channels, such as this article from *MD Dialogue*:

Ms. Tina Perlman, OCP’s Manager of Pharmacy Practice, said that physicians generally have limited awareness of the role of the community pharmacist and the potential gains in working together, but she said it is critical that pharmacists and physicians collaborate and cooperate in an

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<sup>115</sup> The line between internal and external channels is, in many ways, permeable. Members read the newspapers and, as one of the interview participants explained, reporters often read professional journals for story ideas.

effort to maximize patient safety regarding opioid use (Maximizing Patient Safety Together, 2011, p. 20).

The nursing profession was also an important source of texts focused on fear for patient safety, including this RNAO media release questioning the risks of the new physician assistant role introduced to Ontario hospitals: “The board of directors of the Registered Nurses’ Association of Ontario (RNAO) has unanimously endorsed a position statement, which raises serious questions about the level of education and regulatory oversight physician assistants have and how these could jeopardize patients” (Zych, 2010). In a more understated way, the Ontario Pharmacists’ Association raised a very similar fear in the context of a move to consider vending machines with video linking capabilities as a means to connect patients and pharmacists, and dispense certain medications in remote and rural regions of the province: “The OPA has expressed some concerns about remote dispensing and wants to ensure the pharmacists’ role in protecting patient safety remains front and centre” (OPA welcomes health professions bill as “groundbreaking” for Ontario pharmacists, 2009, p. 166). This text, like the majority of pharmacy texts that featured anxiety, was published in a professional journal and not in the mass media.

The risk of adverse outcomes for patients was not the only fear raised by professional organizations. Some texts raised the fear that individuals would not be able to access a health professional or a required diagnostic test or procedure. This argument was made by both physicians (“For more than 100,000 Ontarians, the pressing question is not: ‘Will I find a doctor in my neighbourhood?’ but rather, will I find a doctor at all?” (Campaign for Healthier Care Update, 2008, p. 11)) and by nurses (“Meanwhile, the

public suffers from avoidable system shortfalls, including poor access and lengthy wait times. I say, shame. It's time to put the public first" (Grinspun, May/June 2009, p. 6)). In addition, some texts by the medical profession and directed to members raised the fear that the profession would lose some privilege or exclusivity which it enjoyed at the time: "My fears are confirmed when I hear about clinics managed by nurse practitioners in big-box stores. Nurses who break free and work independently in discount stores, without a physician: a prime example of marked-down medicine!" (Laguë, 2009, p. 22).

In a sense, these multiple appeals to patient safety and access are the mirror image of the efforts to define professional identity by the extent to which a profession is patient centered. The concern for the welfare of the patient or client is foundational for most professions and the argument that a change in interprofessional roles and relations could jeopardize the safety of patients has great power in health care.

### **Anxiety and Divisions**

Anxiety can also stem from texts that draw a clear line between professions. As we saw in the focus groups, readers from the "other" profession are left feeling excluded and singled out for criticism. The distances and differences between professions are emphasized, hindering the development of trust and collaboration. In this line from the OMA's incoming President's inaugural address, Dr. Ken Arnold draws a clear line between physicians and both nurse practitioners and the provincial government: "Our government seems to believe that nurse practitioner clinics are an answer. I respectfully disagree. As the best trained partner in the health-care team, physicians need to maintain best care status with patients" (Arnold, 2008, p. 13). Similarly, in this article from the

*Registered Nurse Journal*, a nursing professor stresses the divisions between nursing and medicine:

The associate nursing professor at the University of Windsor voiced concerns that the health system revolves around physicians. “We should be paying attention to the other health professionals who deliver care ... specifically registered nurses who are actually the primary care providers in the hospital,” Thrasher wrote (Team work, 2010, p. 10).

In an Ontario College of Pharmacists report on workshops designed to foster greater collaboration, the author points out that some division was apparent in the sessions: “Pharmacists, for example, said they were concerned about physicians who consistently agreed to questionable early refills of opioids. They also shared their frustration regarding the limited collaboration and cooperation with physicians” (Workshops emphasize collaboration and communication, 2011, p. 16).

As these three quotes illustrate, the majority of the divisions stressed in these texts revolve around knowledge and quality of practice. The medical profession often stresses the additional education and knowledge they have as compared to nurses and pharmacists. The nursing profession stresses their additional knowledge and regulated status as compared to physician assistants. The pharmacy profession stresses their greater knowledge of medications. The emphasis is on how one profession is different from, and usually better than, the others. This difference and superiority is often the basis for denying another profession’s claim for additional scope of practice and public trust.

## **Anxiety and Rival Symbols**

Anxiety can also stem from one professional organization reacting to the messages of another by disseminating rebuttals and defenses – what Lasswell termed “rival symbols” (1935, p. 128). In this article, for example, the Executive Director of the Canadian Pharmacists Association reacts to a resolution passed at a CMA annual meeting, calling for strict limits on pharmacist prescribing: “Canadian Pharmacists Association Executive Director Jeff Poston later wondered whether doctors might feel slighted if pharmacists had the temerity, at their annual general meeting, to define the suitable duties of doctors” (Kondro, 2007, p. 558). Similarly, the CMA reacted to the RNAO’s criticisms of the physician assistant role in a media release it issued as a rebuttal to the RNAO’s statement: “Canadian Medical Association (CMA) President Dr. Anne Doig decried the ‘disingenuous fearmongering’ of the Registered Nurses’ Association of Ontario concerning the role of physician assistants (PAs) in the delivery of high-quality health care services” (CMA urges collegiality, not confrontation, to improve patient care, 2010). Whether in professional journals, media interviews or media releases, the dissemination of rival symbols continues and deepens debate. As was demonstrated in the focus groups, rival symbols can harden the position of individual practitioners, as they decry the original message from a rival profession and applaud their own profession’s response.

## **Anxiety and Anger**

Anxiety can also be evoked when anger and other negative emotions by professional organizations and practitioners are expressed in both internal and external

channels. These were the least prevalent type of texts, perhaps owing to efforts by professional organizations to limit themselves to a more professional style of rhetoric. Even so, some expressions of strong negative emotions did emerge in the internal and external channels of the medical and nursing professions. Doris Grinspun, for example, expressed her frustration with the limits on medications that nurse practitioners could prescribe: “It’s infuriating when these kinds of artificial and baseless hurdles and statements are informing debate about the scope of NP practice. In reality, they amount to nothing more than political wrangling” (Grinspun, May/June 2009, p. 6). In a single *Toronto Star* article (Boyle, 2009, p. A18), the SGFP advertising and media relations campaign was described as “offensive,” while the OMA was described as “out of touch with its members” and “very offside compared to everyone else.” Suzanne Strasberg, then President of the OMA, characterized the attacks on the association as “insulting.” In contrast, Denis Darby, Executive Director of the Ontario Pharmacists’ Association limited his characterization of the SGFP campaign to “unfortunate” (Ontario’s family doctors say pharmacist prescribing may affect patient safety and care, 2009, p. 270).

As one news media interview participant pointed out, this kind of acrimony is usually kept well behind the scenes between health professions.<sup>116</sup> That so many usually reserved professional associations debated so publicly supports the contention that Bill

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<sup>116</sup> Speaking of the debate over nurse practitioner-led clinics, the reporter stated: “You know, they’re careful about what they say publicly but privately they’re not very careful. They (medical associations) hate them with a passion” (Brackets mine). This may also explain why Teresa Boyle of the *Toronto Star* wrote that the debate between the OMA and the Ontario Hospital Association over the SOGFP campaign was a “rare turf war” and an “unusual public battle” (Boyle, 2009, p. A18).

179 and the efforts of the SGFP to derail it represent an important moment and unique problem (in John R. Hall's sense of the word) for Ontario's health professions

## **Conclusion**

It is important to confirm that the types of messages to which focus group participants most reacted are indeed in evidence here. Had these types of messages been limited to that one organization and to one brief campaign, the questions around which this dissertation is built would have seemed far less interesting and worthy. The textual analysis suggests that messages related to interaction and trust, professional identity, communication, and anxiety were disseminated by all professions included in this study, through a range of internal and external vehicles.

The close analysis described in this chapter also revealed interesting differences in the communication strategies of three different professions during this period of time. Texts by the medical profession were more likely to be categorized in the Anxiety and Negative Identity categories. Texts from the nursing profession tended to focus more on positive identity and less on shared identity, while focusing more on advocacy, as well as defining itself by its expanded roles and tools. The pharmacy profession, meanwhile, focused much less on anxiety (especially in external channels), more on government bridges, more on member education, and more on knowledge as a source of professional identity. The findings from focus groups and interviews suggest the softer stance of the pharmacy profession may stem from the profession's culture, its existing relationship with medicine and a deliberate decision by the leadership of those organizations to take the high road.

Overall, the textual analysis, when integrated with findings from the focus groups and interviews, suggests that, through these messages, practitioners' understanding of interprofessional collaboration – whether it works, who benefits and who is harmed – can be shaped. Members are educated, and informed of their profession's efforts to advocate and promote the profession. Their sense of professional identity is defined and strengthened. Their level of anxiety over changes to the profession and relations with other professions can be heightened or calmed.

It is clear that these messages are not the sole source of identity, tension, knowledge and trust. Lived experience on the front lines of health care is – by all accounts – more determinant than messages in professional journals and the mass media. Still, the comments of focus group participants and interview subjects suggest that the messages matter and are worthy of the close scrutiny this chapter has attempted to provide. The final chapter will consider how this process of influence aligns with the literature of intercultural communication and propose some broader conclusions that can be drawn from this study.

# Chapter Eight - Discussion

## Introduction

This dissertation set out to explore whether and how intercultural communication is facilitated or impeded by the communication practices of different cultural groups within and through media channels. The underlying contention here, in keeping with the work of scholars such as Lasswell (1935), Gudykunst (1988) and Kim (2001), is that messages communicated through the news media, advertising and the communication channels of a particular cultural group can facilitate intercultural communication by creating shared understanding and shared identity, focusing on common goals, reducing the perceived differences between groups, and lowering the level of anxiety members of each group feel as they approach a moment of intercultural communication. At the same time, those messages can serve the opposite purpose, interfering with shared understanding, stressing difference over commonality, and heightening anxiety. Building on the methodology of Liebes and Katz (1990), the study used focus groups to observe how readers actually engage with and interpret texts by their own cultural group and by those of a rival cultural group.

The specific cultural groups this paper considered are two different health professions: pharmacists and nurse practitioners. Though intercultural communication research more often focuses on ethnic, religious, national and linguistic groups, there is ample support for the argument that professions constitute cultural groups (Simmel, 1922/1955; Cooley, 1924; Merton, 1957; Becker et al., 1961; Good & Good, 1993;

Sassen, 2002; O'Day, 2000; Dombeck, 1997; P. Hall, 2005; and Wackerhausen, 2009). More specifically, the research considered these health professions in the province of Ontario, during a period of time (2007-2011) in which the legislation governing the scope of practice of each profession was subjected to a broad consultation and numerous important revisions. The consultations and revisions generated considerable communication activity by the organizations that represent pharmacists and nurse practitioners, as well as medical organizations that saw once exclusive powers being shared with pharmacists and nurse practitioners. The communication activity included advertisements, media relations campaigns, position statements, submissions to government and numerous articles in professional journals and magazines. The organizations sought to influence the shape of the renewed legislation, keep members informed of the progress of the consultation and revision, and engage members in campaigns to influence the government and public. As such, the move by the Government to renew the *Regulated Health Professions Act* (Bill 179) provided an important opportunity to observe the communication activity of professional organizations, and to assess the manner in which these messages are engaged and interpreted.

The data that informs this study was gathered using focus groups involving members of the nurse practitioner and pharmacy professions in Ontario. Both professions are attempting to maintain a shared sense of professional identity in the face of efforts by medical organizations to call into question the wisdom of Bill 179 and the capacity of both professions to carry out their expanded scope of practice. Participants were shown a series of texts created by their own professional organizations, by medical organizations

and by the news media. The texts set the stage for group discussions of interprofessional communication and collaboration, professional identity and the communication practices of professional organizations. Data was also gathered from thirteen, one-on-one interviews with executives of professional associations and regulatory colleges as well as with reporters and editors from both professional journals and the mass media. Finally, data was gathered using a qualitative textual analysis of 207 texts in professional journals and websites, advertising and news media coverage of the debate surrounding Bill 179 in Ontario. Content was grouped into the same four broad thematic categories that emerged from the analysis of the focus group and interview transcripts.

This concluding chapter will begin by comparing the findings from all three methods to the literature on interprofessional communication that was reviewed and summarized in chapter three. Next, the three questions originally proposed in the introductory chapter will be answered using the data gathered and analysed in chapters four through seven. Finally, the four principal themes that emerged from the analysis of the data (Identity, Anxiety, Communication and Interaction) will be discussed and integrated, leading to a discussion of further directions for research and communication practices for professional organizations.

### **Alignment with Existing Literature**

The third chapter reviewed literature from a number of schools of thought within communication studies, focusing on how these schools had considered and studied intercultural communication specifically. Certain core concepts were considered and expanded upon by scholars in a number of these schools. As such, to avoid duplication,

this section will note the important ways in which the findings from the focus groups, interviews and textual analysis aligned with these core concepts and the numerous scholars who articulated them.

## **Cultural Identity**

### **The Need for Identity**

The first core concept that is woven through much of the literature on intercultural communication is cultural identity. Within this admittedly broad concept is the more precise idea that cultural identity, more than simply a shared feature of a group, is a fundamental need of individuals – what Raymond Williams defined as “the essentially non-profitable human needs of nurture and care, support and comfort, love and fidelity, membership and belonging” (p. 195). The same fundamental need (and the accompanying anxiety of losing that identity) was described by Williams’ colleagues in the cultural studies tradition (Hall, S., 1990, 1992, 1996; Hoggart, 1957, 1972, 1987). More recently, some scholars of interprofessional collaboration such as Roberts (1989), Degeling, Kennedy & Hill (2001), Atkins (1998) and Wackerhausen (2009) also expressed the idea that cultural identity is a profound need of individuals. This same need is echoed in the focus group and interview transcripts. This exchange between a participant in the fifth group of nurse practitioners and the moderator – on the topic of the contrast between a poster promoting the nurse practitioner profession and the SGFP advertisement – captures how participants value seeing their group presented and the sense of belonging to a profession:

**PA:** Yeah. Because it's very real. I see my role a lot in here. It's not something you're fetching for to see if there's any truth to it. It's what you do every day. So it does speak of what our profession is all about, what your role is all about.

**Moderator:** Now how do you feel, then, when you read something like that and you feel, "This is my role. This is what I do." How does that make you feel?

**PA:** Very proud, definitely. This is what you went to school for, this is what you want to do. This is how you want to be seen, basically. This is a positive image of what you want people to know of you and what you do, not some garbage useless insult! (LAUGHTER)

Similarly, this professional organization executive described in very positive terms the shared sense of mission and accomplishment the organization's members enjoy as a result of Bill 179 and its expansion of their scope of practice:

And the positive, I believe... the members, the people who we have still as members, and those who stood there and said, "This, this is going to work and we have to go through a rough time first," now feel that they have, um, they've worked hard and they've moved forward, and they're moving [the profession] forward and they're moving healthcare forward. So, um, the feel like a more cohesive group (Professional organization executive).

The need for cultural identity can also be expressed in a negative way, when the claim for identity is negated. One pharmacist focus group participant, for example,

characterized the SGFP campaign as “putting down our profession and our abilities, and I guess creating discord too between us.” (SH – Pharmacist group 3). Another summed it up simply as, “... *really* insulting and it’s putting us down” (SA – Pharmacist group 2).

Finally, this article in the OMA’s *Ontario Medical Review* speaks to the importance of a strong cultural identity both in the minds of members and of the public:

The Ontario Medical Association is maintaining its prominent public profile and reinforcing recognition of physicians as the most trusted health-care providers. A new province-wide radio and newspaper campaign, launched November 10, emphasizes the “unequalled training, knowledge and expertise” of Ontario’s doctors (Henry, 2008, p. 24).

In common with the literature reviewed, these texts (along with several others) point to the importance and value of shared cultural identity and public recognition of the claim to identity within health professions.

### **Fluid Identity**

Much of the literature reviewed posited a concept of cultural identity that is fluid, where barriers between cultural groups can be permeable and shifting. Simmel (1903) wrote of the multiple affiliations of individuals who come together in large cities, whereas Dewey (1922) suggested that the “intermingling of customs” (p. 70) gives individuals the choice to construct their identity from the patterns they see around them. This same concept of identity as a matter of choice and negotiation was also featured in

much of the work in the cultural studies tradition, including Stuart Hall (1996, 1992<sup>117</sup>) and James Carey<sup>118</sup> (1989). Similarly, Kim (2007) wrote of cultural identity as a “flexible and negotiable entity of an individual” (p. 244). Some scholars in interprofessional collaboration tradition have also argued for a concept of identity that is flexible and negotiated (Austin, Gregory & Martin, 2007; Hong, 2001; Kim & Hubbard; 2007).

The results of this study align well with this fluid notion of culture, as participants and texts described the challenges of navigating from old values, tools and practices towards more modern elements of their professional culture. In this quote, a pharmacist participant describes the tension between older, more retail oriented cultural identity of pharmacists and the newer, more patient-focused identity that he and other participants in the focus group ascribe to:

It’s interesting the people that you have here tonight. A lot of the pharmacists that I know are completely retail-oriented. That’s what they do. They are in the profession to make money and to run a business. It’s interesting that not many of them have signed up for this. Probably because a lot of the people that you have here are more interested in the profession (DO – Pharmacist group 1).

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<sup>117</sup> Stuart Hall (1992) wrote of how cultural identity has become “a ‘movable feast’: formed and transformed continuously in relation to the ways we are represented or addressed in the cultural systems which surround us” (cited in Hall, Hell and McGrew, 1992, p. 277).

<sup>118</sup> Carey 1989) wrote of a plurality of that “qualitatively different zones of experience that cultural forms organize in different ways” (p. 47) and later added that the “analysis of mass communication will have to examine the several cultural worlds in which people simultaneously exist – the tension, often radical tension, between them, the patterns of mood and motivation distinctive to each, and the interpenetration among them” (p. 51).

A nurse practitioner, JU described a similar tension between the familiar cultural identity of nurses and the more medical identity of nurse practitioners:

I think one thing that makes NPs unique is because we belong to a bit – as you were saying – we belong a little bit to physicians and a little bit to nursing; I would add in pharmacists there as well because of our prescribing rights (JU – Nurse practitioner group 1).

Similarly, this executive from a pharmacy organization described the movement within her profession from a culture of “black and white” (well suited to dispensing medications) to a culture more at ease with the grey zones and uncertainty that accompany patient education and care: “... uncertainty about the business model, uncertainty about what they’re going to do, if they can do it.” Finally, this article in *Canadian Family Physician* suggested that the permeability of cultural boundaries could allow the principles of family medicine to be “applied, arguably, to any and all health care professionals who come to work in primary care settings. And if we do so, we can build a team of health care professionals who share similar values and principles and commitments to competence” (Oandasan, 2009). Each of these statements (and others like them) is founded on an understanding that professional cultures are not fixed and, in the present context, are subject to considerable negotiation and change.

### **Cultural Identity as a Barrier**

Within the concept of cultural identity, we also find that many scholars from a variety of traditions have argued that cultural identity serves as a barrier or impediment to effective intercultural communication. Though scholars differed on the extent to which

they felt cultural differences should be protected or erased in the interest of advancing intercultural communication, many agreed that different cultural identities and different cultures could serve as a barrier to effective intercultural communication by both limiting understanding and hindering the desire for cross-cultural exchange. The position was neatly summed up by Samovar and Porter (1976): “Culture is a communication problem because it is not a constant; it is a variable. And as cultural variance increases, so do the problems of communication” (p. 6). The sentiment is echoed in works from the Chicago School (esp., Lasswell, 1980); the Columbia School and modernization theory (Katz & Lazarsfeld, 1955; Lerner, 1951; Schramm, 1964); the Palo Alto School (Goffman, 1963; Hall, E. T. 1959 & 1976); as well as intercultural communication research tradition (Kim, 2001; Gudykunst, 1994, 2005; and Starosta, 1984). The cultural studies tradition focused less on culture as a barrier but Raymond Williams’ (1961) notion of structures of feeling similarly presents cultural identity as a hindrance to intercultural communication as different structures prevent members of different cultural groups from seeing the world and responding to experiences in the same way. Finally, a number of interprofessional collaboration scholars take a similar stance and argue that differing cultural identities (i.e., values, goals, terminology and orientation to health) stand in the way of effective interprofessional communication and collaboration (Hall, P., 2005; Roberts, 1989; Degeling, Kennedy and Hill, 2001; Wackerhausen, 2009; Dombeck, 2007; Horsburgh, Perkins, Coyle, & Degeling, 2006).

We do find, in the transcripts from focus groups and interviews, evidence that supports this notion of cultural identity as barrier. This pharmacy organization executive, for example, described how nursing and pharmacy approach collaboration with different

perspectives and, in so doing, can create tensions: “My experience with this profession is that they are, they are nothing if not conservative, from the point of view of... Contrast that with the nurses who say, ‘We can do everything. Without us the system falls apart.’” Similarly, this nurse practitioner described two different orientations to health care (holistic and disease-focused) that can make it difficult for her to work effectively with physicians: “Well I think you can still see the patient as a whole person and, especially in primary health care, we look at the person as a whole as opposed to a disease or a part or in a category” (KR – Nurse practitioner group 4).

Few of the texts gathered for the textual analysis presented distinct professional cultures as a barrier to communication and collaboration, with most pointing instead to differing levels of knowledge and logistical issues inherent in interprofessional collaboration. Oandasan (2009) did refer to a report by The Institute for Healthcare Improvement that suggested the professional culture of physicians is grounded in “a strong belief system related to personal responsibility for quality of patient care and a strong need to practise with full individual autonomy” (p. 1173) – two characteristics that limit the willingness to collaborate and share responsibility. In addition, Rosenthal et al. (2010) similarly pointed to differences between medical and pharmacy culture as a limiting factor to pharmacist expanding their scope of practice and collaborating effectively with physicians: “Can pharmacists change their approach to patient care? Or, are the classic barriers to practice change a convenient script, when the actual barrier is pharmacists’ own psyche and culture?” (p. 37). Apart from these few instances, however, the notion of culture as a barrier is seldom addressed directly in the data gathered from focus groups, interviews and textual analysis. Cultural identity is often implied

(especially in discussions of roles, knowledge and tools) but rarely addressed explicitly as a barrier or a resource.<sup>119</sup>

### **Identity in Contrast**

Finally, within the concept of cultural identity is the idea that cultural identity is often forged both by defining one's own group and, often in less favourable terms, defining the others. The contrast between the two definitions gives strength to the identity. This idea is expressed by scholars in the Chicago School (Simmel, 1903; Dewey, 1922; Lasswell, 1927) as well as cultural studies (Hall, S., 1996; Williams, 2003), scholars of intercultural communication research (Starosta, 1984; Nash, 1989) and those studying interprofessional collaboration (Hall, P., 1983; Austin, Gregory & Martin, 2007; Pecukonis, Doyle & Bliss, 2008; and Wackerhausen, 2009).

The focus group and interview transcripts featured numerous examples of participants who defined their own profession in contrast to other professions, using differences in aspects such as patient-centeredness, power, knowledge and rhetoric to deepen their sense of membership. This nurse practitioner, for example, contrasted her profession's orientation to health care to medicine's orientation in explaining her choice of careers: "It would be more holistic, fitting in with my social work background and my interest in social determinants. So I talked to some people I worked with – the nurse practitioners – and decided that was a better fit than medicine" (KR – Nurse practitioner group 4). Similarly, this pharmacy organization executive defined the profession by

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<sup>119</sup> The word "culture" appears only six times in the texts gathered for the textual analysis, three times in the focus group transcripts and four times in the executive interviews.

contrasting the nature of its practitioners to that of physicians: “They’re cautious, they’re not out there. They’re not more risk-averse where physicians are far more... you know, they just exude confidence, right?”

The documents created by professional organizations and reviewed for the textual analysis showed the same tendency to define one profession in contrast to another, as this Ontario Pharmacists’ Association media release does:

While physicians are the experts in diagnosis, pharmacists are experts in medication and medication management. They have an in-depth knowledge of hundreds of prescription and non-prescription medications and are trained to assess, monitor, support and educate patients on their medication therapy (Ontario pharmacists ready to provide additional safe, accessible services, 2009).

The challenge to interprofessional communication and collaboration is heightened when the contrast is designed to isolate a profession and question its claim to professional identity. This essay from a medical journal article, for example, contrasts the education of nurse practitioners to that of physicians and, in so doing, rejects the claims by nurse practitioners for the authority to diagnose and prescribe:

I remain firmly convinced that the practice of medicine is complex, with many subtleties and variations, and that the only training that develops the expertise required to correctly make a diagnosis and to adequately prescribe medication is medical training (Desroches, 2009, p. 1177).

This approach to defining a profession, then, often turns from definition to the negation of the claim to identity of the other. As we shall discuss elsewhere, the impact on subsequent intercultural communication and collaboration can be negative.

## **Anxiety**

The second core concept with which the findings from this study align is anxiety. Beginning with Lasswell (1935), communication scholars have long recognized that intercultural communication can arouse “insecurity reactions” (p. 155) as members of one cultural group engage and interpret images of another group or by another group. Responses can be defensive and prejudiced (Katz & Lazarsfeld, 1955; Liebes & Katz, 1990), anxious and uncertain (Hall, E., 1959; Gudykunst, 2005; D’Amour, 1997; Pecukonis, Doyle & Bliss, 2008) as well as hostile (Irvine, Kerridge, McPhee & Freeman, 2002) and frustrating (Gui-Young Hong, 2001).

Transcripts from focus groups and interviews included moments that covered this entire range of anxious responses. The ads and articles that were shared with participants elicited much of the anxiety, with participants concerned about how the messages in these texts would affect the way their profession is perceived by the public, as when SH, a participant in the third group of pharmacists, reflected on an earlier comment by PA:

... you know if I was the public and I read *this* (pointing to Appendix 1.11 - the letter to the editor by the Executive Director of the Ontario Pharmacists’ Association in the *National Post*) I’d feel like, “oh yeah, my pharmacist is completely capable.” But if I read *this* (pointing to Appendix

1.2 – the Canadian Press article by Keith Leslie, I'd feel like "(GASP) oh no way!"

Others worried about the effect the messages would have on other professionals with whom they need to interact:

But now that I see this kind of stream underneath – what's coming from *their* professional organization – I suddenly feel, yeah, a little bit threatened by it, that this is what they're hearing from people they probably trust and I don't know how much weight they put to it, I really don't. Uhm, but I don't think it's helping nurse practitioners and physicians to work well together, for sure it's not (SH – Nurse practitioner group 3).

Anxiety was also elicited when a participant's profession was not represented in a text, as this participant illustrated while describing a Government of Ontario television commercial that portrayed a consumer who had just swallowed a pill and wondered if he should be taking it with juice or not. The advertisement presents several options: "And pharmacist wasn't mentioned in *that* example" (PA – Pharmacist group 3).

Anxiety among focus group participants also came when their claim to identity was negated, especially in terms of their level of knowledge, as illustrated by this nurse practitioner reading from the SGFP advertisement: "And I kind of felt insulted that they were saying we *weren't* as educated as they were. They're educated in a different scope for sure..." (SH – Nurse practitioner group 3).

Anxiety can also emerge from unsuccessful interaction with members of other professions in the health care setting, as this medical organization executive explains:

Again, it comes down to, how does the nurse actually enter the practice?

Some of them come in with their elbows up, ready to fight for what they think an NP should be doing. So that sets everybody's teeth off and they end up in conflict with the office staff, with the family practice nurses that are there, and with the docs.

Articles that were gathered for the textual analysis similarly describe tensions arising from media campaigns surrounding interprofessional collaboration. Describing the SGFP campaign, Oandasan (2009) expressed a strong opinion about the messages: "I was shocked and dismayed at the message put forward—yet not surprised. Turf wars are not new. But in primary care they are getting ugly" (p. 1173).

Anxiety was a constant feature in all of the transcripts and a great many of the texts that were analysed. Emotions run high when individuals' sense of identity, their livelihood and the health of their patients are concerned. The challenge, as the work of Gudykunst has made so clear, is that anxiety often precludes and hampers effective intercultural communication. Anxiety and uncertainty render health professionals more likely to work independently and erode the sense of belonging to a team with shared goals.

### **Symbols in the Media**

The literature reviewed for this dissertation also suggested that symbols in the media play a role in intercultural communication. Lasswell (1935) in particular paid

attention to how symbols in the media are received and the impact they have on how members of different cultural groups communicate. Negative symbols will often provoke rejection by members of the group that has been disparaged – what Liebes and Katz (1990) termed a defensive interpretation. Paradoxically, the defensive interpretation of many focus group participants was to ascribe the content of the SGFP campaign to the organization's fear and defensiveness: "... it's indicative of their defensiveness, which means it's sending me the message, 'We're getting close'" (PA – Nurse practitioner group 3).

Lasswell also suggested that negative symbols in the media may prompt the disparaged group to create and disseminate rival symbols. Both the rejection and call for rival symbols was expressed emphatically by JU, a participant in the first group of nurse practitioners: "We've gotta ignore this crap and we've gotta do our *own* good storytelling to the government. That's... they've got the *ultimate* power and we've just gotta get the public on our side and get these stories out to the government." Similarly, the Ontario Pharmacists' Association responded to the original SGFP advertisement by issuing a rival media release (Ontario pharmacists ready to provide additional safe, accessible services, 2009) and providing a quote for the Canadian Press story documenting the campaign:

Ontario's pharmacists fired back Wednesday, calling the doctors' position "unfortunate" and insisting they are qualified for the extra tasks the province is asking of them. "Like doctors, pharmacists are highly trained and regulated health care professionals with clear standards of practice designed to protect patient safety," said Dennis Darby, chief executive officer of the Ontario Pharmacists' Association (Leslie, 2009).

Rival symbols, then, serve to extend the debate, widen the audience and further the anxiety created by the initial negative symbol in the media.

Finally, Lasswell cautioned that in the absence of full information on the outside group, participants in intercultural exchanges will turn to stereotypes that are often disseminated in the mass media. The point was echoed in the work of Gudykunst (1988), and Gudykunst and Kim (1995). The potential for the SGFP campaign to establish these stereotypes and shape the image of their profession was recognized by some focus group participants, including AN in the second group of nurse practitioners:

I think it's entirely possible that physicians who don't have the opportunity to work with other health care professionals if they might think it's a good idea, if they're swayed by enough of this stuff, if they read enough of this stuff, what are they left to think? That it's a bad plan and there's a lot of incompetency out there.

Apart from sparking identification and rejection, and providing stereotypes to inform or misinform intercultural communication, scholars including Kim (2001) and Stuart Hall (1996) have argued that symbols in the media serve to gather individuals to a cultural group, by providing positive images of the group, defining the group to itself and to outside audiences, and building the cohesiveness of the group. As we've seen in earlier focus group quotes in this chapter, members of the nurse practitioner and pharmacy profession did respond to positive images of their own profession in the media by expressing pride and satisfaction with the actions of their professional organizations. BE, nurse practitioner, summed up the impact of symbols in the media for both members of a profession and the public:

I get really *excited* by any articles that discuss *role* of nurse practitioners and the ever-expanding... like the role of them and the profile of them, basically. And both of these I see as increasing our visibility in the general public but also within our profession and our colleagues (BE – Nurse practitioner group 4).

The same impact was described by a pharmacy organization executive who discussed the benefits of the communication and advocacy campaign they mounted in support of Bill 179:

The words that kept coming up and we got was value and respected. And, and you know, the two of them are kind of linked, right? Value: valued in terms of, “I care.” Government sees value and is prepared to pay for it. And is kind of a – that and then... and, “I’m more respected as a professional.”

The findings from focus groups, interviews and the textual analysis all point to an important role for symbols in the media in terms of hindering or helping intercultural communication. In this way, the findings align with much of the literature reviewed. The transcripts and texts demonstrate how symbols can hinder collaboration by negating the claim to identity of another group, heightening anxiety, and focusing on the problems with interprofessional collaboration. The data also show how symbols in the media can foster collaboration, by focusing attention on shared identity, by discussing the advantages of collaboration, and thus lessening anxiety.

It should also be noted that the emphasis on symbols in the media that is found in the work of the Chicago School, modernization theory, interpretive tradition, cultural studies and intercultural communication research is not currently matched by research into interprofessional collaboration in health care. Less attention has been paid by researchers in this tradition to the ways that media coverage, advertising, and professional journals can play in bringing about collaboration and communication that cut across professional boundaries.

### **Education and Overcoming Barriers**

In addition to the more negative roles ascribed to the mass media in the preceding section, there is also a more positive concept woven through much of the literature reviewed for this paper: the notion that education can help overcome cultural barriers. From Simmel's faith in the "power of intellectual and educational interests" (1922/1955, p. 135) and Dewey's confidence that, through education, "intelligent direction may modulate the harshness of conflict" (1922, pp. 121 – 122), the Chicago School was characterized by a widely shared faith in the progressive potential of education and media. That faith was shared by many scholars in the modernization theory tradition, including Schramm's (1964) call for a "nation-wide dialogue" to "weld together isolated communities, disparate sub-cultures, self-centered individuals and groups," in the interest of imparting modern values to traditional societies (p. 44). Edward T. Hall (1960) turned to the *Harvard Business Review* to encourage American businessmen to learn more about how "various peoples around the world have worked out and integrated into their subconscious literally thousands of behavior patterns that they take for granted in each

other” (p. 87). Later, intercultural communication scholars like Samovar and Porter (1976), Gudykunst (1994, 1995) and Kim (2001) took up the call for, and contributed their ideas and insight to efforts to educate those who engage in intercultural communication. Interprofessional collaboration scholars placed equal emphasis on education and shared experience as a means to overcome interprofessional barriers (Pecukonis, Doyle and Bliss, 2008; Roberts, 1989; Hall, P., 2005; Horsburgh, Perkins, Coyle and Degeling, 2006; Wackerhausen, 2009; Björke and Haavie, 2006; San Martin-Rodriguez, D’Amour and Leduc, 2008).

The emphasis on education and shared experience is echoed in the findings of this study. Focus group participants cited the changes happening to attitudes as a result of interprofessional education that brings together members of different professions to learn common curriculum together: “I think it’s changing now too because I think a lot of classes at U of T are inter-collaborative classes where they actually have doctor and nurses and pharmacists in one class” (HE – Pharmacist group 1). Similar programs were described by a professional organization executive who described a mentoring program: “... taking nurse practitioners and family doctors who had learned how to work extremely well together, to provide some guidance and support for new teams that are coming up.” Similar success stories were found in professional journal articles from all three professions included in the analysis, including this article by the Ontario College of Pharmacists on its efforts to “meet with as many pharmacists and physicians as possible to discuss how to safely and effectively use opioids to treat patients with chronic non-cancer pain” (Workshops emphasize collaboration and communication, 2011, p. 16). There is optimism evident in these and other texts. Many practitioners know of these new

approaches to education and speak to the success of the approach. Executives from professional organizations also speak to the success and continue to implement new programs to bring together members of different professions for learning and sharing – programs that may then be reported on in their journals and websites. There is widespread agreement on the goal and the means to achieve it.

## **Power**

As was discussed in the introduction and literature review, the concept of power is evident in some of the literature on intercultural communication, though not all. The theme of power and culture while living under a dominant power was central to much of Raymond Williams' work (1958, 1961, 1980, 2003) and Williams argued that effective communication between cultural groups was only possible in conditions of equality.<sup>120</sup> More recently, Pippa Hall (2005) argued that "gender and social class issues have been factors in the friction and conflict that has existed between professions" (p. 189) and linked these to the cultural identity of different professions.

The frustration of practicing as a nurse practitioner in unequal power relations was emphatically expressed by this focus group participant who moved to Canada from the United States and suddenly saw her level of autonomy decreased substantially in her new place of work:

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<sup>120</sup> "The inequalities of many kinds which still divide our community make effective communication difficult or impossible (1958, p. 317).

I was grieving for a long time. I grieved and I found it extremely difficult to find a place here for myself. I found it... I felt belittled and I felt... demeaned at losing... I, I had a DEA number in the States, which meant I could prescribe any narcotic out there. I could prescribe *any*. I mean, I was entrusted with an enormous amount of responsibility and I handled it, I thought, rather well... I felt it was the most demeaning thing in the entire universe (AN – Nurse practitioner group 2).

This emphatic and direct linkage of scope of practice to a sense of being belittled and demeaned speaks both to the role of power in interprofessional collaboration and to the importance of roles (e.g., prescribing) and tools (e.g., a US Drug Enforcement Agency permit number) as elements of professional identity.

The focus groups also revealed how messages in the media can evoke this sense of unequal power and frustration, as this quote from a pharmacist who had just read the SGFP ad illustrates:

The doctors only want to work on the team when they can be the chairmen. So, you're allowed to make input but they feel like they have the final responsibility and the final decision. And sometimes that's really frustrating (MA – Pharmacist group 1).

The interviews with professional organization executives also included moments in which the inequality of power and its link to collaboration were discussed. In this case, an executive attributes the slow growth in his or her profession's scope of practice in

Ontario (relative to other provinces) to the power of the OMA and the reluctance this creates to engage and challenge the organization:

In many ways, they are very turf-protective. I think our College of [profession] was a bit gun-shy to fight for this kind of stuff. I think the Registrar there... was really nervous about it.

Discussions of unequal power relations were less prevalent in the texts analysed. In one example from the *Registered Nurse Journal*, Burke (2009a) described a pilot program designed to improve the functioning of interprofessional teams by helping physicians acknowledge the unequal power relations and work through them constructively. The same article described how the program stressed the importance of “acknowledging feelings of pain, suffering and humiliation without damaging relationships,” (p. 23) once again suggesting the friction that unequal power relations can bring about.

### **Summing Up the Evidence**

On the whole, the data from the focus groups, interviews and textual analysis that informed this dissertation align well with a wide range of literature on intercultural communication. There is much in the data that speaks to the individual professional’s need for a solid sense of professional identity, as well as recognition that this identity can be flexible and subject to construction and negotiation. There are words that reflect how professional identity can serve as a barrier to interprofessional communication and collaboration. There are also words that demonstrate how identity can be forged in contrast, stressing differences and, often times, suggesting superiority.

Numerous texts and quotes vividly illustrate the role that anxiety can play in interprofessional communication and collaboration. The specific examples and the frank expressions of emotions constitute, for the author, some of the most memorable moments in the research process. Likewise, the data include solid support for the idea that messages in the mass media and in professional journals can influence the shape of interaction on the ground, as practitioners from different professions work together to solve problems in a dynamic and demanding environment. Much of the influence cited by participants and texts was negative but this was balanced by a strong belief in the positive role that education and exchange can play in fostering successful interprofessional collaboration. Finally, the data provide examples and support for the argument that interprofessional collaboration is more challenging in the context of unequal power relations.

### **Answering the Original Questions**

In the first chapter, two key questions were identified that guided the study as a whole. The evidence gathered does go some way in answering these questions, pointing the way also to further research to more fully answer them.

#### **Extent of the Disassociation Strategy**

The first question which this study set out to answer was the extent to which professional organizations use their channels of mass communications to forge a cohesive sense of cultural identity among members and, within this, the extent to which those messages stress differences and disassociation from other professions. The answers suggested by the data are, first, that forging a cohesive sense of cultural identity is indeed

a priority for professional organizations. The textual analysis of more than four years of content found some 200 articles, ads and releases that focus on Bill 179 alone; this does not include those articles on other topics that we nonetheless focused, at least in part, on forging cohesiveness and defining cultural identity. In their interviews, professional organization executives explained that forging identity and cohesiveness is a priority for their organizations, while focus group transcripts pointed to the demand for such campaigns and messages among members. Identity and cohesiveness matter and, as goals, they drive considerable communication activity by professional organizations.

As for the extent to which these messages stress difference and disassociation, the answer is more nuanced. The texts gathered included several instances of negative identification, where difference and superiority were explicitly stated. These were outnumbered, however, by instances of positive identity, which stressed the positive attributes of one profession without then claiming superiority or exclusiveness of those attributes. The instances of negative identification were equal to the number of texts that stressed shared identity: values, goals and priorities that different professions have in common. On the whole, the communication strategy in evidence is diverse and seems to favour messages that do not rely on the association/disassociation dynamic.

The data show, however, that the communication strategy changes when one profession feels its claim to identity is under threat<sup>121</sup> or when backroom channels of communication are no longer working and the profession seeks to influence policy via the

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<sup>121</sup> Such was the case with the OMA, for example, while Bill 179 was being debated. A similar shift in communication strategy is evident in the messages of the nursing profession when the Physician Assistant profession was expanded.

public and media. As the reporters who participated in interviews made clear, messages that stress conflict and difference receive far more coverage in the news media, while advertisements that create anxiety receive more attention from readers.<sup>122</sup> The analysis of news media articles and advertisements reflects the very different communication strategy at work in these, as compared to professional journals.

### **Symbols in the Media, Anxiety and Trust**

The second question posed was the impact the communication practices of professional organizations have on levels of anxiety or trust between members of different professions. The answer suggested by the data is that, in the short term, symbols in the media that stress difference, describe barriers to collaboration and deny the claim to identity of other professions can indeed create anxiety. These messages create negative stereotypes and “bring the elbows up” of people who need to work together. Numerous comments by focus group participants demonstrated this interpretation and response, showing sometimes strong emotion and eliciting a defensive response that often included disparaging remarks about the other profession. Of particular concern to participants is the impact of symbols in the media on professionals with limited interprofessional collaboration experience. Participants felt the impact of these symbols would be stronger in the absence of real-world collaboration.

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<sup>122</sup> See Marcus, Neuman and MacKuen (2000) for a thorough discussion of the role that anxiety plays in stimulating attention, learning and action on the part of voters in the U.S. “We now understand,” they write, “that emotions play a critical role in prompting people to pay attention to politics in an efficient and indeed rational way” (2000, p. 123).

However, numerous comments by focus group participants suggested that any effect the media messages might have on levels of trust and anxiety would be short-lived, as the process of working together would educate professionals on what members of other professions have to offer and would allow members of different professions to work through differences and focus on shared goals. On the surface, then, the evidence gathered does not suggest that messages in the media have a lasting impact on stereotypes, anxiety and trust. The faith in education and shared experience remains strong, especially among participants who had stories of successful collaboration to share. The methodologies selected for this study are not optimal for answering this second question, however. A more appropriate methodology, perhaps as a follow-up study, will be proposed below.

## **Limitations**

There are important limitations to this study that merit mention. The study does not address how professional communications practices actually play themselves out in the field, where health professionals communicate and collaborate. The methodologies selected for this study focus more on messages and interpretation than behavioural effect; rather than field observation, my analysis is drawn from comments by focus group participants and interview subjects, as well as a qualitative textual analysis of articles and advertisements.

Other limiting factors to note include a small sample of participants, drawn only from two health professions (nurse practitioners and pharmacists) out of the 21 regulated health professions in Ontario. Other professions in Ontario have also been affected by

Bill 179, and the process of redrawing practice boundaries between professions is occurring in numerous Canadian provinces. The communication activity of these affected health professional organizations and the interpretation of their members are not considered here. For reasons discussed at the start of this dissertation, the manner in which physicians engage with and interpret the texts from these kinds of campaigns has not been considered.

In addition, only one specific case of professional communication is considered for this study – activity surrounding Bill 179, between 2009 and 2011. The process of redrawing practice boundaries has continued since 2011, as has the discourse on health professions. This more recent communication activity is not captured in this study. A follow-up study that considers a broader range of health professions, in more jurisdictions, and covering more recent activity would be an important complement to this study.

Finally, the study did not directly consider the role of two key actors in the health care system: members of the public and governments. Since the campaign of the SGFP and the rebuttals it precipitated unfolded in advertisements, the news media and interviews, members of the general public were very likely exposed to these messages. Did the texts generate attention and provoke anxiety among patients and their family members? Was the public image on which much of professional prestige rests affected by the campaign and, if so, to what effect? Recall that this was among the chief concerns of focus group participants.

Similarly, though the SGFP campaign was precipitated by a piece of provincial government legislation, and though much of the communication activity by professional

organizations was designed to influence legislators and policymakers, this dissertation does not focus directly on how these government actors engaged the texts of the campaigns and how they interpreted them. It does not consider how the campaigns might have influenced the actions of the Government of Ontario.

These limitations in the scope and scale of the study did, however, make possible a tighter focus on professions and professional culture, greater depth of analysis and saturation in the qualitative findings.

### **Further Directions for Research**

As the preceding section suggested, further research on this topic is needed that involves physicians in a similar process of focus groups during which they interpret and discuss texts by their own profession and rival professions. As what is widely regarded to be the more dominant health profession, it would be interesting to assess whether physicians engage and interpret messages differently than their counterparts in other health professions. With adequate funding, such a study would form an important complement to this study.

A second direction for further research would be to include other health professions that have been affected by Bill 179 and engage them in a similar process of focus groups, executive interviews and textual analysis. Notably, physiotherapists, midwives and naturopaths are all seeing significant changes to their scope of practice as a result of the same legislation. Are the patterns described in this dissertation similar across these other groups or would we find other cultural patterns in the evidence?

A third direction would be to include members of the public in a similar study to determine patterns of engagement, interpretation and effect among these key players in interprofessional collaboration in health care.

To understand the full impact that varying levels of trust and anxiety have on practitioners in the workplace, a longitudinal study of attitudes among health professionals and how these correlate to media consumption would be needed, perhaps blended with an ethnographic study that observes actual interaction and matches this against media consumption. This would provide a fuller picture of the extent to which the discourse of professional journals, the news media and advertising is actually carried into the clinic or hospital. Do practitioners discuss the articles and advertisements with colleagues? Do they take up the ideas and discourse in their dealings with members of other professions? While this study featured quotes and texts to suggest that this may be the case, observing this movement from text to the workplace would likely shed more light on the topic.

Finally, a complementary study into the governmentality of Ontario's health care sector would help to shed light on the various sites of power in the sector and the complex web of relations between each. Nikolas Rose & Peter Miller (1991) sum up the range of associations between different entities that seek to bring about governmentality:

Central to the possibility of modern forms of government, we argue, are the associations formed between entities constituted as "political" and the projects, plans and practices of those authorities - economic, legal, spiritual, medical, technical - who endeavour to administer the lives of

others in the light of conceptions of what is good, healthy, normal, virtuous, efficient or profitable (p. 175).

Clearly, health professional organizations – medical and otherwise – have their place in this process. Indeed, the comments of interviewees and the texts published in the journals and websites of the professional organizations considered in this dissertation strongly suggest that the relationships forged with governments are of the utmost importance.

Rose and Miller (1991) continue their discussion of how relations are established between actors in the political and non-political spheres in modern forms of political power.

The state can be seen as a specific way in which the problem of government is discursively codified, a way of dividing a “political sphere,” with its particular characteristics of rule, from other “non-political spheres” to which it must be related, and a way in which certain technologies of government are given a temporary institutional durability and brought into particular kinds of relations with one another (p. 177).

Such a study of the governmentality of Ontario’s health care sector around the period of change to the *Regulated Health Professions Act* could shed light on the question posed by the authors: “what relations are established between political and other authorities; what funds, forces, persons, knowledge or legitimacy are utilised; and by means of what devices and techniques are these different tactics made operable” (p. 177).

## Integration

The evidence gathered for this dissertation all points to four overarching themes: communication, anxiety, identity, and interaction. Though each was discussed in some detail in preceding chapters, it is important to draw the four themes

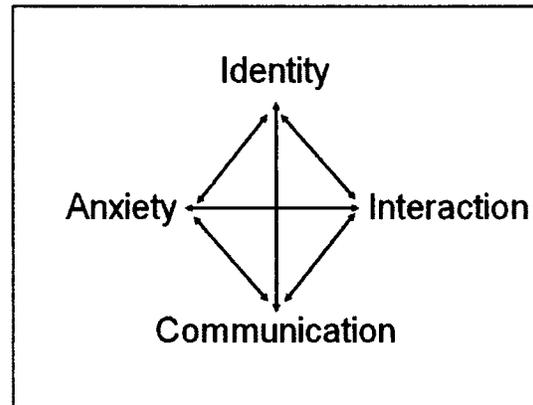


Figure 2 Integrating the Four Themes

together in this final chapter and note the important relationships between them. Figure 2 illustrates the relationships between each theme. The arrows in two directions suggest that these relationships are contingent and dependent, ultimately, on the strategies and orientations of practitioners and the professional organizations that represent them.

Beginning with the top half of the figure, we note that identity is tied to anxiety in that the absence or loss of identity can be a cause of anxiety. When levels of anxiety and uncertainty are high, members of a group will circle the wagons and turn inwards. On the other hand, a confident sense of identity rooted more in positive and shared identity can lower anxiety. Identity is also closely tied to interaction in that successful interaction can help foster a “we” sensibility between groups, whereas identity rooted in negative identification discourages interaction by stressing the differences and barriers between groups. Similarly, anxiety and interaction are closely tied, as successful interaction builds trust and familiarity, lowering levels of anxiety and uncertainty. Conversely, high levels of anxiety discourage interaction, making boundaries seem wider and less surmountable and increasing the sense of risk of unsuccessful interaction.

On the bottom half of figure 2, we are reminded that communication is closely tied to anxiety. Messages that professional organizations create and disseminate to members, the media, the public and governments can serve to heighten anxiety or lower it. Professional organizations choose whether to focus attention on strong positive emotions, the benefits of collaboration and the values that all health professions share. On the other hand, they can choose to accentuate strong negative emotions (e.g., anger, fear), the differences between professions and the barriers to collaboration.

In much the same way, communication is closely tied to interprofessional interaction. Professional organizations can use communication to foster interprofessional interaction or hinder it. Messages that promote learning and report on successful interaction will invite and favour more interaction. Messages that create negative stereotypes and report on failed interaction will have the opposite effect. To use the language of Putnam (2007), it is not simply a matter of adhering to a theory of contact or conflict. Each journal article, media interview and advertisement has the potential to go one way or the other. Both contact and conflict are possible outcomes, depending on the communication strategy adopted by the professional organization and the manner in which those messages are engaged and interpreted by a particular profession. Etiquette,<sup>123</sup> to borrow a concept explored by Goffman and Edward T. Hall, extends to mediated messages too.

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<sup>123</sup> Goffman (1961) characterized etiquette as “flimsy rules” and wrote of the anxiety created when the rules are broken: “To be at ease in a situation is to be properly subject to these rules, entranced by the meanings they generate and stabilize; to be ill at ease means that one is ungrasped by immediate reality and that one loosens the grasp that others have of it” (pp. 80-81).

Finally, and perhaps most important for this dissertation, the evidence suggests important and complex ties between the communication practices of professional organizations and the professional identity of members. Professional identity matters to members and to professional organizations. Society expects and demands much from its health professionals and professionalism can enable and motivate members of a profession to deliver on these. I side with Freidson in this respect:

The development of a specialized body of formal knowledge and skill requires a group of like-minded people who learn and practice it, identify with it, distinguish it from other disciplines, recognize each other as colleagues by virtue of their common training and experience with some common set of tasks, techniques, concepts, and working problems, and are inclined to seek out each others' company, if only to argue with each other. In so far as such a group is what Collins called a "consciousness community" (1979:58), "formed on the basis of common and distinctive experiences, interests and resources (1979:134), it cannot help but be exclusive. If it did not exclude from membership those who lacked any consciousness of common experience, interest and commitment, it would be an entirely different kind of group, perhaps not a group at all (Freidson, 2001, p. 202).

The move to interprofessional collaboration can be experienced as disintegrating for some professionals, as older ways of seeing, thinking and acting conflict with the rapidly changing demands of the profession and changing expectations of the public. It is to be expected, as Raymond Williams (1983) has suggested, that a return to shared

cultural identity will be “a profound and necessary response” (p. 328) to this threat to professional identity.

Professional journals, websites, advertising and media coverage have a role to play in this response. To borrow from Carey (1989), these communication vehicles can be avenues of ritual communication that help to create and repair cultural identities in a rapidly changing environment. The need is to find ways to foster interprofessional collaboration that do not erase cultural identities, that do not create the very tensions and anxieties they are trying to resolve. Claims to identity – by physicians, nurse practitioners, pharmacists and other health professions – matter. These claims need to be respected because the differences between professions can be valuable, allowing the perspectives and roles of the team to begin to match the diversity of the task at hand – human health. Identity claims also matter because, as Putnam (2009) argues, confident and shared cultural identity sets the stage for greater engagement with members of other groups: “bonding social capital can thus be a prelude to bridging social capital, rather than precluding it” (p. 165).

Instead of merely overcoming cultural barriers, the effort should be to build, in addition to a professional identity, a shared identity of health care professional that emphasizes the features of professionalism (rigorous education and continuing professional development, public good, ethical standards, commitment to patient safety and patient centeredness). This shared identity does not preclude a profession-centric identity. There is a place within health care for professional commitment to a particular understanding of, and orientation to health. There is a place for effort to acquire and maintain special skills and knowledge, and for a celebration of the unique features of a

profession's history and structures of feeling. To paraphrase from the focus group and interview participants, let pharmacists be scientists; let nurses care with the heart as much as the mind; and let physicians devote themselves to history, diagnosis and prescription. Stuart Hall (1990) argues effectively for the possibility of such a complex identity. Though he writes of Caribbean identity rooted both in nationality and ethnicity, the larger point of his discussion is relevant to health professions:

Its complexity exceeds this binary structure of representation. At different places, times, in relation to different questions, the boundaries are re-sited. They become, not only what they have, at times, certainly been - mutually excluding categories, but also what they sometimes are - differential points along a sliding scale (p. 228).

Professional identity, then, need not be monolithic, nor the texts by professional organizations that seek to represent and construct that identity. Texts can hail readers as health care professionals, ready to collaborate in the interest of patient safety and health outcomes. They can also hail them as members of a distinct profession, ready to carry on traditions, to express their unique identity and ready to celebrate their positive attributes.

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# Appendices

**Appendix 1: Texts shown to focus group participants**

**Appendix 2: Research instruments and ethics approval documents**

**Appendix 3: Table of texts analysed for the textual analysis**

## Appendix 1.1: Excerpts from Fletcher (2009)

*MD Pulse* was prepared by the Canadian Medical Association to disseminate the findings from the 2008 National Physician Survey. The publication included several articles relating to different findings from the study. Focus group participants were shown an article entitled, “Collaborative care: a necessary evolution” (Fletcher, 2009, p. 40). The article summarizes the findings from a question that asked physician respondents to indicate the health professions with whom they collaborate most regularly. The list includes other physicians but also lists “potential collaborators with different skill sets,” such as “dietitians, nutritionists, nurses, occupational therapists, pharmacists, physiotherapists, psychologists and social workers” (ibid). A paragraph at the end of the article discussed an effort in Nova Scotia to “establish nurse practitioners as collaborators with local physicians to improve care in underserved areas” (p. 43). The chart presented in the article (p. 41) drew particular attention from participants, including those who saw themselves represented and those who did not.

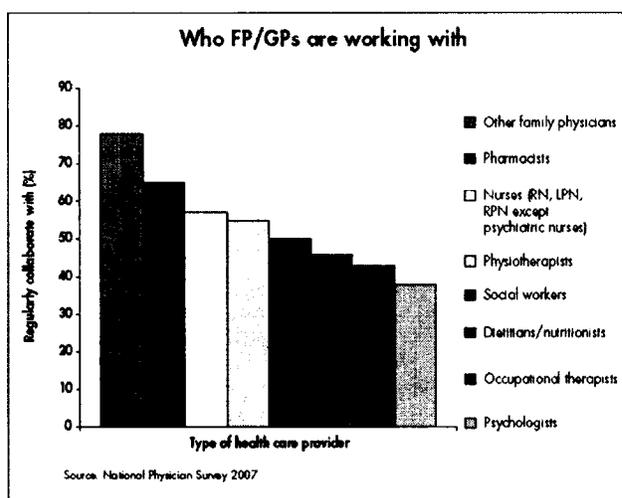


Figure 3 Chart from Fletcher, 2009, p. 41

## **Appendix 1.2: Excerpts from Leslie (2009)**

The article by Keith Leslie of the Canadian Press was published on a number of news websites, including the Canadian Press's own site and YahooNews, in September of 2009.<sup>124</sup> The headline of the original article read: "Letting pharmacists prescribe drugs like letting flight attendant fly plane: OMA." The article went on to quote then OMA section chair Dr. David Bridgeo as saying: "Having these roles filled by non-medical personnel is like having a member of a flight crew fly an airplane... How many people would be comfortable with having someone with less education, training and experience replacing pilots?"

Leslie also included a rebuttal by Dennis Darby, CEO of the Ontario Pharmacists' Association: "Like doctors, pharmacists are highly trained and regulated health care professionals with clear standards of practice designed to protect patient safety... While physicians are the experts in diagnosis, pharmacists are experts in medication and medication management."

Finally, the article cited then Premier of Ontario, Dalton McGuinty: "We want to maximize the professional responsibilities of any one profession, and we think that we can, safely, enable pharmacists to provide the kind of services we're talking about... That's why we're the first province in Canada that's going to move forward with nurse practitioner-led clinics."

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<sup>124</sup> An abridged version was published on the *Toronto Star*'s online Health & Wellness site See the abridged article at: [www.thestar.com/life/health\\_wellness/2009/09/23/ontario\\_doctors\\_oppose\\_new\\_privileges\\_for\\_nurse\\_practitioners\\_pharmacists.html](http://www.thestar.com/life/health_wellness/2009/09/23/ontario_doctors_oppose_new_privileges_for_nurse_practitioners_pharmacists.html)

### **Appendix 1.3: Excerpts from Ontario Medical Association (2010)**

The print advertisement by the Ontario Medical Association (2010) included the same headline as many others in the same series: “Ontario’s doctors: Your life is our life’s work.” The ad featured a Toronto patient and his physician standing comfortably beside one another and brief quotes from each. The patient’s quote included: “Some people you meet you just feel a trust, a connection. It was that way with Dr. Goldbloom.” Dr. Goldbloom’s quote then explains that the patient – Richard – suffered from depression, which neither therapy nor medications had relieved: “But based on his symptoms and what I had learned in training, I was able to suggest a treatment that worked. The change was remarkable.”

More recent versions of this ad are available from the OMA website at <https://www.oma.org/mediaroom/campaign/Pages/campaigna.aspx>.

#### **Appendix 1.4: Excerpts from Section on General and Family Practice (2009)**

The Section on General and Family Practice of the Ontario Medical Association published an ad in major newspapers and magazine in October of 2009. The headline in the ad read: “With today’s healthcare, is an apple a day really your safest bet?” (Section on General and Family Practice, 2009). The headline was accompanied by a large illustration of a person’s fearful face peering from behind her or his hands. The text in the ad discussed the importance of having physicians play a role in collaborative health care: “When nurses, pharmacists and family doctors work as a team, patients benefit. However, when healthcare professionals work without the involvement of a physician, patient care and patient safety could suffer.” The ad goes on to call for more consultation of physicians by the government as it revises the Regulated Health Professions Act: “... would it not be prudent for the government to consult and listen to the most involved and educated front-line healthcare providers: doctors?”

The ad is no longer available on the organization’s website but the Ontario Branch of the Canadian Society of Hospital Pharmacists did publish a PDF version of a second ad in the same series in the News Archives section of their own site at <http://www.cshpontario.ca/web/la/en/pa/1F5D90418E2F43F98F41C2968D9C1008/it/4243A623228347BA8033A7D6F4CD773D/item.asp> .

## **Appendix 1.5: Excerpts from Zych (2010)**

Participants in the focus group with nurse practitioners were invited to review a media release by the NPAO announcing the group's annual conference in Toronto. First issued on November 3, 2010, the headline of the release read: "The future is now: Nurse practitioners gather in Toronto to discuss their ever-expanding contributions to health care in Ontario" (Zych, 2010). The release referred specifically to Bill 179 and the expanded scope of practice for nurse practitioners:

With the adoption of Bill 179 earlier this year, the once future dream of NPs working to their full scope of practice and abilities has arrived. With the elimination of many barriers to practice such as a limited prescribing authority, NPs are excited at the prospect of making even greater contributions to the health of people across Ontario.

The release also applauded recent decisions by the Ontario Government, including "the McGuinty government's leadership in accelerating reform by tearing down artificial barriers that limit nurse practitioners working in all sectors of health care" and "opening the first Canadian NP-Led Clinic (2007) and for funding 25 additional ones as part of the solution to ensure every Ontarian has a primary care provider."

The article also explained that nurse practitioners are "registered nurses with advanced education and decision-making skills to diagnose and treat common illnesses and injuries, prescribe medications, and order lab tests, X-rays and other diagnostic tests."

## **Appendix 1.6: Excerpts from NPAO (2010)**

Participants in the nurse practitioner focus groups were shown a colourful poster published by NPAO. The poster features the headline: “We believe every person deserves the best possible healthcare” and includes photos of four diverse nurse practitioners smiling confidently. The poster makes specific references to the new roles that nurse practitioners can play in Ontario: “We diagnose and treat illnesses, prescribe medications and order diagnostic tests” (NPAO, 2010).

The poster is available to view online at:

<https://www.oma.org/mediaroom/campaign/Pages/campaigna.aspx>

## **Appendix 1.7: Excerpts from Zych (2009)**

Participants in the nurse practitioner focus groups were also invited to review a media release issued by the RNAO on October 20, 2009. The headline read: “Ontario nurses welcome changes to their practice but argue more work needs to be done to reduce wait times and increase access for patients” (Zych, 2009). The release both praised the newly expanded scope of practice for nurse practitioners and lamented certain restrictions that remained:

“While this is a welcome beginning, we’re not there yet. There is an opportunity to remove restrictions so that NPs can better serve their patients,” says RNAO president Wendy Fucile. Unlike most jurisdictions across Canada and around the world, NPs in Ontario are currently forced to prescribe medications from a limited list of drugs. RNAO would like to see the province adopt a model of open prescribing.

The release also called on the government to remove restrictions that prevent nurse practitioners from admitting and discharging patients from hospitals: “NPs face discriminatory practice privileges and that is affecting patient care.”

As well, the release called for Medical Advisory Committees (MACs) in hospitals to be replaced with Interprofessional Advisory Committees (IPACs). Doris Grinspun, executive director of RNAO, was quoted as stating: “The government’s objective of improved interprofessional collaboration won’t happen if you maintain archaic organizational structures that focus power in only one profession. It’s time to move into the 21st century and replace MACs with Interprofessional Advisory Committees.”

## **Appendix 1.8: Excerpts from Grinspun (2009)**

Finally, nurse practitioners in the focus groups were shown a column from the *Registered Nurse Journal* in which the Executive Director of the RNAO – Doris Grinspun – called for the removal of restrictions on the scope of practice of nurse practitioners. In particular, Grinspun (2006) called for the removal of limits on which drugs nurse practitioners can prescribe:

It is shocking that the government ignored the key recommendation for open prescribing that the College of Nurses of Ontario (CNO) called for in submissions to the Health Professions Regulatory Advisory Council (HPRAC). This is why, with your active support, we will push all parties to do what is right for the public by following the rest of Canada and allowing open prescribing. Anything less is unacceptable (p. 6).

The same article called for the new legislation to allow nurse practitioners to admit, treat and discharge patients in hospitals.

Broad-based legislation is necessary so that hospitals can take full advantage of NPs competencies. The *Public Hospitals Act* currently allows NPs to admit patients to emergency departments and other out-patient settings, but not to any in-patient unit in the hospital.

Grinspun characterized these limitations as “artificial and baseless hurdles.” The article can be viewed online at [http://rnao.ca/sites/rnao-ca/files/Executive\\_Directors\\_Dispatch\\_May-June-2009.pdf](http://rnao.ca/sites/rnao-ca/files/Executive_Directors_Dispatch_May-June-2009.pdf).

## **Appendix 1.9: Excepts from Ontario’s family doctors say (2009)**

The pharmacists who participated in focus groups were shown an article from the *Canadian Pharmacists Journal* first published in November/December 2009. The article reported on the SGFP advertising and media relations campaign and included some of the most contentious aspects of the campaign:

The release called it “patently absurd” to think that nurse practitioners can replace family doctors, or that pharmacists have the education and experience to prescribe medications... The SGFP also compared family doctors to airline pilots, and said that having other health professionals take on traditional physician roles was akin to having flight attendants take over flying planes (Ontario’s family doctors say, 2009, p. 270).

The same article also quoted Dennis Darby, CEO of the Ontario Pharmacists Association, who sought to reassure physicians and the public:

“Our 2 professions have worked together for decades with a high level of mutual respect. There will be great value to the health care system if everyone does their part and I am hoping that over time, physicians will see that.”

## **Appendix 1.10: Excerpts from OPA welcomes health professions bill**

**(2009)**

Pharmacists were also shown a second article from the July/August 2009 edition of the *Canadian Pharmacists Journal*, which reported on Bill 179 and the proposed expansion to pharmacists' scope of practice in Ontario. The article included quotes from Dennis Darby, CEO of the OPA, which both praised the legislation and cautioned that the detailed regulations to follow would determine the full impact on his members:

“The legislation is certainly groundbreaking for Ontario,” says the CEO of the OPA, Dennis Darby. “Without this enabling legislation, it would be difficult for pharmacists in Ontario to practice at their highest level. The government clearly wants pharmacists to play a larger role in chronic disease management, for example, and the next step is to work through what we want to see in those regulations” (OPA welcomes health professions bill, 2009, p. 166).

The same article also listed the proposed changes to pharmacists' scope of practice and quoted Mr. Darby on the importance of supporting pharmacists through this period of change:

“We will work not only with the OCP but with other colleges and associations to ensure that all the professionals collaborate as we move forward,” says Mr. Darby.

## **Appendix 1.11: Excerpts from Darby (2010)**

The third article shown to pharmacist participants was a letter to the editor published in the *National Post* on September 30, 2010. Written by Dennis Darby, the letter responded to an earlier article in which the Health Council of Canada called for greater access to prescription decision-support tools for physicians and argued that a more collaborative approach to health would also help ensure patients are not prescribed too many medications. Darby (2010) writes:

As the experts in medication and its management, pharmacists can (sic) working closely with physicians and other health-care providers to ensure drugs are prescribed and used correctly.

Darby also points to Bill 179 and the expanded role it provides for the province's pharmacists:

Once this collaborative model takes greater hold, we will see profound changes in how medications are prescribed, used and monitored.

## **Appendix 1.12: Excerpts from Ontario pharmacists ready to provide (2009)**

The final text shared with pharmacist participants in the focus groups was a media release issued by the Ontario Pharmacists' Association on September 23, 2009. The release came as a rebuttal to the SGFP campaign and included headline reading: "Ontario pharmacists ready to provide additional safe, accessible services to patients in collaboration with other health professionals."

In the release, CEO of the OPA, Dennis Darby, characterizes the SGFP's approach to opposing Bill 179 as "unfortunate" and calls for more collaboration:

Pharmacists know they can and should do more to provide much-needed services to patients in this era of increasing health needs and scarce resources, and that pharmacists, doctors and others need to work in partnership to maintain and improve the health of Ontarians (Ontario pharmacists ready to provide, 2009).

The same release includes praise for the pharmacists' knowledge and training:

While physicians are the experts in diagnosis, pharmacists are experts in medication and medication management. They have an in-depth knowledge of hundreds of prescription and non-prescription medications and are trained to assess, monitor, support and educate patients on their medication therapy.

In addition, the release seeks to reassure the public by pointing out that pharmacists already prescribe medications in other jurisdictions such as the United Kingdom, British Columbia and Alberta.

## **Appendix 2.1: Focus Group Moderator's Guide**

### **Introduction**

I want to start by thanking all of you for coming out today. My name is Bernard Gauthier, I'm a PhD candidate in Communication at Carleton University and I'm preparing a dissertation on the topic of interprofessional collaboration and interprofessional communication. My particular interest is in whether and how the messages health professionals read in their professional journals and in the mass media might influence their ideas about other professions and also in whether and how these messages affect the communication health professionals undertake with members of other professions.

I want you to know that this is a first step in the study I am undertaking. These focus groups will, I hope, help me understand a little more about how you make sense of the messages you see and hear in professional journals and in the mass media. From there, I will also be undertaking a content analysis of various journals and media outlets, using what I learn from these focus groups as a guide. Finally, I will also be interviewing editors and reporters to get a sense of their perspective. In this way, I will hear from you – the audience. I will review the content of the various articles, reports, advertisements and position papers – the texts. And I'll hear from the source of those texts, to give me a well-rounded perspective.

There are no preconceived notions, no right or wrong answers. What I am interested in is hearing about your own experiences, your own priorities and your own observations on the various materials I'll share with you in the next hour and a half or so. Focus groups are very distinct from more traditional meetings in that we're not looking for any kind of a consensus. If you happen to all agree, that's fine. If your opinions are quite different, however, I hope all of you will be willing to share those and explore them a little.

You'll find that I will ask only a small number of questions, allowing you more time to reflect and comment on each, and creating more opportunities for each of you to converse among yourselves rather than merely replying to my questions.

A few ground rules are important to state one more time. I will be audio recording our conversation and later transcribing what was said. I will use the transcript to analyze the focus groups. I won't use anyone's actual name in the transcript. Instead, I'll use a code and only I will have access to the key to that code. I'll also remove any other information from the transcripts that might allow someone to identify any of the participants. Once the study is complete and my dissertation is deposited, I will erase the audio recordings.

I will ensure that your comments in this group are kept completely confidential. I would also ask that each of you agree that what gets said in the room, stays in the room. That way, we can all rest assured that your participation in the groups remains confidential at all times.

## Appendix 2.1, Continued

The other ground rule is that your participation here is completely voluntary. If a question comes up that, for whatever reason, you would rather not answer, feel free to simply say “pass” and I will move on. In other words, you are not required in any way to answer the questions I ask.

Also, you are free to withdraw from the group at any time. Of course, I hope you stay until the end but if you should choose to withdraw, you will still be entitled to receive the incentive.

### A. Membership in a Profession and Sense of Professional Identity

1. Let’s start by going around the table. I’d like to hear from each of you how long you have been a (*select one of nurse practitioner or pharmacist*) and perhaps tell me why you originally chose this profession. What made you want to become a (*select one of nurse practitioner or pharmacist*)?
2. In your opinion, what makes (*select one of nurse practitioners or pharmacists*) different from other health care professionals? What would you say makes your profession distinct?
3. Are there times when you feel particularly attached to your profession? Are there times when you identify with being a (*select one of nurse practitioner or pharmacist*) more than other times? If so, when? Can you give me an example?

### B. Interprofessional Collaboration

I’d now like to talk a little with you about interprofessional collaboration. As you likely know, there is a movement within health care to promote greater collaboration between members of different health care professions. This can include better communication, sharing of decision making, and mutual respect for the contributions of each professional on the team.

1. My first question is, simply, what has been your personal experience with interprofessional collaboration? Have you been part of any interprofessional collaborative teams? If so, describe the experience for me and what you feel about it as a way to deliver health care.
  - Did the collaboration work?
  - What helped it work? What got in the way of it working?
  - Do you feel any uncertainty or anxiety when working as part of an interprofessional team?

## Appendix 2.1: Focus Group Moderator's Guide, Continued

4. As you may also know, changes to Ontario's Regulated Health Professions Act – also known as Bill 179 – will change the way (*select one of nurse practitioners or pharmacists*) practise in this province. Is Bill 179 something that (*select one of nurse practitioners or pharmacists*) talk about in this province?
  - Did you and your colleagues pay much attention to it?
  - Did you talk about it?
  - If not, why not? And if you did, how did the conversation go?

### C. Interpreting and Engaging Sample Texts

As you may have noticed over the past year or so, many professional associations communicated quite a bit about Bill 179 and the changes it would bring to health care in Ontario. Some associations included articles in their professional journals or newsletters, others posted messages to their member websites. Some associations wrote letters to the editor, issued media releases or published advertisements.

1. My first question is simply, did you notice any of this? Did you pay much attention? Why or why not?
  - What messages do you remember seeing?
  - How did you react to these when you first saw them?

What I'd like to do now is share with you a series of articles, statements, advertisements and media clippings – all related to Bill 179 in Ontario. I'll give you a few minutes to read each one and then I will ask you the same series of questions:

2. What's your first reaction to this?
3. Is there anything about this message that draws your attention?
4. Had you noticed this when it was first published? If so, how did you react then?
5. How does this message make you feel as a (*select one of nurse practitioner or pharmacist*)?
6. How does this kind of message make you feel about the organization behind the message?

*Note: Repeat questions 2 through 6 for each separate text.*

## **Appendix 2.1: Focus Group Moderator's Guide, Continued**

7. Overall, how do you feel about these efforts by professional associations to reach out to members, the public and government? Are these kinds of campaigns a good idea for a professional association? Why or why not?

### **D. Personal Interaction with other Professionals**

My last set of questions has to do with whether these kinds of campaigns by professional associations and this kind of media coverage has any impact on the working relations you have with members of other health professions.

1. Do these kinds of messages in newsletters, websites and in the news media have any impact on the level of trust or anxiety you feel towards other health professions?
2. Do you feel these kinds of messages have any impact on the level of trust or anxiety other health professions feel toward members of your profession?
3. Do you feel these kinds of messages have any impact on your ability to communicate and collaborate with members of other health professions?
4. Do you have any other thoughts or comments on this topic or on this study?

Thank you very much for your time. I hope you found the conversation interesting and again I would like to encourage you to keep our conversation around the table confidential by not revealing what specifically was said by you or any other of the participants.

## Appendix 2.2: Focus Group Screening Script

Thanks very much for calling and showing your interest in this study. I would like to ask you a few questions first to make sure I schedule you for the right group.

**1. Can you tell me what your current occupation or profession is?**

- Nurse Practitioner
- Pharmacist
- Other

If “Other”: I must tell you that the study is very much focused on nurse practitioners and pharmacists. I’m afraid that I won’t be able to schedule you for a focus group. I do thank you for your interest.

**2. Can you tell me what province you practice in?**

- Ontario
- Other

If “other”: This study is very much focused on pharmacists and nurse practitioners practicing in Ontario. I’m afraid I won’t be able to schedule you for a focus group. I do thank you for your interest.

**3. Can you share with me a personal email address, surface mail address, or fax number I can use to send you an information letter and consent form? It’s preferable if you don’t use a work email to help protect your confidentiality. I need you to read the letter and sign the consent form before you participate in the focus group. Rest assured your contact information will only be used to send you the document and to follow up and confirm your participation. The information won’t be shared with anyone else, will be stored securely, and will be destroyed once the study is completed.**

*Note and confirm contact information:*

---

**Thanks very much for your interest. I will send you the document right away and will follow up in a few days to make sure you have read it, answer any questions you might have, and confirm your participation. There are instructions in the document to return the signed consent form to me.**

## Appendix 2.3: Focus Group Information Letter and Consent Form



Dear Sir or Madam:

My name is Bernard Gauthier and I am a PhD student in Communication at Carleton University. I am writing to invite you to participate in a study I am conducting into the role of communication in interprofessional collaboration in health care. Specifically, the study will look at whether and how the communication activities of professional associations can help or hinder interprofessional collaboration in health care. My study is being supervised by Professor Karim Karim of the Carleton School of Journalism and Communication.

I am contacting you to invite you to participate in a focus group, during which you and other members of your profession will review and discuss the way your profession is portrayed in professional and news media outlets and the impact this may have on the way you work with members of other health professions.

The focus groups will last between 90 minutes and two hours and will involve a small group of health professionals responding to a series of questions that I will ask. You will also have a chance to read and discuss a series of articles, advertisements and newspaper clippings related to interprofessional collaboration and recent changes to Ontario's Regulated Professionals Act – Bill 179. You will be asked how you feel about these items, how well they draw your attention, and how they influence your collaboration with members of your own and other health care professions.

Other than myself, there will be no observers in the room or any adjacent room. I will audio record the conversation and use the recordings to prepare a transcript of the discussion. That transcript will not include any names or any other information that could help identify the participants. Though you will not be anonymous to me, you will likely be anonymous to the other participants around the table. To help protect your anonymity, I will invite you to only use your first name and I will not ask you to identify your place of work.

Your participation will be kept confidential at all times and, other than myself and the people around the table, your comments will remain confidential.

### **Appendix 2.3: Focus Group Information Letter and Consent Form, Continued**

The risks associated with focus groups are psychological and social. You may find that sharing your personal views and experiences with others is stressful. Similarly, you may find it uncomfortable to share your views with people in your profession. It is possible you will know some of the other participants around the table or that you and they will have colleagues in common. As moderator, I will strive to create a pleasant and positive atmosphere in which there are no right or wrong answers and in which all views and comments are welcome. Rest assured, also, that your participation is strictly voluntary and that you may choose not to answer a question or fully withdraw from the group at any time. If you arrive at the focus group facility on time and then choose to withdraw at any time, you will still receive a financial compensation and you will be able to decide if the comments you have made up until then can be included in the study or not. If not, I will ensure your comments are deleted from any transcripts.

I will securely store all the original audio recordings and transcripts in a locked filing cabinet and on a password-protected hard drive. I will also ensure that all are destroyed once my dissertation is completed, likely in two years time. No other researchers or supervisors will have access to your confidential information.

The study is designed to help find ways to improve interprofessional collaboration in health care. In particular, you and the other participants will help identify the kinds of communication practices that enable more trust and collaboration between members of different professions, and the practices that hinder trust and collaboration.

If you choose to participate in the study, you will receive a \$50 compensation at the close of the focus group or upon your decision to withdraw. As a participant, you will also have the option of reading the dissertation which will serve as the report of findings from the study. I will leave you an email address where you can contact me to request an electronic copy of the report.

This project has been reviewed and received ethics clearance by the Carleton University Research Ethics Committee. If you have any concerns or questions about your involvement in the study, please direct them to the ethics committee chair:

Professor Antonio Gualtieri, Chair  
Carleton University Research Ethics Committee  
Office of Research Services  
Carleton University  
1125 Colonel By Drive  
Ottawa, Ontario K1S 5B6  
Tel: 613-520-2517                      E-mail: [ethics@carleton.ca](mailto:ethics@carleton.ca)

## Appendix 2.3: Focus Group Information Letter and Consent Form, Continued

### Contact Information

If you are interested in participating in one of these focus groups, please contact me to confirm your interest and determine the appropriate time and place:

Bernard Gauthier, MA  
Carleton School of Journalism and Communication  
[bgauthie@connect.carleton.ca](mailto:bgauthie@connect.carleton.ca)  
Daytime: (613) \_\_\_\_\_ Evening: (613) \_\_\_\_\_

If you would like to contact the academic supervisor for this study, please contact:

Professor Karim H. Karim  
Carleton School of Journalism and Communication  
[karim\\_karim@carleton.ca](mailto:karim_karim@carleton.ca)  
(613) 520-2600, ext. 8030

Thank you for your interest in this study. Please complete and sign the “Consent to Participate” section below to signal your informed consent.

\_\_\_\_\_  
Bernard Gauthier, MA

\_\_\_\_\_  
Prof. Karim H. Karim

### Consent to Participate

I, \_\_\_\_\_ have read the information above and understand that I am participating in a research project and I voluntarily agree to participate.

\_\_\_\_\_  
Signature of the Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of the Researcher

\_\_\_\_\_  
Date

One signed copy of this form will be retained by the researcher. The participant will retain the second copy.

## Appendix 2.4 Interview Information Letter and Consent Form



Dear \_\_\_\_\_:  
(insert name of recipient)

My name is Bernard Gauthier and I am a PhD student in Communication at Carleton University. I am writing to follow up on our telephone conversation and invite you to participate in a study I am conducting into the role of communication in interprofessional collaboration in health care. Specifically, the study will look at whether and how the communication activities of professional associations can help or hinder interprofessional collaboration in health care. My study is being supervised by Professor Karim Karim of the Carleton School of Journalism and Communication.

I am contacting you to invite you to participate in an interview, during which we will discuss the communication activities your organization undertook surrounding interprofessional collaboration in health care in Ontario. I will also ask you questions about the impact you feel those activities had.

The interview will last between 30 and 40 minutes. I will record the conversation and use the recordings to prepare a transcript of the discussion. That transcript will not include any names or any other information that could help identify the participants. Though you will not be anonymous to me, your participation will be kept confidential at all times and, other than myself, your comments will remain confidential.

The risks associated with interviews are psychological. You may find that sharing your personal views and experiences with others is stressful. As moderator, I will strive to create a pleasant and positive atmosphere in which there are no right or wrong answers and in which all views and comments are welcome. Rest assured, also, that your participation is strictly voluntary and that you may choose not to answer a question or fully withdraw from the interview at any time. If you decide to withdraw, you will be able to decide if the comments you have made up until then can be included in the study or not. If not, I will ensure your comments are deleted from any transcripts.

I will securely store all the original audio recordings and transcripts in a locked filing cabinet and on a password-protected hard drive. I will also ensure that all are destroyed once my dissertation is completed, likely in two years time. No other researchers or supervisors will have access to your confidential information.

## **Appendix 2.4: Interview Information Letter and Consent Form, Continued**

The study is designed to help find ways to improve interprofessional collaboration in health care. In particular, you and the other participants will help identify the kinds of communication practices that enable more trust and collaboration between members of different professions, and the practices that hinder trust and collaboration.

As a participant, you will have the option of reading the dissertation which will serve as the report of findings from the study. I will leave you an email address where you can request an electronic copy of the report.

This project has been reviewed and received ethics clearance by the Carleton University Research Ethics Committee. If you have any concerns or questions about your involvement in the study, please direct them to the ethics committee chair:

Professor Antonio Gualtieri, Chair  
Carleton University Research Ethics Committee  
Office of Research Services  
Carleton University  
1125 Colonel By Drive  
Ottawa, Ontario K1S 5B6  
Tel: 613-520-2517                      E-mail: [ethics@carleton.ca](mailto:ethics@carleton.ca)

### **Contact Information**

If you are interested in participating in an interview, please sign the “Consent” section below and return the signed copy to me via fax at (613) 233-5880. Once I have the signed form, I will contact you to schedule a date and time that is convenient for you. In the meantime, if you have any questions at all, you can contact me at:

Bernard Gauthier, MA  
Carleton School of Journalism and Communication  
[bgauthie@connect.carleton.ca](mailto:bgauthie@connect.carleton.ca)  
Daytime: (613)                      Evening: (613)

If you would like to contact the academic supervisor for this study, please contact:

Professor Karim H. Karim  
Carleton School of Journalism and Communication  
[karim\\_karim@carleton.ca](mailto:karim_karim@carleton.ca)  
(613) 520-2600, ext. 8030

**Appendix 2.4: Interview Information Letter and Consent Form, Continued**

Thank you for your interest in this study. Please complete and sign the “Consent to Participate” section below to signal your informed consent.

\_\_\_\_\_  
Bernard Gauthier, MA

\_\_\_\_\_  
Prof. Karim H. Karim

**Consent to Participate**

I, \_\_\_\_\_ have read the information above and understand that I am participating in a research project and I voluntarily agree to participate.

\_\_\_\_\_  
Signature of the Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of the Researcher

\_\_\_\_\_  
Date

One signed copy of this form will be retained by the researcher. The participant will retain the second copy.

## **Appendix 2.5: Moderators Guide – Interview**

Also, you are free to withdraw from the interview at any time. Of course, I hope you stay until the end but if you should choose to withdraw, you will have the right to determine whether or not I can use your comments up to that point in the interview for my dissertation.

### **A. Changing Professional Roles and Responsibilities**

1. There has been a good deal of attention paid to changing professional roles and responsibilities in health care over the past year. In your opinion, what makes this an important story? Why is this a topic you and your organization choose to write about or report on?

*Probe for News Media Reporters and Editors:*

- What is it about these changes to health care that makes it newsworthy?

*Probe for Professional Association Executives:*

- What is it about these changes to health care that makes it something you feel your members need to know about?
2. Thinking more specifically about Bill 179 in Ontario and the added responsibilities it awarded members of certain professions, what would you say made this an important story?

### **B. The Decision to Undertake a Campaign – For Association Executives Only**

1. Tell me a little about how the decision was made in the organization to move forward with a campaign on the topic of Bill 179.
  - At what point was the decision made and who was involved in making this decision?
  - On what basis was the decision made? What made the difference in the end between saying nothing and undertaking a campaign?
  - Did the organization conduct the campaign using staff and volunteers or did you call on outside resources? Why is that?
  - What would you say were or are the goals of this campaign? What change are you hoping to bring about?
  - Finally, is there a particular communication strategy guiding this plan? Is there an overall plan in place or is it more a matter of responding to what is happening outside the organization?

## **Appendix 2.5: Moderators Guide – Interview, Continued**

2. To date, what would you say has been the impact of the campaign on the external audiences you are reaching?
  - Have you received any response – positive or negative – from the external audiences you are trying to reach? Governments? The public? The news media?
  - Have other professional organizations responded to your efforts? If so, who and what has been their response?
  - Do you feel your efforts are making a difference with external audiences? How so?
  - If you feel your campaign is making a difference, to what do you attribute your success? What is it about your messages that seems to be working with external audiences?
  
3. To what extent have your efforts had an impact on your internal audiences – specifically your members?
  - Have you received any response – positive or negative – from your members?
  - Do you feel your efforts are affecting in some way your members' sense of belonging to the profession? To their collegiality with other members of this profession?
  - If you feel your campaign is making a difference, to what do you attribute your success? What is it about your messages that seems to be working with internal audiences?
  
4. As you may know, there are some studies on interprofessional collaboration in health care that point to the importance of trust between members of different professions in fostering collaboration. To your knowledge, have the questions of trust and interprofessional collaboration ever come up as these campaigns were planned and the messages created?
  - If so, who raised the issue and in what context?
  - If not, why do you think these issues were not part of the discussion?
  
5. Finally, would you say that the efforts of organizations like yours to communicate with members, governments and other audiences on these topics are having an impact on your members' ability to communicate with and collaborate with members of other professions?
  - Are there ways in which your efforts might make it easier for your members to communicate and collaborate?

## **Appendix 2.5: Moderators Guide – Interview, Continued**

- Are there ways in which your efforts might make it harder to communicate and collaborate?

6. Do you have any other thoughts or comments on this topic or on this study?

### **C. The Decision to Undertake a Campaign – For News Media Only**

1. Tell me a little about how the decision is made in your organization to cover topics such as Bill 179.

- Who is involved in the decision to cover these stories?
- What role do media releases by professional associations play in the decision to cover a story like this?
- What role do articles in professional journals play in the decision?
- What role do advertisements by professional associations play?
- Are there other events or communication vehicles that play a role?

2. To your knowledge, has there been any reaction to the media coverage of these stories?

- Are you aware of any reaction from governments?
- Are you aware of any reaction from other professional associations?
- Are you aware of any reaction from health professionals?
- If there has been a reaction, what would you say is the reason for it? Why is this a story that generates this kind of response?

3. As you set out to cover a story like the debate over Bill 179, what approach do you take?

- What are the different perspectives you would most likely consider?
- Who are the people and organizations you are most likely to speak with?
- What are some of the other sources you might consider?
- What overall question or angle guides your reporting on a story like this?

4. Do you have any other thoughts or comments on this topic or on this study?

### Appendix 3.1 Articles and Advertisements Reviewed for Textual Analysis

Textual Analysis Texts from Medical Sources		
Org,	Title	Source
CFPC	A little help from our friends	Canadian Family Physician, May 2008 vol. 54 no. 5 683-684
CFPC	Advancing an interprofessional care culture within primary care	Canadian Family Physician, Vol. 55: December 2009, p. 1173
CFPC	Breaking the logjams	Canadian Family Physician, Vol. 55: February 2009, p. 224
CFPC	Collaboration between family physicians and community pharmacists to enhance adherence to chronic medications	Canadian Family Physician, 2009,55:e69-75
CFPC	Collaboration between family physicians and psychologists	Canadian Family Physician,2008,54:232-3.e1-5
CFPC	Collaboration in mental health care	Canadian Family Physician, Vol. 54: June 2008, p. 895
CFPC	Dream-team for optimal care	Canadian Family Physician, Vol. 54: February 2008, p. 317
CFPC	Family physician shortages: Are nurses the answer?	Canadian Family Physician, Vol. 54: March 2008, p. 480
CFPC	For family physicians at the heart of interprofessional care	Canadian Family Physician, Vol. 55: December 2009, p. 1169
CFPC	Interprofessional collaboration in family health teams	Canadian Family Physician, Vol. 56: October 2010, pp. e370 - 372
CFPC	Interprofessional education in academic family medicine teaching units	Canadian Family Physician,2009,55:901.e1-5
CFPC	Interprofessional teams: whom are FPs working with?	Canadian Family Physician, Vol. 55: April, p. 385
CFPC	Mechanisms for communicating within primary care teams	Canadian Family Physician, Vol. 55: December 2009, pp. 1220-1226
CFPC	Do NPs pose a threat to FPs? Yes	Canadian Family Physician, Vol. 54: December 2008, pp. 1668-1670
CFPC	Do NPs pose a threat to FPs? No	Canadian Family Physician, Vol. 54: December 2008, pp. 1669-1671
CFPC	Do NPs pose a threat to FPs? Rebuttals	Canadian Family Physician, Vol. 55: January 2009, p. 22
CFPC	Pharmacist and physician collaborative prescribing	Canadian Family Physician, Vol. 55: December 2009, e86
CFPC	Should prescribing authority be shared with non-physicians? No	Canadian Family Physician, Vol. 55: December 2009, pp. 1177-1178
CFPC	Should prescribing authority be shared with non-physicians? Yes	Canadian Family Physician, Vol. 55: December 2009, pp. 1176-1178
CFPC	Should prescribing authority be shared with non-physicians? Rebuttal	Canadian Family Physician , Vol. 55: December 2009, p. e63
CFPC	Supporting primary health care nurse practitioners' transition to practice	Canadian Family Physician, Vol. 56: November 2010, pp. 1176-1182
CFPC	To diagnose, or not to diagnose: That is the question	Canadian Family Physician, Vol. 55: march 2009, p. 320

Textual Analysis Texts from Medical Sources		
Org.	Title	Source
CFPC	We're all in this together	Canadian Family Physician, Vol. 54: December 2008, p. 1649
CFPC	CFPC releases vision for the future of family practice in Canada:	<a href="http://www.cfpc.ca/CFPC_releases_vision_for_the_future_of_family_practice_in_Canada/">http://www.cfpc.ca/CFPC_releases_vision_for_the_future_of_family_practice_in_Canada/</a>
CMA	Family Health Teams enable innovation, measurement is needed to support performance	<a href="http://www.cmaj.ca/content/early/2011/05/24/cmaj.109-3864/reply#cmaj_el_659984?sid=29d7990e-9696-4d0d-a928-162e0d2d6f17">http://www.cmaj.ca/content/early/2011/05/24/cmaj.109-3864/reply#cmaj_el_659984?sid=29d7990e-9696-4d0d-a928-162e0d2d6f17</a>
CMA	Transforming care for chronic health conditions	CMAJ, February 8, 2011, 183(2) pp. E93-94
CMA	Interprofessional collaboration	CMAJ, January 15, 2008, 178(2), p. 190
CMA	Canada's physicians assail pharmacist prescribing	CMAJ, September 11, 2007, 177(6), p. 558
CMA	National health human resources plan "a hard sell"	CMAJ, November 18, 2008, 179(11), p. 1116
CMA	Naturopathic doctors gaining new powers	CMAJ, January 12, 2010, 182(1), pp. e29-e30
CMA	New electronic health record blueprint to call for increased patient participation	CMAJ, July 13, 2010, 182(10), e429-430
CMA	Pharmacist prescribing	CMAJ, January 1, 2008, 178(1), p. 65
CMA	Reflections on Council	CMAJ, October 27, 2009, 181(9), e205
CMA	Steps forward no guarantee that health targets will be met, council says	CMAJ, July 12, 2011, 183(10), pp. E619-E620
CMA	Verdict still out on family health teams	CMAJ, July 12, 2011, 183(10) 1131, pp. 1131-1132
CMA	CMA urges collegiality, not confrontation, to improve patient care	<a href="http://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/Media_Release/2010/PhysAssts_en.pdf">http://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/Media_Release/2010/PhysAssts_en.pdf</a>
CMA	Canada's doctors, nurses, and pharmacists call for "healthy" debate	<a href="http://www.cma.ca/advocacy/doctors-nurses-pharmacists">http://www.cma.ca/advocacy/doctors-nurses-pharmacists</a>
CMA	Increasing pharmacists' powers raises concerns	The Globe and Mail, May 22, 2008. p. L1
CPSO	College of Midwives Joint Statement on Interprofessional Care	DIALOGUE, Issue 2, 2010, pp. 20-21
CPSO	Maximizing Patient Safety Together: MDs, community pharmacists can be allies in battle against opioid abuse	DIALOGUE, Issue 3, 2011, pp. 20-21
CPSO	Medical schools place communications at forefront	DIALOGUE, Issue 2, 2010, pp. 31-32
CPSO	Midwives given expanded prescribing authority	DIALOGUE, Issue 4, 2010, p. 18
CPSO	New policy clarifies doctors' obligations when dispensing drugs	DIALOGUE, Issue 2, 2010, pp. 26 & 29

Textual Analysis Texts from Medical Sources		
Org.	Title	Source
CPSO	New regulations allow pharmacists to refill existing prescriptions	DIALOGUE, Issue 2, 2011, pp. 21-22
CPSO	Regulatory changes widen role of nurse practitioners	DIALOGUE, Issue 3, 2011, pp. 23-24
OMA	Introducing physician assistants to the Ontario health-care system	Ontario Medical Review, February 2008, pp. 10-12
OMA	Academy of Medicine Ottawa hosts "Clinical Day 2008"	Ontario Medical Review, March 2008, p. 36
OMA	Campaign for Healthier Care Update	Ontario Medical Review, May 2008, p. 11
OMA	New OMA President Dr. Ken Arnold sets out challenges, opportunities for 2008-2009	Ontario Medical Review, May 2008, pp. 13-15
OMA	Health Policy Report	Ontario Medical Review, May 2008, p. 58
OMA	Complementary and Holistic Treatments in Women's Health:	Ontario Medical Review, June 2008, page 23
OMA	Health Policy Report	Ontario Medical Review, July/August 2008, page 77
OMA	Health Policy Report	Ontario Medical Review, October 2008, page 34+35
OMA	OMA campaign reinforces Ontario Physicians as most trusted health care providers	Ontario Medical Review, November 2008, page 24
OMA	Academy of Medicine Ottawa to host 2009 Clinical Day, February 27	Ontario Medical Review, November 2008, page 31
OMA	MedsCheck Consult pilot project to begin January '09	Ontario Medical Review, November 2008, page 33
OMA	OMA questions nurse practitioner clinic expansion...	Ontario Medical Review, December 2008, page 16
OMA	Health Policy Report	Ontario Medical Review, January 2009, pp. 72-73
OMA	Health Policy Report	Ontario Medical Review, March 2009, page 45
OMA	Trends and Issues in Health Care: Implications for Physicians	Ontario Medical Review, April 2009, page 22-25
OMA	The London Family Health Group "Shared Care" pilot initiative:	Ontario Medical Review, April 2009, pp. 26-27
OMA	Physician engagement	Ontario Medical Review, June 2009, page 7+16
OMA	Health Policy Report	Ontario Medical Review, June 2009, pp.35-36
OMA	OMA Policy on Accountability in the Health-Care Sector	Ontario Medical Review, July/ August 2009, page 17 to 29
OMA	Health policy Report	Ontario Medical Review, July/ August 2009, page 56

Textual Analysis Texts from Medical Sources		
Org.	Title	Source
OMA	Advocating for Ontario physicians and patients	Ontario Medical Review, September 2009, pp. 24-25
OMA	OMA Position on Bill 179	Ontario Medical Review, October 2009, page 7
OMA	OMA releases official response to Bill 179	Ontario Medical Review, October 2009, page 16
OMA	"Your Life is Our Life's Work"	Ontario Medical Review, November 2009, page 13
OMA	Health Policy Report	Ontario Medical Review, November 2009, p. 32-33
OMA	Health Policy Report	Ontario Medical Review, January 2012, page 40
OMA	"Life's Work" Phase Two	Ontario Medical Review, March 2010, page 7
OMA	OMA "Life's Work" Campaign phase two underway	Ontario Medical Review, March 2010, page 9
OMA	New OMA President Dr. Mark MacLeod delivers inaugural address to Council	Ontario Medical Review, May 2010, pp. 9-11
OMA	OMA "Life's Work" Phase 3 campaign launch:	Ontario Medical Review, October 2010, page 11
OMA	Health Policy Report	Ontario Medical Review, January 2011, page 36
OMA	OMA Election Strategy	Ontario Medical Review, February 2011, pp. 10-11
OMA	Health Policy Report	Ontario Medical Review, February 2011, page 33
OMA	Health Policy Report	Ontario Medical Review, May 2011, page 51
OMA	Health Policy Report	Ontario Medical Review, June 2011, page 37-39
OMA	Health Policy Report	Ontario Medical Review, November 2011, page 44
OMA	Hospital physician leaders in Mississauga focus on best practice sharing	Ontario Medical Review, December 2011, page 24
OMA	Proposed Regulation Changes for Nurse Practitioners	<a href="https://www.oma.org/Mediaroom/PressReleases/Pages/NursePractitionersRegulationChanges.aspx">https://www.oma.org/Mediaroom/PressReleases/Pages/NursePractitionersRegulationChanges.aspx</a>
OMA	Letting pharmacists prescribe drugs like letting flight attendant fly plane: OMA	<a href="http://ca.news.yahoo.com/s/capress/090923/health/health_doctors_fight_competition?printer=1">http://ca.news.yahoo.com/s/capress/090923/health/health_doctors_fight_competition?printer=1</a>
OMA	Your life is our life's work: Dr. Goldbloom	<a href="https://www.oma.org/Resources/Documents/OMA15228ADSGOLRIC.pdf">https://www.oma.org/Resources/Documents/OMA15228ADSGOLRIC.pdf</a>
OMA	Hospitals, MDs in rare turf war, Doctors' association opposes provincial legislation to let nurses, pharmacists take more responsibility	The Toronto Star, Sat Oct 24 2009, P. A18

Textual Analysis Texts from Medical Sources		
Org.	Title	Source
OMA	More Family Health Teams is Good News For Patients: Ontario Doctors	<a href="https://www.oma.org/Mediroom/PressReleases/Pages/MoreFamilyHealthTeams.aspx">https://www.oma.org/Mediroom/PressReleases/Pages/MoreFamilyHealthTeams.aspx</a>
OMA	Nursing Week Statement from Ontario's Doctors	<a href="https://www.oma.org/Mediroom/PressReleases/Pages/NursingWeekStatementfromOntario%E2%80%99sDoctors.aspx">https://www.oma.org/Mediroom/PressReleases/Pages/NursingWeekStatementfromOntario%E2%80%99sDoctors.aspx</a>
OMA	Ontario's Doctors Support Collaboration Among Health Care Professionals	<a href="https://www.oma.org/Mediroom/PressReleases/Pages/CollaborationAmongHealthCareProfessionals.aspx">https://www.oma.org/Mediroom/PressReleases/Pages/CollaborationAmongHealthCareProfessionals.aspx</a>
OMA	With today's healthcare, is an apple a day your safest bet?	Ontario Medical Association Section on General and Family Practice. (2009). Retrieved November 1, 2010, from Family Doctors of Ontario: <a href="http://www.familydoctorsofontario.ca">www.familydoctorsofontario.ca</a>
OMA	Patients' safety will be at risk	<a href="http://www.sgfpnet.com/index.php?option=com_content&amp;view=category&amp;layout=blog&amp;id=61&amp;Itemid=10">http://www.sgfpnet.com/index.php?option=com_content&amp;view=category&amp;layout=blog&amp;id=61&amp;Itemid=10</a>
OMA	Statement in Response to Bill 179	<a href="https://www.oma.org/Mediroom/PressReleases/Pages/ResponseBill179.aspx">https://www.oma.org/Mediroom/PressReleases/Pages/ResponseBill179.aspx</a>
OMA	The Doctors Respond to Hospitals	<a href="https://www.oma.org/Mediroom/PressReleases/Pages/DoctorsRespondtoHospitalCriticism.aspx">https://www.oma.org/Mediroom/PressReleases/Pages/DoctorsRespondtoHospitalCriticism.aspx</a>
OMA	Statement – New Nurse Practitioner Clinics	<a href="https://www.oma.org/Mediroom/PressReleases/Pages/NewNursePractitionerClinics.aspx">https://www.oma.org/Mediroom/PressReleases/Pages/NewNursePractitionerClinics.aspx</a>
<b>TOTAL TEXTS FROM MEDICAL SOURCES</b>		<b>94</b>

Textual Analysis Texts from Nursing Sources		
Org.	Title	Source
CNA	A team approach to better care	Canadian Nurse, January 2010, Volume 106, Number 1, p. 3
CNA	Awareness campaign promotes NPs	Canadian Nurse, November, 2011, Volume 107, Number 9, page 20
CNA	CMA report on health-care transformation: what nurses should know	Canadian Nurse, September 2010, Vol. 106, No. 7, p. 25
CNA	A Collaborative Approach to Fall Prevention	Canadian Nurse, October 2011, Vol. 107, No. 8, pp. 24- 29
CNA	Collaborative Power	Canadian Nurse, May 2011, Vol. 107, No. 5, p. 3
CNA	Another first for Ontario's NPs	Canadian Nurse, June 2011, Vol. 107, No. 6, p. 7
CNA	It's about time	Canadian Nurse, November 2011, Vol. 107, No. 9, Page 16
CNA	Just say yes!	Canadian Nurse, March 2011, Vol. 107, No. 3, p. 1
CNA	NP-led clinics: Ontario leads the way	Canadian Nurse, November 2010, Vol. 106, No. 9, pp. 30-35
CNA	A shot in the arm for collaboration	Canadian Nurse, January 2010, Volume 106, Number 1, p. 2
CNA	A team designed to meet patients' needs	Canadian Nurse, January 2011, Vol. 107, No. 1, p. 36
CNA	Teaming Up	Canadian Nurse, October 2011, Vol. 107, No. 8, pp. 16-18
CNA	Canadian Nurses Association says 'It's About Time' – News Release	<a href="http://www.cna-aiic.ca/en/canadian-nurses-association-says-its-about-time/">http://www.cna-aiic.ca/en/canadian-nurses-association-says-its-about-time/</a>
CNA	CNA advocates for primary, collaborative and community-based care – News Release	<a href="http://www.cna-aiic.ca/en/cna-advocates-for-primary-collaborative-and-community-based-care/">http://www.cna-aiic.ca/en/cna-advocates-for-primary-collaborative-and-community-based-care/</a>
CNA	CNA NP Radio Ad: Bumper to bumper traffic	<a href="http://www.npnow.ca/">http://www.npnow.ca/</a>
CNA	CNA TV Ad: A little math	<a href="http://www.youtube.com/watch?v=wuBq_N-K7UE&amp;lr=1">http://www.youtube.com/watch?v=wuBq_N-K7UE&amp;lr=1</a>
CNA	CNA Poster 1	<a href="http://www.npnow.ca/docs/NP_2011_poster1_e.pdf">http://www.npnow.ca/docs/NP_2011_poster1_e.pdf</a>
CNA	CNA Poster 2	<a href="http://www.npnow.ca/docs/NP_2011_poster2_e.pdf">http://www.npnow.ca/docs/NP_2011_poster2_e.pdf</a>
CNA	CNA Poster3	<a href="http://www.npnow.ca/docs/NP_2011_poster3_e.pdf">http://www.npnow.ca/docs/NP_2011_poster3_e.pdf</a>
CNA	Letter to the Editor of the Westman Journal	<a href="http://www2.cna-aiic.ca/CNA/documents/pdf/publications/Open_Letter_Editor_Westman_Journal_e.pdf">http://www2.cna-aiic.ca/CNA/documents/pdf/publications/Open_Letter_Editor_Westman_Journal_e.pdf</a>
CNA	Open Letter to Premier Selinger of Manitoba	<a href="http://www2.cna-aiic.ca/CNA/documents/pdf/publications/Open_Letter_Premier_Manitoba_SelingerG_e.pdf">http://www2.cna-aiic.ca/CNA/documents/pdf/publications/Open_Letter_Premier_Manitoba_SelingerG_e.pdf</a>
CNO	New authorities for NPs imminent	The Standard, summer, 2011, Vol. 36, No. 2, p. 9

Textual Analysis Texts from Nursing Sources

Org.	Title	Source
CNO	New national framework for NP program approval	The Standard, spring 2011 volume 36 issue 1, p. 8
CNO	New NP practice document	The Standard, fall 2011, vol. 36, no 3, p. 9
CNO	Pharmacists can authorize refills	The Standard, summer, 2011, Vol. 36, No. 2, p. 9
NPAO	Big News for NPs!!!!	<a href="http://npao.org/speaks-out/issues/">http://npao.org/speaks-out/issues/</a>
NPAO	GTA's first nurse-led clinic	The Toronto Star, Sat Jan 2 2010, p. GT01
NPAO	Nurse Practitioners in Ontario	<a href="http://npao.org/wp-content/uploads/2012/02/NPAO-brochure-jan12-web.pdf">http://npao.org/wp-content/uploads/2012/02/NPAO-brochure-jan12-web.pdf</a>
NPAO	We Believe Poster 11	<a href="http://npao.org/wp-content/uploads/2011/07/NP-Poster-11.pdf">http://npao.org/wp-content/uploads/2011/07/NP-Poster-11.pdf</a>
NPAO	We Believe Poster 21	<a href="http://npao.org/wp-content/uploads/2011/07/NP-Poster-21.pdf">http://npao.org/wp-content/uploads/2011/07/NP-Poster-21.pdf</a>
RNAO	Bringing primary care to communities	Registered Nurse Journal, July/August 2009, p. 9
RNAO	Executive Director's Dispatch collects concerns and kudos	Registered Nurse Journal, Sept/Oct 2009, p. 7
RNAO	Government must remove regulatory handcuffs that limit NP practice	Registered Nurse Journal, May/June 2009, p. 6
RNAO	FILLING THE GAP	Registered Nurse Journal, May/June 2009, pp. 12-16
RNAO	Inspiration through action	Registered Nurse Journal, May-June 2009, p. 4
RNAO	Long-time NP reflects on role	Registered Nurse Journal, May/June 2009, p. 11
RNAO	NP-led clinic opens in North Bay	Registered Nurse Journal, Sept/Oct 2011, p. 11
RNAO	Year ahead promises excitement, difficulty	Registered Nurse Journal, May/June 2009, p. 5
RNAO	Pursuing healthy public policy: The next four years	Registered Nurse Journal, September/October 2011, p. 6
RNAO	Ready to collaborate	Registered Nurse Journal, September/October 2010, p. 10
RNAO	Reflections on two years of infectious action	Registered Nurse Journal, March/April 2010, p. 5
RNAO	Ringing alarm bells on changing models of care delivery	Registered Nurse Journal, July/Aug 2009, p. 6
RNAO	Team Building 101	Registered Nurse Journal, July/Aug 2009, pp. 22-23
RNAO	Team work	Registered Nurse Journal, September/October 2010, p. 10
RNAO	Understanding the NP role	Registered Nurse Journal, November/December 2011, p. 9
RNAO	Unregulated health professionals	Registered Nurse Journal, September/October 2009, p. 8

Textual Analysis Texts from Nursing Sources		
Org.	Title	Source
RNAO	Government announces new powers for nurses to advance quality care	<a href="http://mao.ca/news/media-releases/Government-announces-new-powers-for-nurses-to-advance-quality-care">http://mao.ca/news/media-releases/Government-announces-new-powers-for-nurses-to-advance-quality-care</a>
RNAO	Hamilton conference highlights important role Nurse Practitioners play in health	<a href="http://mao.ca/news/media-releases/2011/11/09/hamilton-conference-highlights-important-role-nurse-practitioners-pla">http://mao.ca/news/media-releases/2011/11/09/hamilton-conference-highlights-important-role-nurse-practitioners-pla</a>
RNAO	Nurse Practitioners gather in London to discuss new horizons for health care in Ontario	<a href="http://mao.ca/news/media-releases/Nurse-Practitioners-gather-in-London-to-discuss-new-horizons-for-health-care-in-Ontario">http://mao.ca/news/media-releases/Nurse-Practitioners-gather-in-London-to-discuss-new-horizons-for-health-care-in-Ontario</a>
RNAO	Nurses launch campaign to highlight Nurse Practitioner role	<a href="http://mao.ca/news/media-releases/Nurses-launch-campaign-to-highlight-Nurse-Practitioner-role">http://mao.ca/news/media-releases/Nurses-launch-campaign-to-highlight-Nurse-Practitioner-role</a>
RNAO	Ontario nurses look forward to dialogue and collaboration with new CMA president	<a href="http://mao.ca/news/media-releases/Ontario-nurses-look-forward-to-dialogue-and-collaboration-with-new-CMA-president">http://mao.ca/news/media-releases/Ontario-nurses-look-forward-to-dialogue-and-collaboration-with-new-CMA-president</a>
RNAO	Ontario nurses welcome changes to their practice but argue more work needs to be done to reduce wait times and increase access for patients	<a href="http://mao.ca/news/media-releases/Ontario-nurses-welcome-changes-to-their-practice-but-argue-more-work-needs-to-be-done-to-reduce-wait-times-a">http://mao.ca/news/media-releases/Ontario-nurses-welcome-changes-to-their-practice-but-argue-more-work-needs-to-be-done-to-reduce-wait-times-a</a>
RNAO	Nurses oppose the Ontario government's physician assistant role citing inadequate education, concerns over patient safety and unnecessary costs	<a href="http://mao.ca/news/media-releases/Nurses-oppose-the-Ontario-governments-physician-assistant-role-citing-inadequate-education-concerns-over-pat">http://mao.ca/news/media-releases/Nurses-oppose-the-Ontario-governments-physician-assistant-role-citing-inadequate-education-concerns-over-pat</a>
RNAO	Patients the big winners of McGuinty government's policy to expand Nurse Practitioners' role and scope	<a href="http://mao.ca/news/media-releases/Patients-the-big-winners-of-McGuinty-governments-policy-to-expand-Nurse-Practitioners-role-and-scope">http://mao.ca/news/media-releases/Patients-the-big-winners-of-McGuinty-governments-policy-to-expand-Nurse-Practitioners-role-and-scope</a>
RNAO	Power to nurse practitioners , McGuinty will allow them to discharge, admit patients	Antonella Artuso, The Toronto Sun, Sat Apr 9 2011, p. 7
RNAO	Proposed changes to scope of practice for Nurse Practitioners insufficient to increase timely access to health services: Nurses say	<a href="http://mao.ca/news/media-releases/Proposed-changes-to-scope-of-practice-for-Nurse-Practitioners-insufficient-to-increase-timely-access-to-heal">http://mao.ca/news/media-releases/Proposed-changes-to-scope-of-practice-for-Nurse-Practitioners-insufficient-to-increase-timely-access-to-heal</a>
RNAO	Researchers examine how nurse practitioners are improving access to the health-care system	<a href="http://mao.ca/news/media-releases/Researchers-examine-how-nurse-practitioners-are-improving-access-to-the-health-care-system">http://mao.ca/news/media-releases/Researchers-examine-how-nurse-practitioners-are-improving-access-to-the-health-care-system</a>
RNAO	The future is now. Nurse practitioners gather in Toronto to discuss their ever-expanding contributions to health care in Ontario	<a href="http://mao.ca/news/media-releases/MEDIA-ADVISORY-The-future-is-now.-Nurse-practitioners-gather-in-Toronto-to-discuss-their-ever-expanding-cont">http://mao.ca/news/media-releases/MEDIA-ADVISORY-The-future-is-now.-Nurse-practitioners-gather-in-Toronto-to-discuss-their-ever-expanding-cont</a>
RNAO	Thousands set to benefit from greater access to health care	<a href="http://mao.ca/news/media-releases/Thousands-set-to-benefit-from-greater-access-to-health-care">http://mao.ca/news/media-releases/Thousands-set-to-benefit-from-greater-access-to-health-care</a>
<b>TOTAL TEXTS FROM NURSING SOURCES</b>		<b>59</b>

Textual Analysis Texts from Pharmacy Sources		
Org.	Title	Source
CPhA	A skeptic's collaborative experience	CPJ, JANUARY / FEBRUARY 2007 • VOL. 140, NO. 1 [SUPPL1], p. S4
CPhA	Are pharmacists the ultimate barrier to pharmacy practice change?	CPJ, JANUARY / FEBRUARY 2010 • VOL. 143, NO. 1, pp. 37-42
CPhA	Canadian Collaborative Mental Health Charter	CPJ, JANUARY / FEBRUARY 2007, VOL. 140, NO. 1 [SUPPL 1], p. S12-S13
CPhA	Chiropractors and pharmacists in a family health team: Unlikely allies in the collaborative management of pregnancy-related low back pain	CPJ, MARCH/APRIL 2011, VOL 144, NO 2, pp. 62-65
CPhA	Collaborative mental health care: Effective and rewarding	CPJ, JANUARY / FEBRUARY 2007, VOL. 140, NO. 1 [S UPP L1], p. S 11
CPhA	Community pharmacists' perceptions of their collaborative working relationships with physicians for drug therapy management: An exploratory study	CPJ, May/June 2008, Vol. 141, No. 3, p. 181
CPhA	Debating pharmacy prescribing rights	CPJ, MAY / JUNE 2008, VOL 141, NO 3, pp. 198-199
CPhA	Defining Collaboration	CPJ, May/June 2010, vol. 143, No. 3, p. 109
CPhA	Demonstrating value, documenting care	CPJ, March/April 2008, Vol. 141, No. 2, pp. 114-119
CPhA	Developing a collaborative practice	CPJ, January/February 2007, Vol. 140, No. 1, pp. S9-S10
CPhA	Examining physicians' perspectives during the integration of a pharmacist	CPJ, January/February 2008 • Vol. 141, No. 1, p. 39
CPhA	Expanded pharmacist services will save health care dollars and reduce ER visits: Ontario study	CPJ, November/December 2009, Vol. 142, No. 6, p. 271
CPhA	Expanding Ontario pharmacy scope of practice	CPJ, November/December 2008, Vol. 141, No. 6, p. 313
CPhA	Interprofessionalism: Unattainable goal or child's play?	CPJ, January/February 2010, Vol. 143, No. 1, p. 52
CPhA	Introduction of family health team experiential rotations for undergraduate pharmacy students	CPJ, May/June 2008, Vol. 141, No. 3, p. 165
CPhA	Ontario advisory body recommends that pharmacists be granted authority to prescribe for minor ailments	CPJ, January/February 2009, Vol. 142, No. 1, p. 8
CPhA	Ontario family physician readiness to collaborate with community pharmacists on drug therapy management: Lessons for pharmacists	CPJ, July/August 2009, Vol. 142, No. 4, pp. 184-189

Textual Analysis Texts from Pharmacy Sources		
Org.	Title	Source
CPhA	Ontario the latest province to delve into prescribing rights for pharmacists	CPJ, July/August 2008, Vol. 141, No. 4, p. 214
CPhA	Ontario's family doctors say pharmacist prescribing may affect patient safety and care	CPJ, November/December 2009, Vol. 142, No. 6, p. 270
CPhA	OPA welcomes health professions bill as "groundbreaking" for Ontario pharmacists	CPJ, July/August 2009, Vol. 142, No. 4, p. 166
CPhA	Public opinion of pharmacists and pharmacist prescribing	CPJ, March/April 2011, Vol. 144, No. 2, pp. 86-93
CPhA	Innovative continuing education course ramps up pharmacists' capacity for providing patient-focused care	<a href="http://www.pharmacists.ca/index.cfm/news-events/news/adapt-program-launched/">http://www.pharmacists.ca/index.cfm/news-events/news/adapt-program-launched/</a>
CPhA	Pharmacists Once Again Ranked the Most Trusted Profession in Canada	<a href="http://www.pharmacists.ca/index.cfm/news-events/news/pharmacists-trusted-most/">http://www.pharmacists.ca/index.cfm/news-events/news/pharmacists-trusted-most/</a>
CPhA	Increasing pharmacists' powers raises concerns	Carly Weeks, The Globe and Mail, May 22, 2008. p. L1
CPO	Can we transform the pharmacy culture?	Pharmacy Connection, March/April 2010, p. 4
CPO	Interprofessional study of transfer of care: CNO-led study examines role of health professionals in hospital care	Pharmacy Connection, March/April 2010, pp. 14-15
CPO	Meeting the challenges posed by the expansion of interprofessional care	Pharmacy Connection, FALL 2011, pp. 27-28
CPO	Non-physician Prescribers Project: HPRAC launches Non-physician Prescribers Project	Pharmacy Connection, November/December 2008, p. 29
CPO	Pharmacist-physician collaboration key to patient safety	Pharmacy Connection, November/December 2009, pp. 18-19
CPO	President's Message: Stephen Clement, R.Ph., B.Sc. Phm.	Pharmacy Connection, November/December 2009, p. 4
CPO	Workshops emphasize collaboration and communication	Pharmacy Connection, Summer 2011, pp. 16-17
OPA	A bright light ahead	The Ontario Pharmacist, Winter 2008, p. 5
OPA	Advancing patient care: Final HPRAC recommendations recognize important role of pharmacists	The Ontario Pharmacist, Spring 2009, p. 30
OPA	BILL 179: what the changes mean for you	The Ontario Pharmacist, Winter 2009, pp. 14 - 16

Textual Analysis Texts from Pharmacy Sources		
Org.	Title	Source
OPA	Building relationships: Interprofessional collaboration starts at the community level	The Ontario Pharmacist, Winter 2008, p. 30
OPA	Embracing change: Important wins in 2009 set the stage for an exciting new year	The Ontario Pharmacist, Winter 2009, p. 30
OPA	Family health teams: an update	The Ontario Pharmacist, Winter, 2009, p. 6
OPA	Final HPRAC report recommends health care updates	The Ontario Pharmacist, Spring 2009, p. 8
OPA	Iris Krawchenko: Pharmacist-owner Iris Krawchenko believes that collaboration between healthcare professionals is vital to enhanced patient care	The Ontario Pharmacist, Spring 2008, p. 29
OPA	Learning is always in season	The Ontario Pharmacist, Spring 2009, p. 5
OPA	Mentors offer expertise in pharmacist-physician relations	The Ontario Pharmacist, Spring 2008, pp. 26-27
OPA	OPA and the changing scope of practice in pharmacy	The Ontario Pharmacist, Summer 2009, p. 13
OPA	OPA applauds recommendations to expand scope of practice: Medication management part of HPRAC report	The Ontario Pharmacist, Winter 2008, p. 7
OPA	Proposed legislation would help unleash pharmacists' potential	The Ontario Pharmacist, Summer 2009, p. 11
OPA	Sharpening our focus in 2010	The Ontario Pharmacist, Spring 2010, pp. 6 - 7
OPA	Time to embrace our future	The Ontario Pharmacist, Summer 2009, p. 5
OPA	OPA's Vice President of Professional Affairs helps elevate the profession	The Ontario Pharmacist, Spring 2010, p. 11
OPA	Where do we go from here?: Planning for the future of pharmacy practice	The Ontario Pharmacist, Fall 2010, p. 6
OPA	Working Together	The Ontario Pharmacist, Winter 2008, pp. 19 - 22
OPA	Re: Doctors prescribe too much	Dennis Darby, National Post, Sep 30 2010, p. A19
OPA	Ontario pharmacists ready to provide additional safe, accessible services to patients in collaboration with other health professionals	<a href="http://www.opatoday.com/documents/NewsReleases/NR_20090924_PharmacistCollaboration.pdf">http://www.opatoday.com/documents/NewsReleases/NR_20090924_PharmacistCollaboration.pdf</a>

Textual Analysis Texts from Pharmacy Sources		
Org.	Title	Source
OPA	Ontario pharmacists welcome expanded services to improve patient care and increase access	<a href="http://www.opatoday.com/index.php?option=com_content&amp;view=article&amp;id=557:ontario-pharmacists-welcome-expanded-services-to-improve-patient-care-and-increase-access&amp;catid=44:news&amp;Itemid=255">http://www.opatoday.com/index.php?option=com_content&amp;view=article&amp;id=557:ontario-pharmacists-welcome-expanded-services-to-improve-patient-care-and-increase-access&amp;catid=44:news&amp;Itemid=255</a>
OPA	Pharmacists play big role in medical record system	London Free Press, Letters to the Editor Column, Oct. 2, 2010, p. E3
OPA	We need more tools	The Ottawa Citizen, Oct. 1, 2010, p. A11
<b>TOTAL TEXTS FROM PHARMACY SOURCES</b>		<b>54</b>
<b>TOTAL TEXTS REVIEWED FOR TEXTUAL ANALYSIS</b>		<b>207</b>