

Exploring the Cultural Similarities That Exist Between Military  
and the Broader Healthcare Systems

by

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## Key Messages

Military and civilian personnel provide daily healthcare services to Canadian Armed Forces personnel across Canada. The purpose of the original study (Gilbert, 2013) was to close the gap in the scholarly research, literature, and increase military leadership understanding of subcultural groups as defined within the following areas: (a) group identification, (b) similarities and differences, (c) self-perceptions, (d) perceptions of other groups, and (e) common issues viewed as barriers to improving synergy among the various subcultures. This leadership project explored the original research findings and recommendations, and then examined their relevance for all healthcare leaders including its application within the broader healthcare system.

The author conducted two geographically separate focus groups, consisting of Canadian College of Health Leaders Fellows, Certified Health Executives, and senior health leaders to review the original research findings and evaluate whether or not the findings are consistent and equally applicable to health leaders in the broader health system. Both focus groups agreed that all findings are consistent with and generalizable to the broader health system. Both groups also concluded that the recommendations—with only minor differences considered geographically factored—are also generalizable the broader health system and the lessons learned can be of value to all health leaders across the broader health system.

The opportunity to contribute to health leadership knowledge and create social change is quite significant. The findings may help healthcare leaders learn the importance of understanding organizational culture and subcultures, leveraging shared visions and values; recognizing the significance mutual respect and effective communication play; comprehending group self-perceptions and intergroup dynamics; identifying common barriers to change; and developing strategies to overcome barriers to success.

## **Executive Summary**

### **Context.**

Canadian Forces Health Services (CFHS) underwent a 10-year long cultural integration process that included merging organizational cultures of military, civilian public servant, and civilian third-party contracted groups. This research leadership project used health leaders in the broader health system to validate whether Gilbert's (2013) findings and recommendations were generalizable and transferable to the broader health system.

### **Approach.**

The researcher used two geographically separate focus groups comprised of Canadian College of Health Leaders Fellows, Certified Health Executives, and senior health leaders. Participants received a pre-group information package that provided CFHS organizational background, received the same PowerPoint presentation as given to CFHS senior leaders, and then engaged in open discussion during the remainder of the focus group. Sessions were recorded and transcribed to ensure accuracy. Summaries of the sessions were then distributed to participants for their feedback to ensure accuracy of the agreed-to findings.

### **Literature Review.**

Healthcare organizations are conducting substantial research on healthcare organization culture and studies confirmed organizations within the same system often have very differing and conflicting cultures and subcultures. People have a fundamental need to self-categorize and sort individuals into basic categories based upon distinctiveness from or similarities with the larger social structure. Individuals increase their self-esteem and social identity by joining the group. This literature review confirmed the importance of understanding the roles that cultures and subcultures play in healthcare environments, employee engagement, and transformation.

Health leaders rarely perform cultural analysis to define if the underlying cause for problems is a dysfunctional culture. They must consciously reflect upon cultural dysfunction when examining interpersonal relationships, clinical performance, quality, risk and outcomes management, staff and patient satisfaction, and the cost-effectiveness of medicine.

### **Results.**

Both focus groups shared similar understanding and philosophies in their combined definitions of organizational culture and subculture. Participants from both groups also found the military system findings—as they relate to cultural group self-perceptions, group member perceptions of other groups, and common issues viewed as barriers to improving synergy among the various groups—are consistent within the broader health system because both workforces share many of the same background and experiences. All group members determined the findings are generalizable and transferable to the broader health system. Additionally, both focus group participants believed the recommendations are generalizable and transferable to the broader health system and the recommendations, when applied within the broader health context, would benefit further by the additional comments discussed within this report.

### **Implications for Health Leadership.**

The findings in this project have major implications for health leaders because we require leaders who understand their organizations and the people who work within them. They must have all of the tools necessary to lead, manage, support, communicate effectively, and create and undertake effective change. Increasing synergy and building collaboration are only possible in an environment of mutual trust and respect. Transformation must also be values driven and remain a choice because it is about values, thoughts, and behaviors. Gilbert's (2013) findings and recommendations, as augmented by the findings of this leadership project, provide a glimpse into

how health leaders might use some of their existing knowledge more effectively and add new tools by applying these findings and recommendations within their own organizations.

Implementing these lessons will assist leaders as they guide their organizations into the future while serving and valuing their patients, their customers, and their most valuable asset...their people.

### **Generalizability and Transferability.**

All focus group participants determined the findings are generalizable and transferable to the broader health system. All group members also believed the recommendations are generalizable and transferable to the broader health system.

### **Knowledge Translation.**

It is possible to translate this knowledge into action. Leaders must look within their respective organizations to identify problem areas that would benefit from implementing this learning. The goals and strategies must be tailored to their needs and support their mission, vision, values, and overall organizational goals. Knowledge transfer must be specific, measurable, achievable, and sustainable.

### **Future Work.**

Future research should explore similarities and differences between clinical and non-clinical professions, among physicians and other clinical groups, and look across the various work environments to examine facilities of varying size, complexity, services provided, and client groups. Research should also consider the influences of society, family, occupational training, life involvements, and background experiences play on subcultural development. Finally, continuing research could also identify changes over time because culture changes.

## Leadership Project Report

### Context

The Canadian healthcare industry continues to see an increase in organizational transformation and change across the healthcare sector. Examples of transformational and change initiatives include mergers, service rationalizations, and regionalization efforts. There have been mixed results when it comes to various transformational efforts. In the case of mergers, researchers confirmed one of the biggest reasons for lack of success in merging organizations is a failure in cultural integration.<sup>1</sup> One study offered the key to successful cultural integration is to look at the employee demographics and other cultural factors.<sup>2</sup>

Canadian Forces (CF) Health Services (CFHS) underwent a 10-year long cultural integration process that included merging organizational cultures of military, civilian public servant, and civilian third-party contracted groups. The purpose of Gilbert's (2013) original study was to close the gap in the scholarly research, literature, and increase CFHS senior leadership understanding of subcultural groups as defined within the following areas: (a) group identification, (b) similarities and differences, (c) self-perceptions, (d) perceptions of other groups, and (e) common issues viewed as barriers to improving synergy among the various subcultures. Gilbert found:

- the groups shared similarities related to patient focus, dedication, mutual respect, and caring; commonality due to adversity such as dealing with staffing shortfalls and heavy workloads; feeling part of the same organization; and a common mission, vision, values, and priorities. Differences noted focused on wearing a type of uniform; military mobility versus civilian geographic stability; unique training, levels

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<sup>1</sup> Smith, 2002; Kavanagh & Ashkanasy, 2006; Hirsch, 2015; Ovseiko, Melham, Fowler, & Buchan, 2015; Abbas, Khalid, Butt, & Zafar, 2014.

<sup>2</sup> LaPlante, 2006.

of responsibility, and authority; and beliefs they were different because of higher levels of collaboration and greater patient-centric mentalities than other groups.

- members of each subcultural group perceived themselves as caring, dedicated, hardworking, loyal, professional, knowledgeable, conscientious, patient focused, valued and respected. Most felt they were team players; however, some groups felt marginalized and thought themselves to be underappreciated. Some group members also felt isolated due to their physical locations within or external to the facility or the nature of their occupations.
- members of each subcultural group perceived members of other subcultural groups generally with respect and valued; saw them as caring, dedicated, hardworking, loyal, knowledgeable, conscientious, and patient focused professionals. Group members generally viewed other groups with more respect than they perceived themselves to be respected by other groups.
- common barriers to improving synergy among the various subcultures included poor communication, deficient understanding of the duties undertaken by the various groups within the healthcare facilities; failure to understand cultural differences and similarities, which are at the center of the various groups; perceived lack of accountability within the leadership and management structures; perceived lack of leadership and management knowledge and training necessary to build patient-centric and cross-functional collaboration; and a lacking environment of trust where everyone felt valued and respected.

Gilbert (2013) recommended improved training in leadership, change management, labour relations, and communication; provide guidance for and encourage creation of cross-

experiential opportunities within the healthcare facilities; develop and institute a formal mentorship program; and develop and implement a top-down communication strategy. Gilbert (2013) also believed members of the afore-mentioned groups demonstrated both similarities and differences that appear to be consistent with the broader health system. This leadership project hypothesized that the findings and recommendations were generalizable to the broader health system and health leaders in the broader health system could benefit from the lessons learned by the CFHS. The following research question guided this leadership study: What Canadian military healthcare cultural findings and research recommendations are applicable and relevant to health leaders in the broader health system? The following research sub-questions guided the study:<sup>3</sup>

- What are the similarities and differences that define each subcultural group?
- How do members of each subcultural group perceive themselves?
- How do members of each subcultural group perceive members of other subcultural groups?
- What common issues do members of the various subcultural groups view as barriers to improving synergy among the various subcultures?

The leadership project is strategically important because Gilbert (2013) provided the first international research to address organizational culture within military healthcare systems.

Although there has been substantial research undertaken around the world to examine organizational culture within healthcare organizations, it has not transposed easily to a military healthcare setting due to a lack in understanding the permanent military (“in-garrison”) healthcare workspace. Generalizability from other international sources is also complicated when comparing the literature against Canadian and Canadian Armed Forces (CAF) societal and

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<sup>3</sup> Gilbert, 2013.



cultural artifacts.<sup>4</sup> Similarly, there have been no prior academic efforts to examine whether military healthcare-based organizational cultural research is generalizable to the broader healthcare system. Healthcare systems are reflections of the societies that created them and each organization will also vary in function and purpose because of local societal and organizational cultural influences.<sup>5</sup> Comparison of Gilbert's findings to current literature on organizational culture in the broader healthcare system confirmed strong similarities between the Canadian military health system and the broader health system. Generalizability of Gilbert's findings to the broader health system, as validated by this leadership study, provides a scholarly contribution to understanding cultural and subcultural perceptions. Gilbert's study also provided key messages and implementable strategies that could benefit the broader Canadian health system and other organizational leaders.

The opportunity to contribute to health leadership knowledge and create social change is quite significant. Change is a constant factor in health care and the health leaders are ultimately responsible if they wish to create implementable and sustainable change in order to maintain a healthy organization. It is therefore critical for health leaders to understand the organizational subcultures that exist within their facilities and the dynamics at play, which ultimately strengthen or impact negatively on a work environment. Only by increasing leadership and management awareness could health leaders develop a strategy to provide optimum patient care, sustain their organizations into the future, and continue to meet the demands placed upon healthcare systems in an ever-evolving world. Validation of Gilbert's (2013) research by health leaders in the broader health system helps to establish the strategic importance of this work and the contribution it may bring to health leadership knowledge. Recognizing, validating, and

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<sup>4</sup> Schein, 2010. Cultural artifacts are phenomena one sees, hears, and feels when encountering a group including physical surroundings, language, clothing, observable ceremonies and rituals, and routine behaviours.

<sup>5</sup> Gilbert, 2013.

embracing our similarities and differences are critical considerations for organizational health and for health leaders to create sustainable change in a manner desired by their organizations.

### **Approach**

The intent of the research was to determine whether or not Gilbert's (2013) research was generalizable, transferable, and relevant to health leaders in the broader health system. The research used focus groups as the method for both data collection and data validation. The leadership project consisted of two geographically separate focus groups comprised of Canadian College of Health Leaders Fellows, Certified Health Executives, and senior health leaders. The focus groups were conducted in Ottawa, Ontario, and Vancouver, British Columbia. Both focus group sessions were two hours in duration. Participants of both focus groups received a brief pre-group information package that provided CFHS organizational background and relevant context in preparation for the sessions. The package is attached as Appendix A. Both sessions commenced with participants receiving the same PowerPoint presentation as given to CFHS senior leaders. Group members also engaged in a question-and-answer session during the presentation portion of the activity. Following the presentation, participants were presented with a copy of Gilbert's (2013) original findings and recommendations in addition to a list of research questions with deliverables (Appendix B). Participants engaged in open discussion during the remainder of the data gathering with the researcher filling the role as facilitator. The researchers' role remained limited to answering questions and clarifying research details as requested by the participants.

Both group activities were duplicated to the extent possible in order to standardize facilitator input. Members of the second focus group undertook one additional activity in order to assist in comparing the data between the two focus groups. Upon completing relevant data

collection, participants were advised when there were differences of opinions between the two focus groups and asked to offer opinions for the differences. The additional activity was included to leverage the combined experiences provided within the group and minimize researcher bias. The opinions were recorded as part of the data collection for the second group and form part of the findings.

### **Literature Review/Evidence**

Transformational leaders must possess several special qualities. They must be able to communicate vision and enthusiasm, have a positive outlook, be intuitively insightful, and possess emotional intelligence, which is defined as being aware of their own emotions and able to both understand and regulate other people's emotions.<sup>6</sup> One unique function of leadership that distinguishes it from administration and management is the concern for culture.<sup>7</sup>

The culture of a group can now defined as a pattern of shared basic assumptions learned by a group as it solved its problems of external adaptation and internal integration, which has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relations to those problems.<sup>8</sup>

Organizations within the same system often have very differing and conflicting cultures and subcultures.<sup>9</sup> Such complexity exists within health care systems.<sup>10</sup> Leaders are responsible for beginning culture formation in new organizations and also managing it as organizations mature over time because cultures change over time. Gilbert's (2013) study explored organizational culture from the military government perspective and subcultures. This research examined his work from broader health system organizational culture and subcultural contexts.<sup>11</sup> There was

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<sup>6</sup> Ashkanasy & Tse, 2000.

<sup>7</sup> Schein, 2010.

<sup>8</sup> Schein, 2010, p. 18.

<sup>9</sup> Schein, 2010; Deal & Kennedy, 1982; Kotter, 1996.

<sup>10</sup> Aslin, 2011; Mason & Wesorick (2011), Prywes, 2011; Spaulding, Gamm, & Griffith, 2011.

<sup>11</sup> Schein, 2010. Schein defined four culture categories: a) ethnic, nations, and religious groups are examples of macrocultures; b) government, public, private, or non-profit organizations are examples of organizational cultures;

minimal research related to organizational cultures and subcultures in military healthcare settings, making his research the first of its kind.<sup>12</sup> Gilbert's literature review of organizational culture built upon current relevant understanding of individual identity, collective identity, social identity, and examined pertinent Canadian and CAF values and beliefs. Gilbert examined and aligned Canadian and CAF values and beliefs in an effort to validate generalizability and transferability to the broader healthcare system, which forms the basis for this paper.

The Canadian military ethos finds its basis in defined values and ethics, which are established in CAF practices and customs. CAF members' conduct must always be governed by the principles of Canadian law and Canadian society. CAF and DND directives and policies reflect unique Canadian experiences and societal expectations, thus enforcing social will upon members of the CAF and civilian personnel within DND.<sup>13</sup> Organizations are one of the important artifacts of modern societies and are characterized by the customary concepts institutionalized within each society.<sup>14</sup> Military organizations and the healthcare systems that support them are also a reflection of their societies. It is therefore reasonable that Canadian military healthcare personnel would hold similar values and societal artifacts consistent with their civilian counterparts.

Every modern state has what might be called a "national medical culture," despite consisting of both the particular mix of ways it has for managing health and a certain set of prevailing values and belief that carry across the boundaries of particular "medical communities."<sup>15</sup>

Gilbert also believed several of the findings and related recommendations provide value to the healthcare industry because patient-focused care with emphasis on nurturing caring cultures,

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c) occupational groups that exist within organizations can be referred to as subcultures; and d) units such as intensive care or surgical teams are examples of microcultures.

<sup>12</sup> Gilbert (2013) reviewed a total of 115 academic books and peer-reviewed journals relevant to his study.

<sup>13</sup> Robinson, Lee, & Carrick, 2008.

<sup>14</sup> Meyer & Rowan, 1977.

<sup>15</sup> Last, 2013, p. 80.

improving systems, and making certain staff feel respected, valued, supported, and engaged were significant themes throughout the literature and remain central to most healthcare philosophies.<sup>16</sup>

Theorists believe the environment causes behaviour but behavior also causes the environment.<sup>17</sup> Humans have needs and some take priority over others until those needs become more fulfilled.<sup>18</sup> Some of those needs relate to individual identity and our need for belonging. Individuals: (a) learn best by observing, organizing, and then rehearsing the modeled behavior; (b) are more likely to assume a modeled behavior when it produces outcomes they value; and (c) are more likely to accept a modeled behavior if the model is similar to the observer's behavior, has admired or social standing, and there is functional value to the behavior. Further, it is believed an individual's motivation to imitate is necessary because people require reasons for doing things.<sup>19</sup> People search for groups to join and, while in them, look to preserve the group's status and to promote their personal status by joining in mutual group behaviors.<sup>20</sup> They express and maintain their feelings of respect and pride by representing their group and, in so doing, maintain a favorable self-image while also continuing to promote the group.

People have a fundamental need to self-categorize and this need lies at the center of collective identity.<sup>21</sup> The need is automatic and motivates people to sort individuals into basic categories based upon distinctiveness from or similarities with the larger social structure.<sup>22</sup>

Newcomers will evaluate the group, examine their place within it, the status the general public

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<sup>16</sup> Dixon-Woods, Baker, Charles, Dawson, Jerzembek, Martin, McCarthy, McKee, Minion, Ozieranski, Willars, Wilkie, & West, 2014.

<sup>17</sup> Bandura, 1978.

<sup>18</sup> Maslow, 1943. Maslow subdivided his "hierarchy of needs" further by classifying the first four levels as deficit needs or deficit motivation. Maslow theorized that an individual is in a deficit and consequently feels the need when he or she does not have sufficiency in something.

<sup>19</sup> Bandura, 1978.

<sup>20</sup> Tyler and Blader, 2001.

<sup>21</sup> Ashmore, Deaux, & McLaughlin-Volpe, 2004, identified distinct individual-level elements related to collective identity and developed a collective identity framework.

<sup>22</sup> Turner, Hogg, Oakes, Reicher, & Wetherell, 1987.

holds for the group, and assess both the explicit and implicit importance that membership within the specific group relates to overall self-concept.<sup>23</sup> Individuals increase their self-esteem and satisfy their emotional social identity need by joining the group. Self-esteem and identity increase further through more intergroup differentiation.<sup>24</sup>

Healthcare organizations are conducting substantial research in the areas of merging healthcare organizations and comprehending the roles that cultures and subcultures play in healthcare environments, employee engagement, clinical performance, and transformation. Local leadership and organizational subcultures play an important role in determining overall employees' job commitment and satisfaction.<sup>25</sup> Equally important is recognizing that unhappy leaders and managers can also have a negative impact on employee morale.<sup>26</sup> Health leaders must therefore consider organizational culture in the due diligence process before making the final decision to merge. They can also use cultural assessment as a tool to assess merger barriers and recognize the most effective implementation levers to use during pre- and post-merger processes.<sup>27</sup> The impact culture plays on clinical performance and patient safety are also well-documented. Cultural analysis is rarely performed to define if the underlying cause is a dysfunctional culture. Conscious consideration and reflection of cultural dysfunction is vital when examining the areas of quality, risk and outcomes management, staff and patient satisfaction, and the cost-effectiveness of medicine. Moreover, leaders shape and lead cultures by consciously choosing to do the right things every day and every hour, making choice after choice, until their actions become habits that motivate and drive overall quality, patient safety,

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<sup>23</sup> Ashmore et al.

<sup>24</sup> Ta•demir, 2011.

<sup>25</sup> Lok, Rhodes, & Westwood, 2011.

<sup>26</sup> Marquis & Huston, 2009.

<sup>27</sup> Chan, 2013.

and the financial health of the organization.<sup>28</sup> Given the complexity of today's environment, twenty-first century health care requires leaders who recognise the culture of their organisations, can express a vision capable of motivating employees to adapt to changing environments, and are capable of developing a healthy environment conducive to change.

## Results

Using two geographically dispersed focus groups to review Gilbert's (2013) original research findings and recommendations, participants evaluated the generalizability and transferability to the broader health system. They further evaluated whether or not the lessons learned can be of value to all health leaders and managers across the broader health system. The remainder of this section summarizes responses to the various focus group questions as shown in Appendices C and D.

Question 1-Based upon your experience as health leaders and managers in the broader health system, how would you define organizational culture and subculture? Both groups shared similar understanding and philosophies in their combined definitions of organizational culture and subculture. Defining these terms within both groups was important to ensure they shared a common understanding when exploring the remainder of the research questions.

Question 2-Members of the various subcultural groups within the CF H Svcs Cs had specific self-perceptions. Based upon your own experiences as health leaders and managers in the broader health system, do you feel these perceptions are consistent with the perceptions shared by groups in the broader health system? Why or why not? Gilbert's (2013) original research found all subcultural groups shared similarities in patient focus, dedication, mutual respect, and caring; commonality due to adversity such as dealing with staffing shortfalls and heavy workloads; feeling part of the same organization; and sharing a common mission, vision,

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<sup>28</sup> Rivero, Zemetra, & Herman, 2013.

values, and priorities. The subcultural groups expressed differences through physical identifiers such as wearing a type of uniform and/or clinical clothing; military mobility that takes CAF members away from their homes, families, and workplace; unique training, levels of responsibility and authority, and specialized knowledge and treatment capabilities associated with the different occupations; and beliefs they were different because of higher levels of collaboration and greater patient-centric mentalities than other groups. Overall, members of each subcultural group perceive themselves as caring, dedicated, hardworking, loyal, professional, knowledgeable, conscientious, patient focused, valued and respected; some groups felt marginalized and thought themselves to be underappreciated; most felt they are team players; and some group members felt isolated due to their physical locations within or external to the facility or the nature of their occupations. Members of both focus groups found the findings identified in the military system are consistent within the broader health system because they share many of the same background and experiences. One group noted feeling undervalued in broader health system was most noticeable in clerks and housekeeping staff. This finding was consistent with military findings for clerks. Housekeeping staff for CF medical facilities are external resources with no connected identity. One group also agreed with the finding that workers with 10 or more years within the same culture continued to emulate the culture even when their roles changed.

Question 3-Members of the various subcultural groups within the CF H Svcs Cs had specific perceptions of members from other subcultural groups. Based upon your own experiences as health leaders and managers in the broader health system, do you feel these perceptions are consistent with the perceptions shared by groups in the broader health system? Why or why not? Gilbert's (2013) original research found subcultural group members perceived



other subcultural groups generally with respect and value; saw them as caring, dedicated, hardworking, loyal, knowledgeable, conscientious, and patient focused professionals. Overwhelmingly, group members valued and respected other group members but did not feel they were equally valued and respected by other groups. Criticism was directed generally at leadership and management groups with negative perceptions focused on poor communication, lack of accountability, and an absence of adequate knowledge and training needed to fulfill specific duties. Members of both focus groups found the findings identified in the military system are consistent within the broader health system because they share many of the same background and experiences. One group added group perceptions of other groups are consistent across both health systems where they share same or similar professional groups or services and similar physical type locations. For example, groups may share the same perceptions for professions inside a large medical facility but not able to compare against dissimilar groups such as public health, special services groups, or extended care. They added certain groups may not have defined labels and this can affect feeling respected or valued. Both groups also acknowledged similar feelings of being undervalued across all administrative groups when viewed by professional groups. The Ottawa group disagreed with a perceived lacking in accountability within the leadership and management formations. They felt there is more accountability in the broader healthcare system due to the existing governance board structure, which they believe prevents this perception. The Vancouver group did not agree with the Ottawa focus group, believing the Ottawa experience is Ottawa centric due to a highly sensitized political environment. The Vancouver group did not believe most people understand how a governance board or Ministry of Health department work including accountability model concepts. The Vancouver group agreed there is lack of consistency in perceptions and especially

as they related to government decisions or administrative actions. They felt this may be due to lack of communication, lack of time, and/or lack of interest unless it affects them directly. Both groups agreed perceptions driven by poor communication were consistent with military findings but were more complex in the broader health system due to 24/7 operations and larger, more complex operations. Both groups commented on subcultural differences between frontline care givers, leadership management groups, and additionally between physician and nursing groups. Both focus groups acknowledged a perception that physicians were part of a distinct group due in part to specialized training and status. This differentiation was not explored in more depth due to time limits. The two focus groups contained health leaders and nurses only with no physician representation.

Question 4-Members of the various CF H Svcs Cs' subcultural groups identified several common issues as barriers to improving synergy among the various subcultures. Based upon your own experiences as health leaders and managers in the broader health system, do you feel these issues are consistent with groups in the broader health system? Why or why not? Gilbert's (2013) original research found the common barriers were poor communication, deficient understanding of the duties undertaken by the various groups within the healthcare facilities including cultural differences and similarities, perceived lack of accountability within the leadership and management structures, perceived lack of leadership and management knowledge and training necessary to build patient-centric and cross-functional collaboration, and a lacking environment of trust where everyone feels valued and respected. Members of both focus groups found the findings identified in the military system are consistent within the broader health system because they share many of the same experiences, barriers, and challenges. Both groups offered several additional comments. Barriers exist within professional groups because many

professionals have knowledge and experience in only specific areas; specially trained clinicians are good at what they do in one area but may be challenged in other contexts. Both groups acknowledged a need for leadership training and a requirement for organizations to agree on training and the skill sets needed for jobs. This training must also be provided prior to employees starting in a new position. One group summarized it as “the right training at the right time” but added a need for consistency because the requirements might be different depending upon the organization. Both groups also acknowledged the importance of skill maintenance and the value of mentorship programs but one group stressed the challenge of finding the time required to match mentees with mentors, especially across large organizations. Eliminating the specific CFHS finding for increased top-down communication—needed to address specific CFHS perception issues—both groups agreed communication perceptions were consistent with military findings but, again, were more complex in the broader health system due to 24/7 and larger, more complex operations. Additionally, one group stated problems span across the broader health system organizations (e.g. hospitals, outpatient services, homecare, and front line services) and client groups (e.g. children, the frail, and other vulnerable groups). One group clarified that poor communication should be divided into poor—not relevant or not truly understood—versus one that is ineffective. They felt both aspects must be addressed. One group recommended communicating more often, more visibility, and that communications should be targeted to specific markets because “people hear only what they want to hear”.<sup>29</sup> They also recommended removing the words *top down* communication from the original findings and replacing them with *multi-directional* communication. This change makes the recommendations consistent and applicable across both military and the broader health system domains.

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<sup>29</sup> Group 1.

Question 5-The CF Surgeon General's senior leadership team was presented with several recommendations. Do you feel these findings are equally applicable to health leaders and managers in the broader health system? If yes, to what extent are these lessons learned generalizable to the broader health system? Gilbert's (2013) original research found a need to review leadership and management training for senior health leaders and managers to ensure they had the tools necessary to undertake a new job with transparency and visible accountability rather than acquiring the knowledge through on-the-job experience. Training should include various leadership and management models that have equal application in both civilian and military realms; the ability to define local mission, vision, and values through collaboration and based upon a common understanding of the local culture and the values shared by all groups; knowledge in change management including how to create and sustain change through stakeholder involvement; labor-management training to ensure all leaders and managers understand their duties, responsibilities and organizational expectations when addressing labor-management issues; effective communications with a view to ensuring leaders and managers can communicate effectively and across all areas of their responsibilities; and how to empower members of the healthcare team by creating environments of trust where everyone feels valued and respected. Gilbert also recommended leaders encourage creation of cross-experiential opportunities within the healthcare facilities to create or increase team building opportunities among sub-cultural group members and enable cross-exposure of all personnel to the occupations and duties within the various departments, develop and institute a formal mentorship program for leaders and managers, and develop and implement a top-down communication strategy that will ensure timely communication down and across all levels of the organization with a focus on developing and sustaining institutional credibility. Members of one focus group

noted a need for more defined labels for the broader health system because some labels are implied rather than implicit while the second group found the recommendations to be very general and need to be adapted to local organizations and requirements. One group also felt the broader health system is currently a hybrid culture and containing more complexity due to their more diverse work environments and 24/7 operation. With respect to mission, vision and values, one group felt it is difficult to get the mission known by all and added there is a danger of not making choices when leaders are faced with over-collaboration during vision and values development. One group also stated too many values are not realistic and organizations with too many espoused values actually speak to the culture of the organization. Both groups commented extensively on training and education noting experience, training, and education need to match role. This is especially crucial when removing valuable clinicians from clinical roles and placing them in leadership or management roles without adequate training and preparation. Health leaders must also consider how to provide satisfaction to clinicians while they transition from one knowledge and skill set area into another. Training, education, and preparation must also be part of succession planning because it takes years to prepare senior leaders and managers for their roles. Further, such planning must be based on organizational structure, which will vary among facilities. The process used for promotion within an organization could also have negative impact because it might be based on factors not relevant to new positions in leadership. Finally, one group commented it is also critical for all groups to understand and accept that leaders and managers have specific bodies of knowledge and learning that should be valued.

Question 6-To what extent do the findings of your discussions align with the findings as presented from the CF H Svcs Cs? Members of both focus groups found Gilbert's (2013)

findings and recommendations developed for the military health system, specifically the CFHS, are consistent within the broader health system and therefore generalizable and transferable.

Question 7-Do you have any additional comments you would like to include as part of these discussions? Members of both focus groups felt the research leadership project was worthwhile, interesting, addressed a need in an understudied area, and is very applicable and relevant to general health care. They further acknowledged the very complex nature of understanding organizational cultures and subcultures and that multiple areas remain available for future research. One group summarized both groups' opinions effectively, wherein they stated it is critical that leaders and managers understand their culture and how cultural dynamics work if they are to be successful. Further, they must understand their employees' needs and know how to influence and leverage the existing cultural and subcultural networks.

### **Lessons Learned**

Gilbert (2013) produced the following lessons learned that are applicable to all healthcare leaders because leaders play a role in creating, embedding, managing, and sometimes changing culture.<sup>30</sup> Many organizations and particularly service organizations share similar drivers of change including new technologies and business models, changes in societal values and public expectations, political will, changes to funding formulas, and continuous restraint programs that affect staff levels and services. However, the economic model in health care is unique because the major drivers of demand for services are the physicians and the patients. Uniquely, they have no direct connection to the leaders who are challenged to pay for the demand generated by them.<sup>31</sup> These lessons, as originally present to CFHS leadership, have been supplemented by the conversations captured during the focus groups. At the core of this information is the need to

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<sup>30</sup> Schein, 2010.

<sup>31</sup> Dickson, Lindstrom, Black, & Van der Gucht, 2012.

acknowledge and state clearly that leaders and managers are professionals in their own right with specific bodies of education, knowledge, skill sets, and experience. Further, these capabilities place leaders in both unique and demanding roles. They are empowered to lead, manage, guide, and protect their workforce while serving their patient and client groups. They must provide these services across multiple venues and environments including hospitals, outpatient services, homecare services, and front line services that support vulnerable populations. They are also responsible to multiple stakeholders with direct and indirect influence over their activities. With these considerations in mind, it is essential health leaders use relevant tools to create success:

- Study participants stated some groups perceived their leaders were unaware of changes occurring within their healthcare facilities and group members did not feel valued. These findings are consistent with Gilbert (2013). It is therefore important to undertake a new mission and vision analysis whenever the situation changes and review organizational values to ensure they reflect both the current reality and the planned future. Evaluating organizational strengths, weaknesses, opportunities and threats (SWOT) is critical. Especially relevant to service industries and health care, the SWOT analysis should include internal and external environmental scans to ensure organizations are fulfilling their service mandates, operational efficiency, and potential. Leaders should also examine softer elements such as culture and the roles of key staff. It is important to involve stakeholders in refining an organization's mission, developing its vision, and defining its values because these activities ensure they meet the organization's needs today and into the future. They should be reflective of the organization itself and the organization's most valuable asset, its people. While it is certainly not possible to involve everyone in these ventures,

especially in large organizations, it is critical to ensure that leaders understand and have representation from as many of the subcultures possible so they feel inclusive within the process and truly believe the end products are reflective of them, their groups, and their organization. People will feel valued by this process and additionally will feel connected to other groups through commonly-defined shared values and meanings. Having stated that, there is a danger of not making choices when defining vision and values through collaboration. Having an overabundance of values also creates risk because too many espoused values might not be realistic and therefore not reflect the overall culture of the organization. This is even more critical during organizational change management efforts where leaders are making a conscious effort to modify the organization's vision or redefine its values to meet organizational goals and needs.

- Research identified that many individuals, including those within the leadership team, lacked role clarity and a perception existed that some leaders and managers were not being held accountable for their actions. Perceived lack of accountability was also a finding in Gilbert (2013). All leaders and managers must clearly understand who is responsible and accountable, who they are supporting and who supports them, and who should be consulted or informed as they relate to supporting the mission, vision, and goals. The SixSigma RASCI templates are examples of tools that can assist in clarifying roles and communication.<sup>32</sup>

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<sup>32</sup> SixSigma RASCI (Responsible, Accountable, Consulted, Informed) tools are available at <http://sixsigmatutorial.com/what-is-raci-download-raci-rasci-matrix-templates-six-sigma/141/>. SixSigma methodology improves any existing business process by constantly reviewing and re-tuning the process. SixSigma uses a methodology known as DMAIC (Define opportunities, Measure performance, Analyze opportunity, Improve performance, Control performance) to achieve this goal.



- All focus group participants agreed leadership and management education, training, skill set development, and experience are critical for success. These findings are consistent with Gilbert (2013). Health leaders must know how to lead themselves, engage others, achieve results, develop coalitions, and undertake successful system transformation consistent with the LEADS in a Caring Environment Capabilities Framework.<sup>33</sup> They accomplish effective health leadership by “being” true to themselves and remaining authentic; “caring” and demonstrating their commitment to their patients, clients, employees, organizational wellness, and living their organization’s mission and vision; and “doing” via leading themselves, engaging others actively, achieving results, developing appropriate coalitions, and transforming systems.<sup>34</sup> The following tools and education will assist leaders in developing their leadership capabilities as described above:
  - The Myers-Briggs Type Indicator (MBTI) and 360 degree feedback self-awareness assessments can be very useful tools to develop leaders. Skills scans can also assist leaders in ensuring they have the right people in the right place. Leadership self-assessment tools are also available that will assist in identifying personal characteristics that support or inhibit leadership development.<sup>35</sup>
  - It is important to match the specific role to the right person and the process for selecting the right person must be linked to a realistic and effective succession planning process. Planning is essential because it takes years to develop qualified and effective senior leaders and is even more critical in organizations with limited high-value human resources and redundancy. Such planning is particularly

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<sup>33</sup> Dickson & Tholl, 2011.

<sup>34</sup> Rowling, 2012.

<sup>35</sup> Goethals, Sorenson, & Burns, 2004.

important when removing valuable clinicians from clinical roles and placing them in leadership or management roles without adequate training and preparation.

Health leaders must also consider how to provide satisfaction to clinicians while they transition from one knowledge and skill set area to another. Whenever possible leaders should make every effort to provide new and career-advancing staff with the necessary training and experience they require in advance of undertaking their responsibilities, rather than acquiring them over time through on-the-job experience. Forcing someone to learn on the job while other options are available increases personal stress and reduces job satisfaction. The stress can also create situations that might impact organizational outcomes and interpersonal relations negatively.

- There was a broad consensus across both study groups that health leaders required formalized leadership training in order to be successful in guiding and managing their organizations. This finding is consistent with Gilbert (2013). Health leaders must be educated in various leadership paradigms and learn how to apply this understanding in a complex work environment.<sup>36</sup> Charisma is an important mechanism of culture creation; however, it is not a reliable mechanism for embedding or socializing culture because leaders who have such charisma are rare and the impact on the organization is difficult to predict.<sup>37</sup> Education, experience,

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<sup>36</sup> Many professionals in Gilbert's (2013) study lacked formal education in leadership and management, which undermined their effectiveness, negatively impacted the organization in achieving its mission and goals, and adversely and dramatically undermined interpersonal cultural relationships.

<sup>37</sup> Schein, 2010.

and mentoring are therefore key multipliers in building individual capability and capacity in these areas.<sup>38</sup>

- The research clearly identified a need for all leaders to have profound cultural competence. This finding is consistent with Gilbert (2013). It is essential to ensure leaders have a deep understanding of organizational culture. Leaders must understand the cultural changes that occur within organizations from their founding and early growth, transition into midlife, and through maturity into decline if they are to understand how culture changes. They must be able to rapidly decipher elements of their own culture in order to assess relevancy for their change programs. Culture management must further consider the influence of globalization because organizational culture is becoming more multicultural.<sup>39</sup> The *Implications Wheel* is an example of one tool that can assist leaders in understanding what effects decisions might have in the future and can be valuable in examining cultural impacts.<sup>40</sup> The knowledge will assist leaders in working with the various groups more effectively based upon a common understanding of the values and considerations shared by all groups. As stated previously, research findings clearly show that there remains much to learn and apply in the areas of cultural understanding, cultural merging, and organizational change.<sup>41</sup>
- Both focus groups recognized health leaders lacked knowledge in change management strategies. This finding is consistent with Gilbert (2013). Leaders must be knowledgeable in change management techniques, know how to engage

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<sup>38</sup> Curtis & O'Connell, 2011.

<sup>39</sup> Schein, 2010.

<sup>40</sup> Barker, 2011.

<sup>41</sup> See footnote 1.

staff in complex labor-management environments, and understand how to create and sustain transformational change through stakeholder involvement.

Transformation must be values driven and remain a choice. Therefore, leaders must model the behaviour through values-based leadership and example while creating an environment of respect and trust.<sup>42</sup>

- The research found many subcultural groups lacked a clear understanding of the duties other groups performed, which impacted negatively their perceptions of other group members. This finding is consistent with Gilbert (2013). Consequently, when and where possible, health leaders should provide guidance for and encourage creation of cross-experiential opportunities. The intent should be to create or increase team building opportunities between staff members and across professional groups thus enabling cross-exposure of all personnel to the occupations and duties within the various departments. Various diversity tools are available to increase cultural awareness.<sup>43</sup> Local tools can also be developed and local activities undertaken to foster cultural sensitivity and enhance team building. Such interactions should be used as opportunities to increase perceived value and respect, enhance interdepartmental and inter-professional communication, and enhance understanding of the benefits and challenges that accompany all forms of work.
- Study participants acknowledged the importance of mentorship. Gilbert (2013) recommended instituting a formal mentorship program within CFHS. Formal mentorship programs are powerful enablers for leader and management development. Mentoring allows individuals assuming new duties or wishing to expand their

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<sup>42</sup> Rowling, 2012.

<sup>43</sup> Ingram, 2008; Hofstede, n.d..

learning to have access to others with previous knowledge and experience in their specific areas of interest. It is important to recognize that both mentees and mentors have responsibilities within the mentor-mentee relationship. These responsibilities must be honoured and respected if it is to be successful. Additionally, mentees need not restrict themselves to having such a relationship with only one other individual. Each relationship is important and mentees should look for mentors with desirable qualities they wish to emulate and seek to increase their knowledge and experience from sources willing to openly share. The benefits truly become force multipliers when leveraging such capabilities from more than one source.

- Focus group members clearly agreed that leaders must be effective communicators and that such training was lacking. This finding is consistent with Gilbert (2013). Too often organizations fail to understand the importance of communication and suffer the inevitable consequences. The following strategies will assist in developing and implementing a good and effective multi-directional communication strategy that will ensure timely, targeted, repetitive communication across all channels of the organization and with a focus on developing and sustaining institutional credibility:
  - Identify all stakeholders and ensure all have a clear understanding of the overall organizational strategy to ensure they are all headed in the desired direction and manner.
  - Undertake an internal and external communications audit to examine current communications practices, define audiences that factor in subcultural differences, and ensure leaders are communicating to the right groups and in the most effective ways. Utilizing an independent auditor will bring a fresh perspective.

- Explore existing research and undertake internal studies to measure staff satisfaction, organizational wellness, identify success and challenge areas, and include the lessons learned within the communication plan.
- Look at the tools that exist currently within the organization such as annual reports, newsletters, and websites to see if they can be better utilized and develop your own tools and templates to support organizational assessment and communications planning.<sup>44</sup> Centralize primary communication sources, such as websites, to create an area of “one-stop shopping” and use technology including social media to engage audiences.
- Provide training that empowers leaders, champions, change agents, and key members of the healthcare team to create an environment of trust, which actively encourages everyone to make organizational communication part of their daily responsibility.

Implementing such complex and far-reaching strategies is certainly not easy and must be part of an overall strategic plan based upon an organization’s mission, vision, and values. The complexity increases when part of the strategic plan entails shifting or merging organizational cultures with sometimes disparate visions and values. Leaders must not develop such a strategic plan in isolation. There is a critical need to undertake a consultative process—an honest conversation—with both internal and external stakeholders involved in this process. One must consider areas of responsibility, areas of influence, and areas of interest when developing such a strategy.

### **Implications for Health Leadership**

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<sup>44</sup> Research Administration Performance Improvement and Development, 2011.

Healthcare organizations require twenty-first century leaders who understand themselves, their organizations, and the people who work within them. They must know how to lead themselves, engage others, achieve results, develop coalitions, and undertake successful system transformation consistent with the LEADS in a Caring Environment Capabilities Framework.<sup>45</sup> Leaders must be true to themselves because organizations require leaders who possess the necessary knowledge, understanding, skills, and who can build and sustain trust. Increasing synergy and building collaboration is only possible in an environment of mutual trust and respect. It is not a simple case of whether or not such trust and respect exist. Rather, it is about perception and people's ability to communicate an accurate perception, especially in the face of a constantly changing world. Trust is a form of capital and leaders have the responsibility to raise and use the capital for the organization's benefit. They must understand that trust is not permanent and followers can lose trust in their leaders whenever they perceive their personal interests are threatened.<sup>46</sup> Leaders also must make values-based decisions that reflect their commitments to those they serve and fulfill their organization's mission and vision. By leading themselves effectively, they can engage others to look within their organizations for similarities that link directly to these findings and recommendations or other examples of engaging staff for successful outcomes.<sup>47</sup> They can also challenge the norm and examine the differences to see if these lessons learned are applicable outside of the specific research areas of this study. "Peeling back the layers of the onion to find the root cause" creates incredible opportunities to examine cultural and organizational paradigms from a new perspective and find innovative ways to lead and support the organization, the people, and their patients and clients.<sup>48</sup> Implementing these

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<sup>45</sup> See footnote 33.

<sup>46</sup> Salacuse, 2006.

<sup>47</sup> MacLeod & Clarke, 2009; Rowling, 2012.

<sup>48</sup> Auter, Wylie, & Valente, 2005.

lessons learned or any transformation requires that leaders engage others and develop coalitions to achieve results. Such engagement will also work to continuously strengthen and renew trust.

Engaging others and developing coalitions necessitates good, timely, and effective communication in order to achieve one's goals. Only in this way can leaders lead other leaders and professionals effectively. Only in this manner can they deal with tomorrow's expectations while simultaneously meeting the daily healthcare needs of their patients and clients. The value of communicating effectively also cannot be over-emphasized. Leadership could not exist without the human ability to communicate and is "fundamental to building relationships and therefore the ability to lead."<sup>49</sup> Good leaders must also be able to create meaning and exchange it with others. "Language is the critical link between the created presence and the uncreated future...good leaders translate ambiguity into clear messages that convey the rationale for change and enroll others in a compelling strategy that fosters alignment and commitment."<sup>50</sup> Change agents do not need to be in high authority positions in order to be transformational. "In fact, we need to have no authority except the authority of our own souls...being transformational is not about position but about values, thoughts, and behaviors. We become transformational change agents through choice—our own."<sup>51</sup>

Healthcare systems are a reflection of their societies because societal members construct them and leaders share a dual role as both actors and audience within healthcare organizations. Health leaders must recognize they are influenced by both realms but ultimately responsible if they wish to create a healthy and sustainable learning organization. The implications for leadership is therefore clear. Leaders must nourish themselves and other leaders, providing all with the tools to lead their organizations into the future. They must do all of this while serving

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<sup>49</sup> Salacuse, 2006.

<sup>50</sup> Souba, 2010.

<sup>51</sup> Quinn, 2000.



and valuing their patients, their customers, and their most valuable asset...their people. Consequently, a good health leader LEADS and models the way while constantly looking for or creating opportunities to implement these lessons as part of their day-to-day practice.<sup>52</sup> Twenty-first century leaders must strive to create a learning culture that is proactive, be committed to learning to learn, have faith in people and the ultimate goodness in human nature, believe that the cultural environment can be managed, commit to truth through inquiry and pragmatism, maintain a positive orientation to the future, commit to full and open communication based upon task relevancy, commit to cultural diversity, be systems thinkers, and believe that analyzing and reflecting on one's culture is an important and necessary part of learning.<sup>53</sup>

### **Generalizability and Transferability**

Focus group participants all agreed Gilbert's (2013) findings and recommendations are generalizable and transferable to healthcare-related audiences and leaders can benefit from the conclusions outlined in this paper. The literature, as presented within this paper, also supported use of this information across the broader health system. Organizations vary in mission, vision, values, goals, size, cultural influences, and other environmental effects. They all contain cultures in varying size and complexity with some cultures newly developing and others deeply entrenched. However, all organizations still are influenced to some degree by the same considerations discussed in Gilbert and within this leadership project.

Notwithstanding these findings, one must acknowledge that all findings are not necessarily applicable to all settings across the broader health system and when compared to the military system. The broader health system consists of larger and more complex operations, have larger facilities, and provide services that vary substantially from the military experience.

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<sup>52</sup> Dickson & Tholl, 2011.

<sup>53</sup> Schein, 2010.

## Knowledge Translation

The Canadian Institutes of Health Research uses the *Knowledge to Action Cycle* seven-step process for knowledge translation: 1) identify the problem and choose the relevant knowledge; 2) adapt the knowledge to the local context; 3) assess barriers to use of the knowledge; 4) select, tailor, and implement interventions; 5) monitor use of the knowledge; 6) evaluate outcomes; and 7) sustain knowledge use.<sup>54</sup> In creating an initial dissemination plan, one must recognize new knowledge is socially constructed, initially discussed, negotiated, and finally adopted. This occurs: a) both through communication by people with influence and through all social networks that connect peers with similar organizations; b) by having peers, opinion leaders, and knowledge champions present; and c) by precisely tailoring messages that reflect values, use appropriate language, and meet organizational needs.<sup>55</sup> Focus group participants discussed all of these factors during their deliberations. Group participants formed the initial group of knowledge users and recognized the value of the knowledge as discussed within this paper. They also identified several problems that were the catalysts for the findings and recommendations. Participants recognized several barriers to knowledge implementation that would prevent using a cookie-cutter approach to information dissemination. Barriers include professional power dynamics, varying sizes and types of facilities, care services models, and locations where caregivers provide services.

It is possible to translate this knowledge into action. Leaders must examine each finding and recommendation, and then look within their respective organizations to identify problem areas that would benefit from implementing this learning. Senior leaders must identify goals and develop strategies that would allow implementation within their organizations. The goals and

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<sup>54</sup> Parry, Salsberg, & Madaulay, 2014; Graham, Logan, Harrison, Straus, Tetroe, Caswell, & Robinson, 2006.

<sup>55</sup> Greenhalgh, Robert, & Bate, 2004

strategies must be tailored to their needs and support their mission, vision, values, and overall goals. Knowledge transfer goals must be specific, measurable, achievable, and sustainable.

As part of a detailed communication plan, leaders must identify organizational groups responsible for knowledge transfer, peers, opinion leaders, and knowledge champions throughout the organization. The plan must also identify individuals and team members responsible for the different settings for dissemination. The communications plan must explore all forms of communication that makes best use of these peers, opinion leaders, knowledge champions, and people with influence. The plan should consider using all social networks that connect peers with similar organizations and tailor messages precisely that are reflective of organizational values, use appropriate language, and are adapted to meet specific organizational needs.

Applying this knowledge within organizations should not be limited to particular groups or individuals. Leaders, managers, supervisors, clinicians, and non-clinicians can benefit from these lessons because applying them will assist in increasing transparency, accountability, and improve cross-organizational relationships. Senior leaders should consult with organizational stakeholders to identify and prioritize those who would benefit from this knowledge and work to identify blind spots within the organization. Ascertaining blind spots can identify additional barriers to success and produce possible mitigation strategies. These same stakeholders will be critical in identifying key messages for their tailored audiences. Key messages should leverage the centrality that patient care plays within healthcare environments and incorporate values, cultural artifacts, and organizational and group missions, visions, and goals. “Why should I care?” should be at the heart of any message and the messages should be continuously over-communicated to ensure they are heard and entrenched.

The Knowledge to Action Cycle also requires timely selection, tailoring, and implementation of interventions, monitoring appropriate use of the knowledge, outcome evaluation, and knowledge use sustainment.<sup>56</sup> Senior leaders must therefore ensure their dissemination plan includes sustainable strategies for these processes. Only in this way could organizations create sustainable change and only in this manner can they meet their goals and fulfill their vision of the future.

### **Future Work**

The intent of Gilbert's (2013) research was to undertake a phenomenological inquiry that examined the current organizational culture and subcultures within the CFHS primary care outpatient service facilities, explore the significance such cultures play on subcultural perceptions, and identify barriers to improving synergy across the organization. Gilbert's research did not, however, explore similar groups within the broader health system. The scope of this leadership research project was limited to reviewing Gilbert's findings and recommendations with a view to confirming its application with the broader health system. All focus group participants acknowledged the need and benefit of conducting future research across the various broader health system work environments. As noted by both focus groups, problems span across all health organizations in the broader health system and are compounded by the varying sizes of facilities, organizational complexity (e.g. hospitals, outpatient services, homecare, front line services, and daytime versus 24/7 operations) and client groups (e.g. children, the frail, and other vulnerable groups). Researching the similarities and differences across these services might assist leaders in understanding commonalities and challenges that can assist them in improving work environments, enhance collaboration, and optimize patient care. Consistent with other research study recommendations, it would be worthwhile to study doctors, nurses, and non-

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<sup>56</sup> Graham, et al., 2006.

clinical managers through multiple analytical lenses.<sup>57</sup> Despite knowing that many occupations are trained in the same manner and share similar values and skill sets, there is no clear consensus whether or not occupations have cultures.<sup>58</sup> Such analyses would help to provide a greater understanding of shared and differing values, norms, and assumptions both within and across subcultures.

Research could also benefit from examining whether or not cultural identifications are rooted in acculturation, enculturation, societal influences, occupational training, life involvements, and/or entrenched through various background experiences. Understanding these cultural artifacts might help leaders communicate more effectively, build better relationships, lead and manage more effectively, and support others in providing services to their patients and clients. Finally, all research is only a snapshot in time. Consequently, it is important to re-examine all research findings in order to validate these early findings, conclusions, lessons learned, and identify changes over time.

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<sup>57</sup> Skela Savi• et al., 2008.

<sup>58</sup> Schein, 2010.

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## Appendix A: Focus Group Pre-Brief Information Package

### ***Canadian Forces Health Services Overview and Context:***

The Canadian Armed Forces (CAF) is the military component of the Department of National Defence. The Canadian Forces (CF) Health Services (CFHS) is the component of the CAF responsible for providing all healthcare services to CAF personnel and the CF Health Services Group (CF H Svcs Gp) is the authority organization responsible to administer the CFHS.

### ***The Past***

In 1994, the CFHS underwent a dramatic downsizing and restructuring entitled Operation PHOENIX. The aim of that restructuring was to provide a more operationally-focused medical service that could achieve its objectives with fewer uniformed members. The restructuring also saw the closure of seven CAF hospitals, capability reductions to out-patient services, elimination or downsizing of several military medical professions, and a shift to a much greater reliance on civilian employees and the Canadian broader health system. The new reality also necessitated military medical personnel to be imbedded in or work regularly with Canadian hospitals in order to maintain their clinical competency and obtain specialized “just-in-time” training prior to operational deployments.

CFHS began undergoing a massive organizational and paradigm change commencing in 2000, which also saw the centralization of all navy, army, and air force medical resources under a new command entitled the CF H Svcs Gp. The cross-organizational restructuring set the stage for CFHS as it exists today.

### ***The Present***

CF H Svcs Gp personnel provide medical support to domestic operations and provide international support for deployed CAF operations ranging from high-intensity war to humanitarian assistance. CAF military personnel staff the medical field units and are responsible to provide health care during deployed operations. Their organizational structure and culture remain militarily focused in order to support military operations and operational practices are consistent with public perceptions of military organizations.

CF H Svcs Gp personnel also deliver healthcare services on all CAF military bases. The provision of these services is known as *in-garrison* care. Unlike the medical field units, CF H Svcs Gp military personnel and civilian public servants staff the CAF medical facilities known as CF Health Services Centres (CF H Svcs Cs). Third-party civilian clinicians with no employer-employee relationship to the CF H Svcs Cs leaders and managers provide additional clinical support in locations where military clinicians are in short supply. Currently, they are imbedded within all CF H Svcs Cs. The military personnel, public servants, and third-party civilian clinician contractors provide in-garrison health care consistent with broader Canadian healthcare system standards, administrative support processes, and practice norms. To restate, CF H Svcs Cs are physically designed and provide the same healthcare services as are available in healthcare facilities across Canada. The staffs within the CF H Svcs Cs provide outpatient clinical assessment and treatments services, diagnostic and therapeutic services including

laboratory, diagnostic imagery, pharmacy, and physiotherapy care, minor day surgeries, dental care, mental health and psychosocial services, and administrative support services.

The most visible difference with public health facilities is that the senior leadership and some clinical and support personnel are CAF members. Having stated that, all CAF non-clinical leadership personnel hold active Certified Health Executive certification with the Canadian College of Health Leaders and also hold public degrees and credentialing where appropriate. Similarly, all military clinicians received their clinical training through non-military universities and maintain their clinical expertise in accordance with their respective federal or provincial clinical colleges and provincial regulatory bodies. In addition, all CAF clinical personnel undergo a mandatory maintenance of clinical readiness program by working within Canadian hospitals on a fulltime or regular part-time basis.

As stated previously, the CF H Svcs Gp has undergone massive organizational and paradigm change since 2000. Figure 1 provides a high level structure for CF H Svcs Gp and Figure 2 shows locations for out-patient medical facilities across Canada. The originally envisioned CF H Svcs C military-to-civilian staffing ratio was intended to be 50:50; however, the personnel distribution was more reflective of a 75% to 80% civilian presence due to CAF operational commitments and other factors. The organizational culture has consequently developed a civilian persona due to the lack of consistent military presence. The culture also contains several subcultures with disparate philosophies that affect negatively leadership efforts to create needed organizational change. There has been no research prior to my study (Gilbert, 2013) that examined cultural merging within Canadian military organizations or explored the similarities and differences that healthcare leaders can use to successfully merge organizational cultures and build upon their combined synergy.

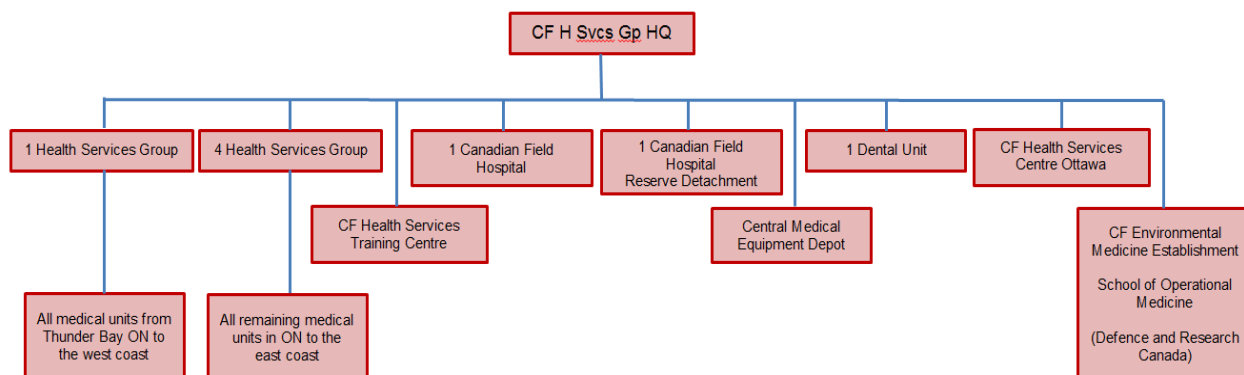


Figure 1. CF H Svcs Gp Organization.

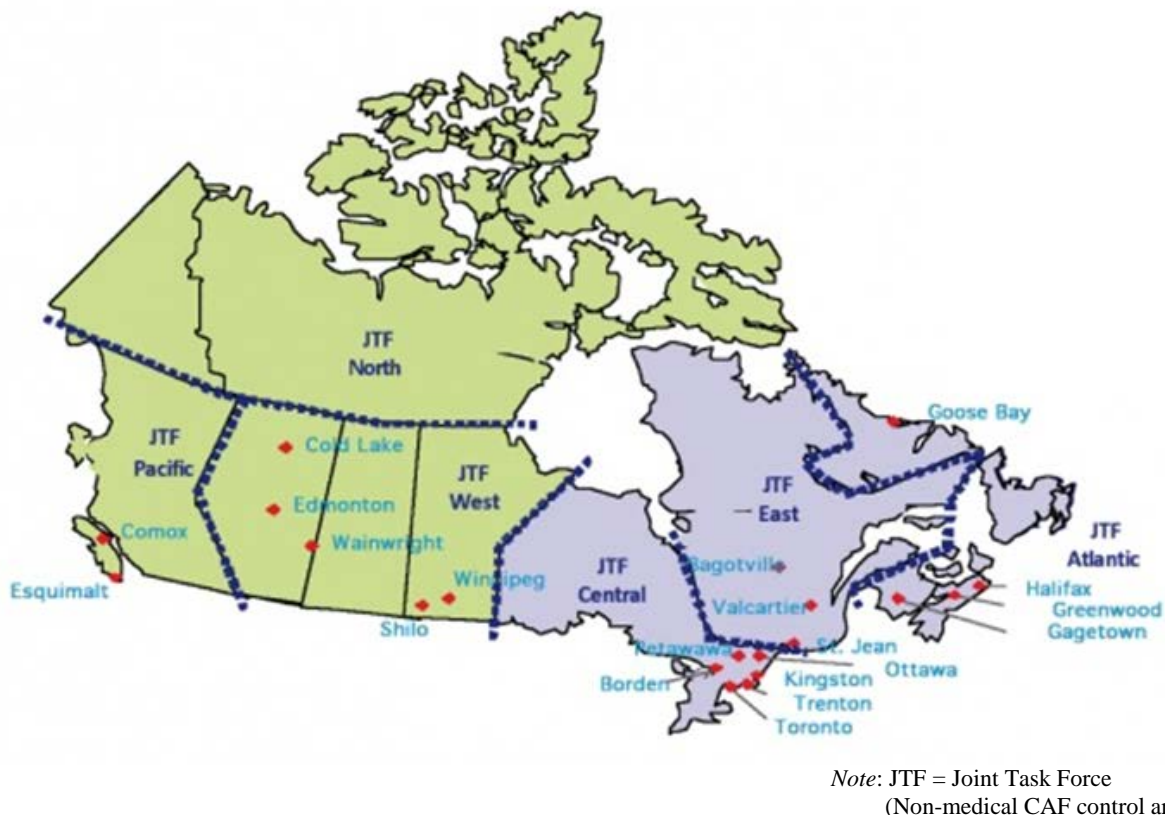


Figure 2. CF H Svcs C Locations Across Canada.

### ***Cultural Context***

The CF H Svcs Cs underwent a 10-year long cultural integration process that included merging organizational cultures of military, civilian public servant, and civilian third-party contracted groups. The Canadian healthcare industry also continues to see an increase in organizational transformation and change across the healthcare sector. Examples of transformational and change initiatives include mergers, service rationalizations, and regionalization efforts. There have been mixed results when it comes to various transformational efforts. In the case of mergers, researchers confirmed one of the biggest reasons for lack of success in merging organizations is a failure in cultural integration. They offered the key to successful cultural integration is to look at the employee demographics and other cultural factors.

The intent of my leadership project is to validate the transferability of my initial findings (Gilbert, 2013) to the broader health world and bring practical knowledge to Health Leaders and Managers in the broader health system. Although the three CF H Svcs Cs' groups discussed above appear to be distinct, the research found members of these groups demonstrated both similarities and differences that appear to be consistent with other Canadian organizational groups (Gilbert). It is hypothesized that Health Leaders and Managers in the broader health system can benefit from the lessons learned by the CF H Svcs Gp leadership. Validation of these theses and the other research findings by Health Leaders and Managers in the broader health system would help to establish the strategic importance of this work and the contribution it may bring to health leadership knowledge.



***Focus Group context:***

Focus group participants will be shown the same presentation given to the CF H Svcs Gp senior leadership. Participants will then be provided with specific questions to enable discussions.

## List of Acronyms

CAF	Canadian Armed Forces
CF	Canadian Forces
CFHS	Canadian Forces Health Services
CF H Svcs C(s)	Canadian Forces Health Services Centre(s)
CF H Svcs Gp	Canadian Forces Health Services Group
JTF	Joint Task Force (Non-medical CAF control areas)

## Participant Informed Consent

This form constitutes part of a process called “informed consent” and allows you to understand this study before deciding whether or not to take part in this research.

**Purpose of this Study:** You were selected as a representative of the Canadian College of Health Leaders (CCHL) to participate in a study intended to validate or invalidate the transferability of the initial findings from Gilbert (2013) to the broader health world and bring practical knowledge to Health Leaders and Managers in the broader health system. This study is being conducted by Dr. Randy Gilbert, CCHL Fellow candidate.

**Procedures:** This qualitative research is based on focus group participation. There may be a requirement to conduct a second focus group in the event there is inadequate time to answer all research questions within the mutually-agreed period. The focus group(s) will be either visually and voice recorded or voice recorded only. A transcriptionist will also capture conversations. The recording will only be used by the researcher for the purposes of validating the transcription and assisting the researcher in data interpretation.

**Voluntary Nature of the Study:** Participation in the study is voluntary and you are free to withdraw at any time. You are not compelled to take part in this research project and you will not be penalized in any way for declining to participate. If you choose to take part, you are free to withdraw at any time without prejudice. If you do elect to withdrawal from the study, your views cannot be removed from the data collection because the data collection is based on group participation.

**Risks and Benefits of being in the Study:** There are no perceived risks to participating in the study.

**Payment:** There will be no payments, honorariums, thank-you gifts, or reimbursements provided by the researcher to participants.

**Confidentiality:** This is not anonymous research. Your views cannot be kept confidential from other participants due to the collaborative nature of the data collection. Personal information will not be collected by the researcher other than what you provide through this informed consent and as mutually shared and agreed upon between participants and among participants and CCHL. Information collected will be grouped to identify common themes and trends based on the participation of all focus group participants. Grouping the data will prevent identifying individuals who could otherwise be identified by their role. The researcher will not make your identity available to others and identifying information will not be included in the final report. The researcher will keep data for a period defined by CCHL.

**Use of the Information:** The recordings and transcripts collected during data collection will be used solely as defined in “Purpose of this Study” and as explained within this Informed Consent document. Aggregate data as presented in the final Fellowship Program Leadership Project Report may be used in future academic and professional journals, other publications, or presentations as agreed upon between the researcher and CCHL.

If you have any questions or would like additional information about this research, you may contact the researcher by email at [rgincanada@gmail.com](mailto:rgincanada@gmail.com).

**By signing this form, I acknowledge I have read and understood my rights to participate in the study. I provide my free and informed consent to participate in this research project.**

Name: (Please Print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Appendix B: Detailed responses from Gilbert (2013)

## F = Findings

- (F1). *What are the similarities and differences that define each subcultural group?*
  - Similarities:
    - Patient focus, dedication, mutual respect, and caring.
    - Commonality due to adversity such as dealing with staffing shortfalls and heavy workloads.
    - Feeling part of the same organization.
    - A common mission, vision, values, and priorities.
  - Differences:
    - Wearing a type of uniform and/or clinical clothing. Merriam-Webster dictionary (n.d.) defines *uniform*, in part, as “dress of a distinctive design or fashion worn by members of a particular group and serving as a means of identification; broadly: distinctive or characteristic clothing.” Therefore, this statement remains valid for all groups wearing differentiated clothing such as scrubs, lab coats, or other similar group identifiers.
    - Military mobility due to postings, deployments, and other tasks, which take them away from their homes, families, and workplace. Mobility can also be a differentiator for other occupations faced with regular work-related travel when compared to individuals working a regularly scheduled occupation in one location.
    - Unique training, levels of responsibility and authority—both clinical and leadership or managerial in nature—and specialized knowledge and treatment capabilities associated with the different occupations.
    - Beliefs they were different because of higher levels of collaboration and greater patient-centric mentalities than other groups.
- (F2). *How do members of each subcultural group perceive themselves?*
  - Caring, dedicated, hardworking, loyal, professional, knowledgeable, conscientious, and patient focused.
  - Valued and respected; some groups felt marginalized and thought themselves to be underappreciated.
  - Most felt they are team players; however, some group members felt isolated due to their physical locations within or external to the facility or the nature of their occupations.

- (F3) *How do members of each subcultural group perceive members of other subcultural groups?*
  - Generally with respect and valued; seeing them as caring, dedicated, hardworking, loyal, knowledgeable, conscientious, and patient focused professionals.
  - Overwhelmingly better valued and respected than group members perceived themselves.
  - Criticism was directed generally at leadership and management groups; negative perceptions focused on poor communication, inadequate knowledge and training needed to fulfill specific duties, and lack of accountability.
- (F4). *What common issues do members of the various subcultural groups view as barriers to improving synergy among the various subcultures?*
  - Poor communication.
  - Deficient understanding of the duties undertaken by the various groups within the healthcare facilities including the cultural differences and similarities, which are at the center of the various groups.
  - Perceived lack of accountability within the leadership and management structures.
  - Perceived lack of leadership and management knowledge and training necessary to build patient-centric and cross-functional collaboration.
  - A lacking environment of trust where everyone feels valued and respected.
- (F5) *The CF Surgeon General's senior leadership team was presented with several recommendations:*
  - Review leadership and management training for senior leadership and managers. The training should include the importance of understanding organization-wide accountability, transparency, and ensure all leaders and managers have the requisite knowledge and skills needed to fulfill their duties. The end state is to provide leaders and managers with the tools they require in advance of undertaking their responsibilities rather than acquiring them over time through on-the-job experience. Training should include:
    - exploration of various leadership and management models that have equal application in both civilian and military realms. Leaders should also receive training on mission analysis and how to conduct visioning exercises at the unit level. Engaging all stakeholders in defining local mission, vision, and values to support the organizational mission is critical if leaders desire stakeholder support, aspire to create sustainable collaboration, and wish to increase synergy across the organization. This knowledge combined with a strong comprehension of various leadership paradigms will assist leaders in working with the various groups more effectively based upon a common understanding of the values and considerations shared by all groups.
    - knowledge in change management including how to create and sustain change through stakeholder involvement.

- labor-management training to ensure all leaders and managers understand their duties, responsibilities and organizational expectations when addressing labor-management issues.
- effective communications with a view to ensuring leaders and managers can communicate effectively and with confidence across all areas of their responsibilities. Training should include strategies to empower members of the healthcare team and create environments of trust where everyone feels valued and respected.
- Provide guidance for and encourage creation of cross-experiential opportunities within the healthcare facilities. The intent should be to create or increase team building opportunities among sub-cultural group members with facilities and enable cross-exposure of all personnel to the occupations and duties within the various departments.
- Develop and institute a formal mentorship program for leaders and managers, which will enable those individuals assuming new duties to have access to others with previous knowledge and experience in the specific areas of interest.
- Develop and implement a top-down communication strategy that will ensure timely communication down and across all levels of the organization with a focus on developing and sustaining institutional credibility.

## Appendix C: Focus Group 1 (Ottawa) Responses

### Q1. Based upon your experience as health leaders and managers in the broader health system, how would you define *organizational culture* and *subculture*?

Response:

#### **Culture:**

- Group based
- Shared/common behaviour norms, values, beliefs
- Primary alignment/direction
- Leaders, at least in part, define culture (e.g. norms); however, as an organization matures, the power dynamic becomes more greatly influenced by others within and across the organization (unspoken culture)
- Key for cultural stability in health care is centred on the mission (e.g. patient centric, role of the organization)
- Cultures from previously same origins become differentiated over time and might not be evident to those both within and external to the divergent organization until faced with adversity; cultural differences become evident during times of distress/challenge; how people deal with adversity becomes part of the new emerging culture. It is also how success is “celebrated”
- Culture will vary by location
- Environment dependent
  - Authoritarian ORs/field hospitals
    - Emergency generated
  - Vary across health sectors (contexts) and not just within facilities (e.g. inner city v. homecare RNs in same organization)
  - Scope dependent upon location
  - Politics driven
  - Who/where you serve
  - Impacted by locally unique circumstances (e.g. a medical facility in a small town where many of the staff members’ relatives are their patients)
  - Transient employees
  - Age/gender differences in workforce influence cultural changes over time (e.g. aging population of worker will influence the culture as they age and their personal norms, values, and beliefs change)
  - Employee selection and makeup influence cultural development
  - Retention of skilled./culturally oriented individuals
- Where you work and the type of job you do heavily influences the culture (e.g. ER requires an authoritarian structure v. public health, which might require a more collaborative approach). Consistent with military. The nature of and the extent that multidisciplinary teams are used will also influence culture.

- Both formal and informal groups affect/influence culture (e.g. informal communications crossing subcultural groups can directly and indirectly influence cultural development and stability)
- Can be substantially influenced by “small p” politics
- More difficult today to have a single organizational culture due to the various diversities within the workplace (ethnicity, globalization, social cultural diversity)
- Military and the broader health systems face similar challenges
  - Stable aging public servants
  - Overall cultural impact of an aging population both within health care and within society
  - Transient younger employees
- Important to note it is not possible to truly compare military healthcare culture to the broader health system culture because there is no single such culture within the broader health system; there are many different healthcare cultures due to the very diversity of health care. The comparison therefore is to look at each as a part of the many and varying cultural traits that make up healthcare cultures including the military and examine the similarities and differences.

**Subculture:**

- Demographic differences (organization and people)
- Heterogeneous needs, views, and beliefs
- Defined by adversity (i.e. resilience)
  - more common today
  - show up during times of distress and challenge
  - allows for diversity
  - also influence by informal groups and cross subgroup communications
- Dependent on role/task (e.g. pharmacists and clerical workers will approach tasks differently and will work to differentiate subcultures)
- Share common vision, values, norms, and beliefs that bind them to the larger culture but might also be substantially different and unique based upon factors such as roles, tasks, and scope.

**Q2. Members of the various subcultural groups within the CF H Svcs Cs had specific self-perceptions (F2). Based upon your own experiences as health leaders and managers in the broader health system, do you feel these perceptions are consistent with the perceptions shared by groups in the broader health system? Why or why not?**

Response:

- Findings identified in the military system are consistent within the broader health system because they share many of the same background and experiences. The findings are therefore generalizable and transferable.
- Additional discussion points:
  - Culture dependent/driven by situation (e.g. emergency situations demand authoritarian/hierarchical structure; however, although but non-emergent situations

within the same environment might function better in a more collaboration, teamwork, and respectful discussions, some group members might not be comfortable/willing/able to move away from the hierarchal model. LEAN was shown to be a successful method to overcome such change resistance

**Q3. Members of the various subcultural groups within the CF H Svcs Cs had specific perceptions of members from other subcultural groups (F3). Based upon your own experiences as health leaders and managers in the broader health system, do you feel these perceptions are consistent with the perceptions shared by groups in the broader health system? Why or why not?**

Response:

- Findings identified in the military system are consistent within the broader health system because they share many of the same background and experiences. The findings are therefore generalizable and transferable.
- Additional discussion points:
  - Disagree with “Perceived lack of accountability within the leadership and management structures”. There is more accountability in the broader health system due to Board structure to prevent this perception.

**Q4. Members of the various CF H Svcs Cs’ subcultural groups identified several common issues as barriers to improving synergy among the various subcultures (F4). Based upon your own experiences as health leaders and managers in the broader health system, do you feel these issues are consistent with groups in the broader health system? Why or why not?**

Response:

- Findings identified in the military system are consistent within the broader health system because they share many of the same experiences and challenges. The findings are therefore generalizable and transferable.
- Additional discussion points:
  - Specially trained clinicians are good at what they do but may be challenged in other contexts
  - Mentorship programs are important and worthwhile
  - Communication problems are the same; however, the problems span across organizations in the broader health system (e.g. hospitals, outpatient services, homecare, front line services “in the field”) and client groups (e.g. children, the frail, and the vulnerable)
  - Clarified that poor communication should be divided into poor and ineffective v. only poor; a poor communication strategy (not relevant; not truly understood) v. ineffective communication strategy are two things and both need to be addressed
  - Need good and effective communication strategy
  - People hear what they want to hear; therefore, communications need to be targeted



**Q5. The CF Surgeon General’s senior leadership team was presented with several recommendations (F5). Do you feel these findings are equally applicable to health leaders and managers in the broader health system? If yes, to what extent are these lessons learned generalizable to the broader health system?**

Response:

- Recommendations identified in the military system are consistent within the broader health system and therefore generalizable and transferable.
- Additional discussion points:
  - Recommendations are very general and need to be adapted to local organization and needs
  - Tough to get mission known by all
  - Danger of not making choices when there is collaboration on defining vision and values. Too many values are not realistic and reflect back on the culture of the organization.
  - Background/training/education needs to match role. This is especially critical when removing valuable clinicians from clinical roles and placing them in leadership or management roles without adequate training and preparation; understand and accept that management has a specific body of knowledge and learning
  - Consider how we provide satisfaction to clinicians while they transition from one knowledge and skill set area to another
  - Training, education, and preparation must be part of succession planning; takes years to prepare senior leaders and managers
  - Succession must be based on organizational structure:
    - How promotion occurs
      - May be based on factors not relevant to new positions in leadership

**Q6. To what extent do the findings of your discussions align with the findings and recommendations as presented from the CF H Svcs Cs (F1)?**

Response:

- Findings and recommendations identified in the military system are consistent within the broader health system. The findings and recommendations are therefore generalizable and transferable.
- Military findings addressed the need for “a top-down communication strategy”; the broader health system needs two-way including bottom up (e.g. ombudsman). Discussion clarified both organizations recognize the need for two-way communication
- Informal networks must be taken into account (e.g. word of mouth mail delivery)
- It is critical that leaders and managers understand their culture and how cultural dynamics work if they are to be successful; they need to understand their employees’ needs; they need to know how to influence and leverage the existing cultural and subcultural networks

**Q7. Do you have any additional comments you would like to include as part of these discussions?**

Response:

- Interesting project in an understudied area
- Very complex understanding the subcultures
- Discussed potential for response bias and lack of knowledge in subject areas by respondents to provide informed answers. Discussions clarified these concerns were recognized in the original study
- Very applicable and very relevant to general health care

## Appendix D: Focus Group 2 (Vancouver) Responses

**Q1. Based upon your experience as health leaders and managers in the broader health system, how would you define *organizational culture* and *subculture*?**

Response:

**Culture:**

- Culture has many levels and can be stronger/more pronounced in one area while less visible in others (see it in units); can be great and small.
- Values, behaviours, attitudes, norms that develop over time.
- Strong affiliation to physical buildings/departments (e.g. despite rebranding due to regionalization, people still refer to the facility where they work; work in particular unit).
- Can be effected by organizational change (e.g. regionalization has undermined the traditional culture associated with facilities...“owned a piece of the rock”).
- Some cultures (and subcultures) might be in constant change while others may be very stable:
  - Very complex and diverse bureaucracies in constant flux (constantly defining and redefining who/what they are); heavily influenced by political whim. At odds due to conflict between traditional professional norms (physician-led, safety based, bureaucratically rooted) and rapid change.
  - Isolated subcultures (“living in a bubble/closed-door units”) with no external influences or reason to change remain enduring; professional change (research-based advances in practice/improving care) will occur but team dynamic will remain enduring.
  - Some will actively resist change.
- Different cultures within locations dimensions, over time, interact with each other; should be considered longitudinal but affected over time.
- Shift from macro levels (can be aligned by attitudes or professions).
- Can have multiple cultures/subcultures within an organization.
- Shared vision, values, mission and goals (e.g. Providence Health Care is religious based and has a substantially different culture that non-religious based healthcare organizations).
- Can also be strongly influenced/build commonality through shared experiences and not just clinical outcomes (i.e. how does someone feels after going through a clinical/supportive process).
- Can be heavily influenced by larger organizational cultural norms (e.g. military culture, physician authority within the system) or other commonalities such as work ethics, level of professionalism that are considered organizational cornerstones.
- Culture can change over time.

- Be identified by physical location.
- Patient-centred models affect organization.
- Pre-existing values of the culture help define it (e.g. for military).
- Culture of the staff affects both culture and subcultures.
- Diversity (e.g. ethnicity) affects both culture and subcultures.

### **Subculture:**

- Can develop at different levels and with different dimensions within the primary culture (differences within/across health authorities, facilities/working environments such as hospital v. public health v. community support v. extended care v. multi-disciplinary teams).
- Aligned along clinical pathways, recognized/established formed groups without linkages to our defined groups (nurses v. housekeeping staff v. food services) and established functional/professional/reporting relationships (e.g. nurses following doctors' orders).
- As in the larger culture, local values, norms, beliefs, practices such as work ethics, level of professionalism, looking to the future v. looking to the past, can differentiate subcultures.
- Can change over time and due to people joining/leaving the subgroup.
- Influenced by ethnicity, education and training, profession, personal background and experiences.
- Can have multiple subcultures within the same primary culture or cultures.

**Q2. Members of the various subcultural groups within the CF H Svcs Cs had specific self-perceptions (F2). Based upon your own experiences as health leaders and managers in the broader health system, do you feel these perceptions are consistent with the perceptions shared by groups in the broader health system? Why or why not?**

Response:

- Findings identified in the military system are consistent within the broader health system because they share many of the same background and experiences. The findings are therefore generalizable and transferable.
- Additional discussion points:
  - In the broader health system, “lack of respect” (feeling undervalued) most noticeable in clerks and housekeeping staff; [with clarification] consistent with military findings for clerks. Housekeeping staff for CF medical facilities are external resources with no connected identity. No direct comparison for Medical Technicians but similar perceived lack of respect for orderlies (recognized they are different occupations but share a similar feeling of being undervalued).

- New study released—lower self-worth in non-professional trades (e.g. housekeeping, food services) because the broader health system does not invest in education or professional development within non-professional groups.
- Consistent with the broader health system: (military finding) those with 10 or more years within the culture continued to emulate the culture even when their roles changed (e.g. retired military doctor returns as contractor is consistent with similar broader health system scenarios).
- Acknowledged acculturation/enculturation considerations were outside of the research scope...future research.
- Findings consistent across both domains.

**Q3. Members of the various subcultural groups within the CF H Svcs Cs had specific perceptions of members from other subcultural groups (F3). Based upon your own experiences as health leaders and managers in the broader health system, do you feel these perceptions are consistent with the perceptions shared by groups in the broader health system? Why or why not?**

Response:

- Findings identified in the military system are consistent within the broader health system because they share many of the same background and experiences. The findings are therefore generalizable and transferable.
- Additional discussion points:
  - Consistent across both health systems where they share same/similar professional groups/services and similar physical type locations (e.g. same for professions inside a medical facility but not able to compare against dissimilar groups such as public health, special services groups, extended care, etc.).
  - Certain groups may not have defined labels and this can affect respect/being valued.
  - Consistent across both domains with commonality especially similar across admin groups (feeling undervalued).
  - Do not agree with Ottawa focus group: a governance board prevents similarity with CF finding on accountability; believe the Ottawa experience is Ottawa centric (highly sensitized political environment). Do not believe most people understand how the Board or Ministry of Health work including concepts of the accountability model. Vancouver group agrees perception of lack of accountability consistent with the military finding.
  - Agree there is lack of consistency in perceptions...especially in government decisions or admin actions. This may be due to lack of communication, lack time, lack of interest unless it affects them directly.
  - Communication perceptions consistent with military findings but more complex in the broader health system due to 24/7 operations and larger, more complex operations.

**Q4. Members of the various CF H Svcs Cs' subcultural groups identified several common issues as barriers to improving synergy among the various subcultures (F4). Based upon your own experiences as health leaders and managers in the broader health system, do you feel these issues are consistent with groups in the broader health system? Why or why not?**

Response:

- Findings identified in the military system are consistent within the broader health system because they share many of the same experiences, barriers, and challenges. The findings are therefore generalizable and transferable.
- Additional discussion points:
  - There is a need for organizations to agree on training and the skill sets needed for jobs, and provide this prior to starting in a new position.
  - Strong need for physician leadership training.
  - Need consistency; this may be different dependent upon the organization.
  - Right training at the right time.
  - Formal mentorship programs necessary to receive and learn unique skill sets from different leaders.
  - Challenges:
    - Time required to match mentees and mentors.
    - Time to train and to keep broader views when under attack from others.
    - Skill maintenance.
  - Top down communication not as necessary in the broader health system v. military system; multi-directional communication (clarified this original research finding referred to a specific situation within the military situation—need for more regular communication and more top-down decision making from Ottawa national headquarters—but overall research recognized the need for multi-directional communication; this was consistent with the broader health system).
  - Remove the words “top down” and replace with multi-directional communication; communicate more; more visibility. This change makes recommendations consistent across both domains.

**Q5. The CF Surgeon General's senior leadership team was presented with several recommendations (F5). Do you feel these findings are equally applicable to health leaders and managers in the broader health system? If yes, to what extent are these lessons learned generalizable to the broader health system?**

Response:

- Recommendations identified in the military system are consistent within the broader health system and therefore generalizable and transferable.

- Additional discussion points:
  - Need more defined labels for the broader health system (e.g. integrity) because they are implied but not implicit.
  - Broader health system currently has hybrid cultures with more complexity due to their more diverse work environments and 24/7 operation; however, the findings remain generalizable.
  - Need more research into areas of common interest.

**Q6. To what extent do the findings of your discussions align with the findings and recommendations as presented from the CF H Svcs Cs (F1)?**

Response:

- Findings and recommendations identified in the military system are consistent within the broader health system. The findings and recommendations are therefore generalizable and transferable.

**Q7. Do you have any additional comments you would like to include as part of these discussions?**

Response:

- Worthwhile and interesting project.
- Interesting and useful discussions.
- Multiple areas remain for future research.