PROMOTING CHANGE THROUGH COLLABORATION: RESHAPING THE PROFESSIONAL BOUNDARIES OF FAMILY PHYSICIANS THROUGH THE DIVISION OF FAMILY PRACTICE

by

Vivian Wing Yan Chan

B.Sc., McGill University, 1997

M.P.P., University of Southern California, 1999

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Abstract

A collaborative framework is increasingly being used to promote change in the way health services are being provided. Collaborations have been studied mostly from a team perspective in health services research (HSR); system and institutional levels of analysis are underutilized. Applying an (neo) institutional perspective, this dissertation explored the role of interorganizational collaborative relationships in promoting practice change in family physicians. Specifically changes in the professional boundaries of family physicians were examined. The dissertation is comprised of two parts. The first study was a systematic qualitative examination of the HSR literature on the concept of professional boundary for family physicians. Fifty articles were reviewed. Conceptual distinctions used by family physicians to describe their role and their work were synthesized to form a multi-faceted notion of professional boundaries of family physicians (i.e., task-related, object-related, and relational). The second study was a case study of a new organizational form, the Division of Family Practice, in a suburban community in British Columbia. The new organizational form employed a collaborative framework to promote system and professional practice change in primary care. Findings were generated from interview texts, organizational documents, and participant observations. The study investigated how professional boundaries of family physicians are being reshaped through family physician's involvement in collaborative relationships under the Division of Family Practice. Conclusion: collaborations provide a physical as well as a social space for partners (family physicians, the health authority, the government, and the medical association) to share, challenge, and shape each other's perspectives, values, interests, and goals. The case study demonstrated the Division of Family Practice was successful at disrupting the physician institution and reshaping professional boundaries for family physicians as 1) the profession of family practice is undergoing a process of deinstitutionalization: the professional boundaries of family physicians are not as clear and distinct as they once were and have become a weakened institutional element; 2)the Division was able to disturb and reformulate the reward and sanction mechanisms for family physicians; and 3) the Division has enabled core assumptions and beliefs about family practice to be broken down and redefined.

Preface

The research has been approved by the Behavioural Research Ethics Board at the University of British Columbia. The certificate (UBC BREB) number is H10-01700.

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List of Abbreviations

BC – British Columbia

BCMA – British Columbia Medical Association

CHARD – Community Healthcare and Resource Directory

CSC – Collaborative Services Committee

DFP – Division of Family Practice

DOI – Document of intent

EMR – Electronic medical records

FHA – Fraser Health Authority

FSFPIP – Full Service Family Practice Incentive Program

GP – General practitioner or family physician

GPSC – General Practice Services Committee

HA – Health authority

HSR – Health services research

IHI – Institute of Healthcare Improvement

MOCAP – Medical On-Call Availability Program

MOHS – Ministry of Health Services

MRP – Most responsible physician

SGP – Society of General Practitioners

SSC – Specialist Services Committee

WRSS – White Rock/South Surrey

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Chapter 1 - Introduction

A collaborative framework is increasingly being used to promote change in the way health services are being provided. Health care professionals and health services agencies are being encouraged to collaborate. Most notably the Institute of Healthcare Improvement (IHI) in the United States is leading the movement to improve health care through collaborations: their programs and initiatives are designed to enable "committed individuals and organizations to innovate together, share knowledge, and collaborate on the rewarding work of improving health and health care" (Institute for Healthcare Improvement, n.d.). At the professional level, the Institute of Medicine in the United States reported the "competency to practice as part of an interdisciplinary team" as one of the five core practice competencies (Cashman, Reidy, Cody, & Lemay, 2004). The desired goals in health care collaborations are usually to create a continuum of care and to provide more efficient care.

Collaborative relationships in health care can happen at various organizational levels from organizational partnerships to interdisciplinary team-based care. Different strategies are employed as "incentives", and each will resonate differently with stakeholders (the health care providers and agencies). Service providers are motivated to collaborate because it might improve patient care – electronically-based information systems, case management, disease management, practice-based guidelines, and evidence-based medicine are strategies to coordinate care. Health services agencies (administrators) are motivated by system efficiencies resulting from collaborations; demand management, financial integration, provider contracts, and physician profiling and incentivization (e.g., pay for performance) are

positioned as system efficiencies resulting from collaborations (Suchman, Eiser, Goold, & Stewart, 1999).

Over the last decade, there has been renewed interest and effort in primary care redesign and reform in Canada. The concept of collaborations and “inter” disciplinary relationship is a dominant feature of this set of reforms (British Columbia Ministry of Health Services [BCMOHS], 2007). In 2000 the Federal, Provincial, and Territorial leaders agreed that "improvements to primary health care are crucial to the renewal of health services" and emphasized the importance of multi-disciplinary teams in the renewal process. Subsequently, the Government of Canada invested $800M in the Primary Health Care Transition Fund (PHCTF) to support large-scale primary care redesign and renewal initiatives (Watson & Wong, 2005). In British Columbia, the provincial government spent $74M on the PHCTF initiative (Health Canada, 2006). The initiative took place from April 2002 to March 2006. Activities were centred on three areas. In the area of improving health outcomes, the initiative sought collaborative approaches (i.e., service integration, multidisciplinary teams, information transfer between health authorities and care providers) to chronic disease management. Drawing from the IHI, the quality improvement collaboratives in British Columbia brought together “organizations and individual practitioners in an effort to improve care for people with a specific chronic illness” (BCMOHS, 2007).

In spite of strategic efforts by government and health care administrators in British Columbia (BC) to promote collaborative relationships in the primary care renewal process, historically engagement in these relationships by family physicians had been low. Health services

researchers have studied and reported on the difficultly to engaging family physicians in teamwork (see Hansson, Friberg, Segesten, Gedda, & Mattsson, 2008)[1]. Potential reasons for lack of engagement with (interdisciplinary) collaborative initiatives from a system level include inflexible health care professionals' regulatory and legal frameworks, misaligned financing mechanisms, and a lack of vision of what patients and providers want in a primary care system (Watson & Wong, 2005). Family physicians not engaged in these collaborative efforts would invariably be absent in the primary care renewal discussion and scheme.

This dissertation aims to bring together two research disciplines, i.e., health services and organizational theory research, to understand the phenomenon of collaboration and its implication on practice change in professionals, specifically family physicians. The goal is to contribute to theory development in three research areas: firstly in health services research, this dissertation aims to contribute to the understanding of how collaborative relationship can lead to practice change. Collaborations are a growing phenomenon in the health care sector and are actively being studied by health services researchers. Emerging trends in health services research (HSR) use qualitative approaches to understand the process of collaborative relationships and draw from an array of theoretical perspectives such as institutional (e.g., Hansson et al., 2008) and ecological (e.g., Wells & Weiner, 2007). I will assume an institutional perspective to delineate the interdependences between organizational, social, and political contexts to actor's behaviour. Participants' professional identities and jurisdictional claims have been raised as potential explanatory variables to success of collaboration (Hudson, 2002; Molyneux, 2001). The connection between professional

[1] The terms Family Physicians and General Practitioners (FP/GP) are frequently used synonymously. I will use these terms interchangeably in the rest of the dissertation.

institutions (such as professional boundaries) and collaborations warrants further investigation and can potentially bring new insights to collaborative practices in health services.

The second area of contribution is to further the boundary literature. Scholars have posited different types of boundaries: Lamont and Molnar (2002) categorized boundaries as social and symbolic boundaries; Zietsma and Lawrence (2010) presented a distinction between boundaries and categories to tell apart people versus objects. However, the qualities and characteristics of boundaries have not been fully explored. Through unpacking the concept of professional boundaries of family physicians, the goal is to inspire new ideas and theoretical development.

The third area of contribution is to advance the understanding of disruption of institution by examining the reshaping of professional boundaries. The neo-institutional literature describes types of institutional work, where actors are involved in the creation, maintenance, and disruption of institutions. Lawrence and Suddaby (2006) reviewed a series of articles on institutional work; they reported where institutional change was examined, "the emphasis is primarily on the creation and emergence of new institutions, rather than the work that is done to disrupt existing ones" (p.48). The goal of this dissertation is to be able to illustrate the process of disruption of institutions, that is, the reshaping of the professional boundaries of family physicians.

1.1. Review of Literature

1.1.1. The Concept of Collaboration in Health Services Research

Definitions of collaboration from health services research have traditionally come from nursing (Henneman, Lee, & Cohen, 1995; Kramer & Schmalenberg, 2003; Street & Blackford, 2001), have a team perspective – whether it is using terms like "teamwork", "interdisciplinary teams", or "multidisciplinary teams" (Cashman et al., 2004; Dieleman et al., 2004; Dobscha, Leibowitz, Flores, Doak, & Gerrity, 2007; Fairchild, Hogan, Smith, Portnow, & Bates, 2002; Hansson et al., 2008; Henneman et al., 1995; Kramer & Schmalenberg, 2003; Molyneux, 2001; Shaw, de Lusignan, & Rowlands, 2005; Street & Blackford, 2001), and have been studied within an intraorganizational context (Cashman et al., 2004; Kramer & Schmalenberg, 2003; Molyneux, 2001; Todahl, Linville, Smith, Barnes, & Miller, 2006).

At the basic level, a collaborative relationship in health services is seen as a relationship between health professionals in the provision of care (Xyrichis & Lowton, 2008). Usually, the relationship is described as comprising teams and resulting in teamwork. Henneman, Lee, & Cohen (1995) offered multiple descriptions and definitions of collaboration as a concept for HSR purposes. Collaborations are: "joint involvement in intellectual activities" (American Heritage Dictionary 1983, as cited in Henneman et al., 1995, p.104); "…joint communicating and decision-making process with the expressed goal of satisfying the patient's wellness and illness needs while respecting the unique qualities and abilities of each professional" (Coluccio & Maguire, 1983, as cited in Henneman et al., 1995, p.104); and "[a] cooperative venture based on shared power and authority. It is non-hierarchical in nature. It

assumes power based on a knowledge or expertise as opposed to power based on a role or function" (Kraus, 1980, as cited in Henneman et al., 1995, p.104).

Extracting from these definitions, the defining attributes of collaborative relationships are: they involve two or more people; they have voluntary participation; they imply planning and decision making amongst participants; participants perceive themselves to be involved in a joint intellectual endeavour; participants consider themselves as members of a team; and participants work towards a common goal. The common goal is the provision of patient care.

Teamwork is interdisciplinary (or multidisciplinary) in nature. It attempts to integrate care delivered by health care providers from different disciplines. However, integration is not necessarily required for collaboration to be achieved. An example is if a downstream service and an upstream service are merged (e.g., in regionalization, hospital services and community services are managed by a single entity). They are mandated to integrate vertically and provide coordinated services, but the integration is not by choice. Collaboration can lead to integration, but not necessarily vice versa. It is thus important to be clear about the motivation and incentives in the development of the relationship (e.g., voluntary versus involuntary; personal, societal, financial incentives versus political sanction). There are a number of reasons why we want to collaborate rather than just integrate. One being collaboration is considered to be a more assertive and equitable strategy in comparison with other strategies such as compromise, competition, accommodation, and avoidance (Kilmann & Thomas, 1977, as cited in Henneman et al., 1995, p.104).

There is also an element of societal incentive in the definition provided by Himmelman (2002) who described four levels of interorganizational relations where collaboration builds upon networking, coordinating, and cooperating. Comparing and contrasting the descriptions of cooperation and collaboration, collaborating stakeholders strive to achieve a common goal that is greater than the sum of the benefits for the individual stakeholders.

To *cooperate*, there must be information exchanging, alteration of activities, and sharing of resources for mutual benefit and to achieve a common purpose.

To *collaborate*, the same criteria must be met as cooperation (exchanging information, altering activities, and sharing resources), but additionally the intent is to enhance the capacity of another for mutual benefit and to achieve a common purpose.

Health systems seek collaboration and teamwork because they will result in better patient care. Better patient care, in the form of a continuum of care and more efficient care, is often what is presented as the "greater" common goal. There might be other commonalities as to why people and organizations choose to collaborate. The field of organizational science is able to offer other insights into the study of inter-professional and interorganizational relations. These concepts are gradually being integrated into the planning, studying, and undertaking of collaborations in health care.

1.1.2. Collaboration as Conceived in Organizational Science

Whereas in HSR, collaboration is often between professionals and groups (e.g., inter-professional teams) (Berendsen et al., 2006; Berendsen, Benneker, Meyboom-de Jong, Klazinga, & Schuling, 2007), the concept of collaboration in organizational science can be at a group level or an organizational level.

The field of interorganizational relations began to flourish in the 1960's. Interorganizational relations took an organizational perspective in explaining interactions and transactions with the environment. An organization's survival, success, and growth will be affected by the different types of environment in which it is embedded. One of the ways for organizations to survive is to cooperate with others (Katz & Kahn, 1966; Parsons, 1956; Selznick, 1949). Cooptation is a mechanism to avert threat to an organization's stability and existence. This perspective illustrates the interdependence between the focal organization and the environment.

The above understanding of cooperation is based on an assumption of interdependence between an organization and its environment (i.e., a "matched order" perspective). Definitions of cooperation (and collaboration) in organizational science vary based on different theoretical grounding such as economics, political science, psychology, sociology and business ethics, and structural features of the collaborative relationship (e.g., formal versus informal; horizontal versus vertical collaborative relationships; and tightly versus loosely coupled relationships).

In 1991 in the Journal of Applied Behavioural Science, a series of articles was published on collaborative alliances. Gray and Wood summarized six theoretical perspectives (Gray & Wood, 1991; Wood & Gray, 1991) that can be set in two broad categories – those that take the perspective of a focal organization looking out to external organizations and the environment; and those that consider the organization as one of the many agents within the environment. In 1995, the Academy of Management Journal also published a special issue on intra- and interorganizational cooperation. The introduction by Smith, Carroll, and Ashford (1995) define cooperative relationships as those whereby "…individuals, groups, and organizations come together, interact, and form psychological relationships for mutual gain or benefit" (p. 10). Smith et al. also provided a social constructionist definition by Ring and Van de Ven (1994), where collaborative relationships are "socially contrived mechanisms for collective action, which are continually shaped and restructured by actions and symbolic interpretations of the parties involved" (Ring & Van de Ven, 1994, p. 96).

Informal versus Formal Collaborative Relationship

A formal collaborative relationship is one that is governed by contractual obligations or some other formal structure. There are many reasons for health care providers to develop formal collaborative relationships (e.g., to integrate care delivery). In regionalization, hospital services and community services are managed by a single entity and thus integrated. Services are mandated to vertically integrate and provide coordinated services so patients can have a smooth discharge back to the community from the hospital. As mentioned earlier, the integration is not by choice. The outcome of such coordination would be vastly different than

one that was developed through voluntary motivation. In an informal collaborative relationship, the parties contribute as a result of behavioural norms rather than contractual obligations (Smith et al., 1995, p. 10), that is, voluntary and self defined relationships. It is important to be clear about the motivation and incentives in the development of the relationship.

A common form of collaborative relationship in health care delivery is the formation of interdisciplinary (or multidisciplinary) care teams (McCallin, 2001). Informal relationships (e.g., interpersonal trusts) between team members might need to develop first before their association evolves into a formal collaborative relationship (McAllister, 1995).

Horizontal versus Vertical Collaborative Relationship

The regionalization example illustrates a vertical collaborative relationship: an upstream service (the hospital) develops a formal relationship with a downstream service (community services). A horizontal collaborative relationship may form between competing organizations, teams, or co-workers. Relationships between participants in health care (organizations, teams, and providers) can be horizontal or vertical in nature.

Loosely- versus Tightly-coupled Collaborations

The collaborative relationship between organizations can be loosely-coupled or tightly-coupled. Coupling deals with the degree to which participants are linked and are interdependent (Barringer & Harrison, 2000).

For this dissertation, a collaborative relationship is a voluntary arrangement where members share resources and enhance the capacity of each other enabling benefits for each other (the other members can achieve their desired perceived benefit). The current project examines collaborative relationships between family physicians and health services agencies to promote linkages between different levels of patient care. Currently, these organizational forms are loosely-coupled; they have different funding mechanisms and operate separately.

Collaboration & Change

In health services collaboration, different service providers and agencies need to change their current way of working. Instead of providing care with their existing service parameters, collaboration is seeking change in practice, integration of services, and development of partnerships. Service providers and organizations need to exert cooperative behaviours, alter activities, and share resources with each other in order to collaborate. Collaboration and collaborative relationships are examined from an organizational change perspective for this dissertation (i.e., the interrelatedness of organizational change and collaborative relationships).

Understandings of Why Organizations Collaborate

In order to understand how collaborative relationships can lead to change in practice, one must appreciate why organizations come to collaborate in the first place. The reasons why organizations seek inter-organizational collaborative relationships can be understood through different levels of analysis and by various theoretical lenses (Barringer & Harrison, 2000; Smith et al., 1995). It is a prominent topic in organization science research around strategy, transaction costs, and resource dependence (Gulati, 1995; Ouchi, 1980; Pfeffer & Salanick, 1978; Williamson, 1981), social construction and institutionalization (e.g., Lawrence, Phillips, & Hardy, 1999; Phillips & Hardy, 2002), organizational networks (Uzzi, 1997), and organizational learning (e.g., Ingram & Baum, 1997; Reay, Casebeer, Golden-Biddle, & Hinings, 2009). Adopting Smith et al.'s (1995) categories for theories used to study inter-organizational relationships, the five perspectives why organizations collaborate are: exchange theories perspective, attraction theories perspective, power and conflict perspective, institutional theory perspective, and population/community/network perspective (i.e., organizational ecology theories).

Exchange theories perspective: "Theories of exchange may be most appropriately employed to explain the conscious and calculated reasons for parties' coming together to cooperate and continuing to engage in cooperative relationships" (Smith et al., 1995, p. 18). Exchange theories assume interdependency exists between the focal organization and its environment; organizations have limited rationality; and organizations cooperate as a result

of potential benefit exceeding the perceived cost and/or risk. Contingency theory, transaction cost theory, social psychological theories of exchange, micro and macro sociological theories of exchange, and economic theories of exchange are categorized within this section.

It is prevalent to use exchange theories to explain reasons for collaboration in health services research. A lack of financial incentive from the government (the funder/administration) to motivate change in behaviour is often cited as a barrier to redesign initiatives, for example, physicians perceive they have a large workload and insufficient financial compensation (Keating, Landon, Ayanian, Borbas, & Guadagnoli, 2004). Financial incentives are extrinsic motivators for changing physician practice (Conrad & Perry, 2009). Extrinsic motivators are effective but the effect dissipates as soon as the incentive is removed.

Attraction theories perspective somewhat overlaps with exchange theories; however, the distinction is "attraction" to collaboration is a result of noneconomic reasons such as "value or status similarities and differences, complementary needs, aspects of personality, goal congruence, and information needs" (Smith et al. 1995, p. 18). The team-based environment is perceived to promote efficient sharing of information, role recognition between team members, communication, and job satisfaction (Dieleman et al., 2004). Communication (Street & Blackford, 2001), trust between group members (Hennenman & Lee, 1995; McAllister, 1995), and physician's organizational identification (Dukerich, Golden, & Shortell, 2002) positively relate to his voluntary cooperative behaviour in his affiliated health

care system. Goal incongruence (Shaw et al., 2005) is a perceived barrier to actualizing collaborative behaviour.

Power and conflict perspective: The dynamics of collaborative relationships can also be understood from a power and conflict perspective. Tension resulting from power differences and conflicts between stakeholders can be a potential barrier to developing a well functioning inter-professional collaborative relationship (Kramer & Schmalenberg, 2003). There are two concepts of importance here: the desire of members to achieve stability and/or to reduce inequity.

There is an argument for and against collaborative relationship when one has a desire for stability. The lack of perceived control by participants of collaboration negatively impacts their involvement in collaborative relationships (Cashman et al., 2004; Fairchild et al., 2002). However, the lack of perceived control over its environment would also be a reason for an organization to collaborate according to resource dependency theory (Pfeffer & Salancik, 1978).

With respect to the concept of equity in collaborative relationships, political theory would see collaboration as a process of joint decision making between voluntary members, a temporary structure, and agreed-upon rules (Roberts & Bradley, 1991, as cited in Wood & Gray, 1991). Tension would arise if members perceived power was going to be disproportionately distributed. A major contention in primary care reform relates to health

care providers taking issue with scopes-of-practice in developing interdisciplinary care (Watson & Wong, 2005), for example, health care providers might perceive there will be a disproportionate amount of power or jurisdiction going to one discipline or there will be an unjust infringement on their professional jurisdiction.

Population/community/network perspective: This perspective is interested in predicting collaboration and cooperative behaviour with aggregated conditions of the system within which collaboration occurs (Smith et al., 1995). Co-location of services, smaller teams, occupational diversity, and organizational support in terms of recognition and reward are structural factors associated with teamworking (Xyrichis & Lowton, 2008).

Institutional theory perspective focuses on how social construction of reality shapes the way collaboration develops or not. Attitudes and behaviours towards collaboration are not just based on situational factors but are driven by cultural, historical, and social factors, for example, professional identities (Hansson et al., 2008). Physicians are highly institutionalized; their beliefs, attitudes, and behaviours are developed through their training and interactions with other health professionals and healthcare organizations (Abbott, 1988; Becker, 1977, 1961). Classical institutional theory literature posits a resistance to change rather than the ability to change for highly institutional forms (Meyer & Rowan, 1977; Zucker, 1977). Changes in practice towards collaborative care have been challenging for

groups with strong professional identities (Scott, 2001; Greenwood, Suddaby, & Hinings, 2002; Suddaby & Greenwood, 2005).

Physicians are seen to be at the top of the health care services hierarchy (e.g., patient care is initiated and terminated by the physician's order); they are the most powerful group of actors in the health care sector. Physician's professional discourse has definite implications on how health care is delivered and structured[2]. Institutional theory provides great insight into why introducing health system change (which invariably involves physicians) is so difficult.

Institutions promote stability (organizational persistence) and resistance to change. "Institutionalization occurs whenever there is a reciprocal typification of habitualized actions by types of actors" (Berger & Luckmann, 1967, p. 54). That is, actors come to see themselves as actors of type X and thus will perform actions of type X. There is a mimetic nature to action; other types of behaviours are inconceivable[3]. An institution cannot persist in its environment if it is not considered legitimate. Legitimacy enhances the continuity and the credibility of structure and action. Rather than an economic conception of legitimacy, the notion of cultural support is evoked – social fitness with the environment (Scott, 1991; Suchman, 1995)[4]. Legitimate organizations are seen to be more meaningful, more trustworthy, and more predictable (i.e., credible); their actions are recognizable and

[2] The definition of discourse here involves the social construction of reality which include a (meso) context-focus as well as grand discourses (macro concepts) (Philips & Hardy, 2002).
[3] However, the relationship between action and social structures are recursive. The structural properties of the social systems are both the medium and the outcome of the practices of actors (Giddens, 1984, p. 25).
[4] Legitimacy can be defined as "a generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions" (Suchman, 1995, p. 574) .

culturally supported. Introducing change is difficult when the existing structure and action appear desirable, proper, and appropriate.

Institutional theory assumes organizational elements such as routines, tasks, and structures are "rationalized" to serve technical purposes but they exist for social ones. Institutions are "frameworks of programs or rules establishing identities and activity scripts for such identities" (Jepperson, 1991, p. 146) such that individuals within institutions have shared stories of what practice is all about and have some functional or historical account of why the practice exists, that is, "rationalized myths". Actors develop shared meanings through a social construction of reality (Berger & Luckmann, 1967). The professionalization of physicians exemplifies institutionalization, and professional boundary plays a role in maintaining and shaping the physician institution.

The theoretical contribution to HSR is to look at how collaborative relationships affect change (or non-change) in professional practice. In particular I apply an (neo) institutional lens to examine the role of collaborative relationships in maintaining and shaping the physician institution. In this dissertation, the focus is on professional boundaries. Strategies to reengage family physicians in the redesign of primary health care in BC – for example, the primary care demonstration project (2000) and the development of new fees for shared care between GPs and specialists (2006) – generally used financial incentives to change practice behaviour. System transformation and primary care reform should look beyond strict exchange theory assumptions. Strategies should incorporate ideas from other theoretical frameworks to understand physician attitudes and behaviours towards primary care reform.

1.1.3. Professional Boundaries and Social Identification

Physician (professional) boundaries are an institutional element which enable certain activities, and limit others, for both physicians and other associated actors[5]. Abbott (1988) defines professions as exclusive occupational groups applying abstract knowledge to particular cases (p. 8). Professionals delineate the boundaries of their professional role, that is, who can be in the exclusive occupational group and who can hold the unique knowledge. According to social identity theory, self-distinctiveness is necessary to foster a stable and positive self-identity (Tajfel & Turner, 1985). In addition to the distinctiveness of a group's values and practices from other comparable groups, the prestige of the group and the presence of a salient out-group will reinforce the in-group identification (Ashforth & Mael, 1984). Thus, boundaries play an important role in maintaining self-identity because boundaries are conceptual distinctions made by social actors to categorize objects, people, practices, or time and space (Lamont & Molnar, 2002, p. 168). They help bring order and a method of classification into our social reality.

Physicians, as a class of professionals, are characterized on the basis of a number of considerations such as their training and their accreditation. The training of becoming and the practice of being a physician have many codified and formalized elements. Becoming a physician involves specified procedures such as becoming specialized in a certain type of

[5] Institutional elements provide templates and scripts for action.

medicine, passing a licensing exam, and taking the Hippocratic Oath. Furthermore, classifications of physicians can be further refined by the tasks they perform (e.g., surgery versus health promotion), the populations they treat (e.g., acute versus ambulatory patients), and by the location and time at which they provide their services. Practice is limited by formalized regulations such as a physician's scope-of-practice. Professional boundaries define who is able to provide certain services, and in this way, boundaries demarcate a physician's practices and identities.

Given physicians draw from a whole host of "conceptual distinctions" to define their practices and identities, there is scope for further deconstruction of physician (professional) boundary as a construct. Boundaries can be categorized as symbolic and social boundaries (Ferlie, Fitzgerald, Wood, & Hawkins, 2005; Lamont & Molnar, 2002). The limitation with the above distinction is that boundary definitions are difficult to operationalize and differentiate; both terms are involved in the construction of social reality and relate to objects, people, activities, and time and space. Referring to the boundary object literature (Star & Griesemer, 1989; Bowker & Star, 1999; Carlile, 2002), Zietsma and Lawrence (2010) suggest using distinct terms to distinguish between people and groups (i.e., boundaries) and to distinguish between objects (i.e., categories). Professional boundary encompasses distinctions between tasks, objects, people, and time and space. One of the theoretical contributions of this dissertation is to unpack the concept of professional boundary. I propose that professional boundary is multi-faceted and is constructed through task-related, object-related, and relational components.

The concept of multi-faceted qualities of professional boundaries is inspired from the work done by Jepperson (1991) and Scott (2001) on institutional carriers. As with other institutional elements, professional boundaries have various repositories and carriers that represent different forms of rules and controls. Jepperson (1991) delimited three types of carriers of institutionalization: formal organization, regimes, and culture (p.150). *Formal organization* defines a structural form. *Regimes* have some central authority system to monitor and sanction explicitly codified rules; however, regimes are not necessarily structural (e.g., professions, constitutional system). *Cultural* carriers are rules, procedures and goals that are not within the "formal organization" and are not enforced by a "central" authority. Cultural rules are customary and conventional in character. Scott (2001) re-conceptualized carriers as symbolic systems, relational systems, routines, and artifacts (p.77-83). *Symbolic systems* are widely held beliefs by groups/collectives or individuals (e.g., laws, values, typifications, and schemas). *Relational systems* are based on patterned expectations according to social positions and power differentials (e.g., regimes such as professions, governance systems, and social identities). *Routines* can be described as patterned actions, deeply ingrained habits, procedures, or "habitualized" behaviours and routines (e.g., protocols, roles, scripts). A routine is "an established or prescribed way of doing something; a more or less mechanical or unvarying way of performing certain actions or duties" (Oxford English Dictionary, n.d.). Feldman and Pentland's (2003) definition for organizational routine noted the shared understanding of routine in their definition, where a routine is a "repetitive, recognizable pattern of interdependent actions, *involving multiple actors*" (emphasis added). Whether it is a formal procedure is not an essential consideration of the core definition. *Artifacts* are objects that possess symbolic values or represent some

conventions or standards. Cultural-cognitive institutional elements reflect the tacit knowledge of actors, based on "inarticulated knowledge and beliefs" (Scott, 2001, p. 80)[6].

By explicitly examining professional boundaries as multi-faceted, I acknowledge different carriers codify and form the "boundary" concept. I classified professional boundaries as task-related, object-related, and relational because they inform the daily activities of professionals. *The theoretical contribution in the boundary literature is to inspire new ideas in how boundaries are conceived and studied.*

Professional boundaries have the ability to organize professional identity – identification to the physician occupational group can be consistently brought about using the three forms of boundaries (tasks-related, object-related, and relational). What it means to be a professional is to have exclusivity over some abstract knowledge, to be an expert. The access to that knowledge differentiates one professional group from another competing group (Abbott, 1988). Boundaries demarcate a professional sphere of jurisdiction and assist physicians in maintaining professional autonomy, which subsequently contributes to professional identity (Hotho, 2009).

[6] The degree of institutionalization depends on the degree of explicit codification and formalization, the length of the history of the structure/task, and the degree of embeddedness in a network of structures/tasks (Zucker, 1987, p. 456). The extent of the taken-for-grantedness of an institutional element will depend on the degree of institutionalization. Fewer alternatives are available to organizational members in a highly institutionalized environment; the rationale for action is deemed to be exogenous (e.g., "according to the guideline, this is the way the task is suppose to be performed").

But, why does identification matter? Identification is important because professional identity affects professionals' attitudes as well as enables and limits their behaviours (Ashforth, Harrison, & Corley, 2008). Increased social identification increases ingroup cohesion, prompts cooperation with ingroup members (and increased competition with outgroup), and encourages organizational citizenship behaviour[7] (Dutton, Dukerich, & Harquail, 1994, p. 255). While Dutton et al. (1994) posit social identification to have positive organizational effects between members within the same group (i.e., within the profession), it can also lead to negative organizational effects when members remain insular and resistive to change. Organizational persistence is especially prevalent in highly institutionalized forms like physicians – the degree of institutionalization depends on the degree of explicit codification/formalization, the length of history of the structure or task, and the degree of embeddedness in a network of other tasks (Zucker, 1987, p. 456). Professionals such as physicians are highly institutionalized because their work has a long history, is formalized, and is tightly coupled in the network of health care delivery (Abbott, 1988; Becker, 1977; 1961; Freidson, 1970). The professionalization of physicians enables certain actions and limits others, and it is reinforced by professional identities and professional boundaries.

Professionalization limits a physician's ability to break loose from the current interpretative orientation/scheme and to replace an existing institutional mold with an alternative template (Greenwood & Hinings, 1996). Taking the classical institutional perspective, physicians should be resilient to radical change (DiMaggio & Powell, 1983; Meyer & Rowan, 1977). Although the majority of the time physicians remain impermeable to radical change, the

[7] Organizational citizenship behaviour is the organizationally functional behaviour that extends beyond role requirements and is not contractually guaranteed.

physician profession does change radically from time to time (e.g., Hotho, 2009). Scholars have been theorizing about institutional mechanisms that lead to changes that are beyond isomorphic changes (e.g., Greenwood et al., 2002; Oliver 1991, 1992). Neo-institutional theories propose drivers of radical change to involve micro-processes of institutionalization and the role of agency.

1.1.4. Institutional Change - Shift in Professional Boundaries

Endogenous and Exogenous Variables Have Been Shown to Introduce Radical Change

Neo-institutionalism supports the idea that stability and change are dynamically related (Zietsma & Lawrence, 2010). Theories introduce mechanisms that generate radical change such as the concepts of deinstitutionalization and reinstitutionalization. To be able to draw from an alternative template, the new institutional element must become legitimate and there is an erosion of the old institutional element (Hinings & Greenwood 1988; Oliver, 1992). Deinstitutionalization comes about either by exogenous or endogenous forces (Zucker, 1987; Oliver, 1992).

Exogenous factors might result in a weakening of existing institutions or deinstitutionalization. Health care services are evolving to adopt a more corporate-management discourse (Scott, 2000). As the corporate-management discourse permeates the health care sector, the physician institution is increasingly being challenged and taken less for granted. As a result, we might be able to observe strategic actions to challenge the institutional environment by physicians and other institutional actors.

Endogenous conditions for radical change involve the role of agency in institutions (Dacin, Goodstein, & Scott, 2002; DiMaggio & Powell, 1991). Agency is the ability to intervene or to influence a process or the state of affairs (Giddens, 1984). Oliver (1991, 1992) criticized classical institutional theory for assuming actors are overly passive and conforming. In instances where organizations and organizational agents are exposed to various competing pressures (e.g., social, political, and functional), organizations and organizational agents are able to respond strategically to competing pressures and generate alternative responses[8]. Institutional entrepreneurs – actors who can mobilize resources and have the power to legitimate institutions (DiMaggio, 1988, p. 14-15) – can promote institutional change to align with their interests and worldviews.

Another perspective of the role of agency in institutions is the importance of inter-subjectivity, social interaction, and communication as components of agentic processes (Emirbayer & Mische, 1998, p. 973). Weick (1995) noted that culture, norms, and ideologies are imperfectly transmitted during socialization and re-socialization so the meanings within a group are not perfectly identical (as cited in Karnøe, 1997, p. 425). Sensemaking is a continuous process because of a "chronic slippage between cognitive maps and the phenomena to which they refer" (Karnøe, 1997, p. 426). Words and languages are imprecise, for example, discrete labels are used for subject matters that are continuous. The social context that actors are embedded in can affect meaning. Individuals use experience (i.e., historical and social context) to interpret and make sense of ongoing circumstances and

[8] Oliver (1992) introduced concepts of power and agent's need for stability and control from resource dependency theory (Pfeffer & Salancik, 1978).

situations to decide on appropriate actions. They must apply the right context so interpretation and social action can be seen as appropriate. Variations in interpretation and power differentials within groups weaken existing institutions and create an opportunity for new/alternative institutional templates to develop (Zilber, 2002).

Interpretative variations stem from an actor's ability to be reflective – what Giddens (1984) refers to as the knowledgability of actors – and the dynamics between institutional members. As health care environment is increasingly based on managerial ideology; physicians are redrawing interpretative schemes to expand professional jurisdiction to make sense of such change (Hotho, 2009). Hotho's (2009) study describes physicians' attempts to redefine the social structure of the physician profession that enables and limits their actions as a response to change in the organizational field. The redefining of professional boundaries is for self-identity and self-enhancement purposes and helps to reassert that physicians are at the top of the health care hierarchy. This illustrates that organizational participants do not always conform to conventional patterns, but respond variably, sometimes creating new ways of acting and organizing (Scott, 2001, p. 77). Physicians' actions highlight both practical evaluation and projective agency (Emirbayer & Mische, 1998). According to Emirbayer and Mische (1998), actors are reflective and will attempt to reconfigure "received schemas" and generate "alternative possible responses" to problematic situations in their lives (p. 984), and they will also make more deliberate judgments in response to the emerging demands, dilemmas, and ambiguities of presently evolving situations (p. 971).

Radical organizational change involves modifying interpretive orientation and drawing upon alternative institutional templates. Greenwood and Hinings (1996) referred to the internal dynamics as an endogenous condition for change[9]. Reproduction and persistence of institutions does not just inexplicably happen, that is, actors take part in creating and maintaining the routines; same goes for the disruption of institutions. The notions of agency, interests, and sensemaking are central to explicate the origins, reproduction, and erosion of institutional practices and organizational form. The creation, maintenance, and disruption of institutions have been theorized to be "institutional work" (Lawrence & Suddaby, 2006)[10].

The redefinition of jurisdictional boundary and organizational domain can only occur if there is a disruption of the extant institution. Institutional work will involve actions to reconfigure actors' belief systems and to alter abstract categorizations of boundaries and meaning systems (Lawrence & Suddaby, 2006). Changes in meaning and belief systems have to occur with actors who are involved initially in the transformation and subsequent actors who are taking up the new practice.

The theoretical contribution to the area of institutional work is to illustrate the disruption of professional boundaries. I offer the emergence of collaborative relationships in the case study of the Division of Family Practice in White Rock/South Surrey as an example of introducing change in family physicians' practice. The inter-subjectivity of the actors and the social interaction and communication features of the collaborative relationships will be

[9] They focused on interests, values, power dependencies, and capacity for action, but actor's interpretation and meaning making are also involved in the internal dynamics.

[10] In parallel, the boundary literature introduced the concept "boundary-work" to describe the discursive practice used to draw a symbolic boundary between focal participants and others (Gieryn, 1983).

highlighted. For family physicians that engaged in such collaborative relationships, they underwent redefinition of their existing institutional templates. The nature of collaborations required physicians to be open to changing their practice jurisdiction and way of working (i.e., their professional boundaries). "Redefining" their existing interpretative schemes is part of the disrupting process of institutionalization (Hinings & Greenwood, 1988; Lawrence & Suddaby, 2006).

1.2. Research Questions

I. How do interorganizational collaborative relationships enable family physicians to redefine their professional boundaries?

II. What is the role of professional boundaries in practice change for family physicians?

1.3 Research Design

In this dissertation, I investigated the concepts of professional boundaries by examining the texts that help shape the social production of these concepts (Phillips & Hardy, 2002). Institutionalization does not simply arise out of a pattern of action; institutions are constituted through discourse (Phillips, Lawrence, & Hardy, 2004, p. 635). Institutionalization via historical, cultural, political, and social factors can be carried on via

texts (as a social practice). Changes in institutionalization can also be seen in texts. There are two parts to the dissertation. The first section involved a systematic qualitative examination of the health services research literature on the concept of professional boundary. The second part is a case study of a collaborative initiative involving family physicians in a community in BC.

Part 1 of the dissertation involved understanding the construction of GP professional boundaries (i.e., professional boundaries of family physicians) within the context of the health care sector. The professional discourse in health care permits family physicians to be autonomous and maintain a high-status amongst other health care providers (Abbott, 1988). I was interested in the kind of discursive devices family physicians used to create professional boundaries in their work. I drew from the HSR literature to access the talk and text of actors (family physicians, health services providers, administrators, and researchers) making conceptual distinctions about the role of family physician and their work. A systematic qualitative examination on the HSR literature was completed. I concentrated on issues of resistance to change by family physicians and how concepts were used as facilitators or barriers to change within primary care. My analysis was grounded on the boundary and institutional literature as outlined in the previous section. Themes about professional boundaries as a key institutional element that enable/limit physician practice and the institutional work done on professional boundaries were summarized. The findings are presented in Chapter 2.

Part 2 of the dissertation is the case study of the Division of Family Practice in the White Rock/South Surrey community in the province of British Columbia. The aim of the case study is to explore the ability of inter-organizational collaborations to facilitate change in professional boundaries drawing on an (neo) institutional theory perspective. The case study is not meant to be an evaluation of the inter-organizational collaborative or a descriptive case study of the Division of Family Practice from a traditional HSR perspective.

I first reviewed the macro-system context around primary care change for family physicians in that community. Through an analysis of historical documents, interview data, and participant observation data, I examined the historical relationships between family physicians and health services agencies and concerning issues related to change and resistant to change by family physicians in BC; findings from HSR literature (Part 1) supplemented this part of the analysis. The purpose was to gain a better grasp of the historical, cultural, political, and social context of introducing primary care change with family physicians in the White Rock/South Surrey community leading up to the development of the Divisions of Family Practice. The case study went on to address how GP professional boundaries are being reshaped through family physician's involvement in collaborative relationships. Findings were generated from interview texts from study participants, texts from organizational documents, and fieldnotes and memos from participant observations. Through a thematic analysis (Braun & Clarke, 2006; Miles & Huberman, 1994), I compared understandings of the collaborative relationship and perceptions of GP professional boundaries. The case study is presented in Chapter 3 of the dissertation.

Formularized notions of professional boundaries were examined through selected HSR studies, contractual, organizational, and governmental documents associated with the Division of Family Practice, interview texts, and other relevant documents. The project assumed a multi-dimensional definition of professional boundaries, that is, task-related, object-related, and relational boundaries. In the conclusion (Chapter 4), I offered up how interorganizational collaborative relationships (the involvement with the Division of Family Practice) affect the reformulation of GP professional boundaries and offered up new ideas on the concept of professional boundary and its role in practice change.

Chapter 2 - Qualitative Examination of GP Professional Boundary

In this chapter, the construction of professional boundaries of family physicians (i.e., GP professional boundaries) and boundary work were examined through a systematic qualitative review of the HSR literature[11]. Grounded by the boundary and the institutional literature, I propose that professional boundaries are constructed through task-related, object-related, and relational components. These tasks, objects, and relationships help shape GP professional boundaries and are institutional carriers that organize the actions of family physicians. As mentioned in the introduction chapter, the three modes of professional boundary are inspired by the literature on institutional carriers. Together they form a more comprehensive picture of the professional boundary concept.

For *task-related boundaries*, actors are making distinctions based on routines, procedures, and "patterned actions" (Scott, 2001). Actors use task-related boundaries to define "what I do" and "what I do not do". An example of task-related boundaries for physicians would be the types of procedures they deem as within their "scope-of-practice"; an orthopaedic surgeon is trained to perform surgery related to joints but not related to internal organs. Once the orthopaedic surgeon fixed the joint (post-operation), the patient is discharged from his care. Physiotherapists are responsible for the rehabilitation of the joint and internal medicine physicians are responsible for taking care of post-operative complications.

Object-related boundaries relate to what actors perceive to have ownership over and the degree of control actors perceive to have over objects and artefacts (i.e., "what do I own" and

[11] The pluralize form of boundary is used because I assume there is variation in the social construction of professional boundary (i.e., multiple realities exist).

"what do I have control over"). Objects can be conceptual or physical in nature. The physician profession is highly autonomous (Freidson, 1970). Physicians have control over access, training, credentialing, and evaluation of technical performance, and they are free from control by others, at least with regards to the technical component of their work. An object-related boundary that is associated with a physical object would be the distinction made by physicians with respect to their office. It is run as a private practice and is a distinct organizational entity apart from hospitals and other private practices.

Relational boundaries are distinctions made around social relationships – "with whom do I associate with" and "what is the nature of the relationship". Classifications based on social relationships will create positional distinctions and power differentials amongst social actors, and values and beliefs based on social groupings. The most evident relational distinction with respect to physicians is their relationships with other health care providers. Physicians remain the principal driver of patient medical care. Amongst physicians, there is a social perception that certain physician specialties are more distinguished and this has implications on their attitudes and behaviour towards each other. Although there is a high level of respect and cooperation between family physicians and specialists, Marshall (1999) found the two branches of professionals disagree about financial parity and who can order diagnostic procedures. However, relational boundaries are increasingly being challenged, for example. the nature of doctor-patient relationships is shifting from physician-led to patient-focused; physicians are being asked to be part of team-based approach to patient care (e.g., Dieleman et al., 2004; Dobscha et al., 2007; Shaw et al., 2005).

Task-related, object-related, and relational boundaries are interrelated – tasks are assigned to specific professionals (physicians can assess patients and prescribe care), and positional distinctions result from task-related classifications (nurses follow physician orders). The first half of the analysis illustrates how these three modes of boundaries form the concept of professional boundaries for family physicians.

Next, I explored the idea of boundary work by family physicians. Similar to the institutional literature, the role of agency is introduced in the boundary literature through the concept of "boundary work" which describes the discursive practice used to draw a symbolic boundary between focal participants and others (Gieryn, 1983). Institutional work and boundary work both involve actors creating, maintaining, or disrupting something that is socially-constructed. The boundary literature also features the use of discursive devices, for example, individuals and/or groups utilizing rhetorical devices such as metaphor, hyperbole, irony, sarcasm, and syntactical devices. There are three genres of boundary-work: expulsion, expansion, and protection of autonomy (Lamont & Molnar, 2002), and they roughly map to the work to create, to maintain, and to defend boundaries. Expulsion refers to contests between rival authorities when each claims to be legitimate; transgression of the symbolic boundaries of legitimacy is sanctioned. Expansion is when rival epistemic authorities try to monopolize jurisdictional control over a disputed ontological domain. Protection describes action to protect against encroachment or exploitation by outside powers. For the purpose of this project, I assume professional boundaries are a form of institutional element thus I used the term "boundary work" to mean actions to create, to maintain, or to disrupt the institutional element of GP professional boundaries.

The analysis of boundary work involved applying a neo-institutional lens to examine the concepts used in the HSR literature to explain resistance to change by family physicians. Actions and actors are conceived as enforcing or disrupting boundaries. The act of enforcement is the work to protect/maintain boundaries, and the act of disruption is the work to expand/contest boundaries. In order to reflect the micro-processes of institutionalization and deinstitutionalization, it was important to illustrate how actors are involved in maintaining and shaping boundaries (Dacin, Goodstein, & Scott, 2002; Greenwood & Hinings, 1996; Powell & DiMaggio, 1991).

2.1. Methodology

The intent of the analysis is two-fold: 1) to consider the construction of GP professional boundaries as multi-dimensional, and 2) to examine the subject of resistance/acceptance to change by family physicians as boundary work. I was interested in how meso and grand discourses shape and are shaped by social objects and ideas in an organizational setting (Phillips & Hardy, 2002). Pertaining to this dissertation, attention is on the professional discourse of family physicians. The qualitative examination involved discovering the discursive devices used in shaping the family physician's professional role and work. I systematically sampled from the HSR literature because I wanted to access the talk and text employed in forming the conceptual distinctions of the role and work of a family physician. Actors involved in the social construction of GP professional boundaries goes beyond family

physicians and include patients, physician specialists, and health services providers, administrators, and researchers.

The process of selecting relevant journal articles involved consulting with librarians who specialize in health services research. I tested numerous search terms (MESH subject headings) such as *physician's practice pattern*, *"Diffusion of Innovation"*, *family physician*, *physician boundary*, and *attitude of health personnel* to determine what terms would provide the most relevant results. Through an iterative process, the following search terms provided the most fruitful articles: "*Physician, family* AND *Attitude of health personnel* AND *Physician's role"*. The purpose was to access the text and talk by actors about (i.e., claims about) who are family physicians and what makes them family physicians.

Literature searches were conducted in the month of September 2010 on OVID Medline, Psych INFO, and EBSCO. Searches conducted on Psych INFO and EBSCO did not generate a significant number of articles of relevance and thus were excluded. Two hundred and thirty articles were retrieved from the OVID Medline database (n=230) [12].

The focus of the analysis was to elucidate the construction of GP professional boundaries; thus, I excluded articles that were specifically reporting descriptive statistics on practice pattern, studies with survey results mostly focused on demographics, studies that were too

[12] Using the same search strategy, the literature search was updated in July 2012. Sixteen new articles were found (published since September 2010). Eleven articles were kept for further review based on the abstract of the articles. Of the eleven articles, three articles were excluded because the content was not close enough to the research topic upon detailed examination; two articles were excluded because they were already in the previous review. The remaining five articles were supportive of the dissertation findings (no new or different findings) and thus were excluded in the data analysis.

clinically focused (i.e., focused on a specific clinical decision), and studies where family physicians were not the primary focus. Sixty seven articles were selected for further analysis (n=67).

I read each of the 67 articles and further filtered out articles that were not appropriate for the analysis. A further 17 articles were excluded because the quality of the study or the content was not close enough to the research topic upon detailed examination. Fifty articles remained in the review (n=50) (Appendix A). Using the Atlas.ti 6.2 program, I coded each article for passages that described family physicians' conceptions of self and their experiences with existing and new work roles, arrangements, and interventions. Through an iterative process, codes were refined and themes were developed as I reread the articles and reviewed the list of codes (Miles & Huberman, 1994). I examined how themes aligned with concepts from the boundary's literature (Gieryn, 1983; Lamont & Molnar, 2002; Star & Griesemer, 1989). I teased out concepts of GP professional boundaries based on claims about who are family physicians, what makes them family physicians, and what makes them distinct as a medical professional. Texts from the literature were used to illustrate how GP professional boundaries are made up of object-related, task-related, and relational boundaries. Concepts related to the resistance and acceptance to change by family physicians were presented as illustrations of boundary work by family physicians.

2.2. Findings

2.1.1. The Concepts of GP Professional Boundaries

Scholars and physicians themselves are continually attempting to define the profession of family practice. Most conceptual models portray family physician's role by their clinical competencies and relationships with patients (Norfolk & Siriwardena, 2009; Stange, 2008; Starfield, 1998; Weiss, 2004). The World Organization of National Colleges, Academies and Academic Associations of General Practitioners/ Family Physicians, WONKA, sees family physicians providing "personal, comprehensive, and continuing individual care in the context of the family and the community" (Chekland et al., 2008, p. 791). Family physicians claim to be generalists (Stange, 2008) and aim to provide holistic care (Checkland et al., 2008). Many would concur with Barbara Starfield that the core elements of family medicine are comprehensiveness, continuity of care, access, and coordination of care (Lessard et al., 2010).

Concepts like *comprehensive, continuity of care, and relationships with patient, patient's family, and community* help us envision the type of care family physician provides. Clinical practice is central to physician identity and is prominently featured in conceptual models about family physicians; however, very few models acknowledge the business side of the physician's clinical practice and its contribution to the physician identity. It is only when scholars are discussing the problems with family medicine that the operation of a clinical practice is highlighted (e.g., Beaulieu et al., 2006; Beaulieu et al., 2009; Samoil, 2008;

Wilson, 2008)[13]. Drawing from the clinical work and the day-to-day administrative experiences would provide more complete descriptions of the family physician's professional identity and clearer delineation of GP professional boundaries.

Professional boundaries as an institutional element provide templates and scripts for action (Scott, 2001) – enabling certain activities while limiting others for both physicians and other associated actors. When describing the role of family physicians, the selected articles revealed distinctions made by actors based on tasks, objects, and relations that guide family physician actions.

2.1.1.1. Task-related Boundaries

Family physicians distinguish themselves from other specialities by being a generalist (Grant et al., 2009; Stange, 2009), having a *broad scope of practice* (Beaulieu et al., 2008), and having a holistic approach to care (Checkland et al., 2008; Weiss, 2004). They claim to be able to provide "a basket of services" (Weiss, 2004) and to juggle multiple agendas, for example, family physicians have to contend with patient's acute and chronic problems and provide health promotion and disease prevention advice (Campbell et al., 2008). Beaulieu et al. (2008) found residents in family medicine recognized the broad scope of their field:

> "I had specialist friends who said, 'You're just in family medicine.' I said, 'But I have a much broader range of skills than you. I will be able to deliver a child, care for a grandfather or treat depression.'..." (Resident in family medicine) (p. 1158)

[13] Problems are issues raised by researchers about the barriers of practicing as a family physician or being in family medicine.

Terms such as comprehensive, generalists, and broad scope of practice give a sense that the task-related boundary is expansive. Family physicians see themselves as the *coordinator* (the "quarterback", the "conductor") of patient's care. "[Family] physicians have traditionally assumed the role as lead (and, sometimes, sole) dispenser of care" (Mirand et al., 2003, p. 17). Clinical tasks are both "curing" and "caring" (Hansson et al., 2007). Curing involves the biomedical aspect of care, and tasks would be *prescribing drugs, performing procedures, and providing referrals. "*They [cardiac patients] know we don't have the time or the skill [for nutrition education], they would see our focus being on tablets, a specialist or on a test" (Pomeroy et al., 2008, p. il27).

Table 2.1: Tasks Associated with Family Physicians

Tasks	Selected Passages
Solve complex problems	"[GPs] were delegating the 'medical' work to their nurses, but that the 'complex' work that they retained was more difficult..." (Checkland et al., 2008, p. 798) "The chronic disease nurses are a great help. They have checklists and templates so they don't forget things. I actually think they're better at it than we are. They're a bit more blinkered than we are. We're such generalists we don't stick to the narrow things we go off looking at all sorts of things. I'd encourage nurses to develop specialist skills. I'm definitely in favour of it. . . . We are dealing with very complex problems. The magnitude of them. They go to the nurses for routine screening. Screening is what the nurses are doing (GP 15/Big)." (Checkland et al., 2008, p. 798) "...the capacity to solve a variety of problems at the primary care level..." (Beaulieu et al., 2009, p. e17).
First contact	"Some family physicians and most specialists interviewed defined family medicine's scope of practice on the basis of functions, two of which – first response to any patient's enquiry, and the coordination and integration of the care

Tasks	Selected Passages
	experienced – they considered to be the discipline's foundation and core" (Beaulieu et al., 2008, p. 1157)
Be available	"... responsibility for being available to ensure continuity of care" (Beaulieu et al., 2009, p. e17) "...the general practitioner's job was to be available..." (Green, 1993, p. 609) "First contact. A visit to an FP is a point of entry into a complicated healthcare system. Ideally, FPs act as the patient's advocate within that system, serve as the most accessible member of the medical team, and make appropriate and informed referrals. At times, however, patients may believe the FP's role of "gatekeeper" conflicts with these ideals." (Weiss, 2004, p. 34)
Address multiple agendas	"Addressing a number of agendas within a single consultation was seen by many doctors as a key skill of good family practice..." (Campbell et al. 2008, p. 230)
Integration and coordination of patient care	"...disliked sharing clinical responsibility for a given patient with another physician." (de Stampa et al., 2009, p. 53) "Some family physicians and most specialists interviewed defined family medicine's scope of practice on the basis of functions, two of which – first response to any patient's enquiry, and the coordination and integration of the care experienced – they considered to be the discipline's foundation and core" (Beaulieu et al., 2008, p. 1157)
Prescribe drugs, perform procedures, & provide referrals	"...the decision to perform procedures, the decision regarding which procedure to perform, and (for the most part) the decision to prescribe an ethical pharmaceutical." (Burns & Muller, 2008, p. 377) ""I think they should leave the prescribing up to us." [GP7]" (Hughes & McCann, 2003, p. 603) "Most were comfortable with the role of GP as gatekeeper and saw it as their responsibility to decide who should be referred on the basis of family history. However, they were less certain about their role in counselling the patient regarding genetic risk." (Watson et al., 1999, p. 422)
Admit patients to hospital (admitting privileges)	"...the decision to admit patients to the hospital (from the community..." (Burns & Muller, 2008, p. 377)

Tasks	Selected Passages
Treatment of chronic diseases	"...shows that most general practitioners felt responsible for treatment of chronic diseases." (Whitfield et al., 1989, p. 276)
House calls	"Physician house calls are an important service for selected patients." (Keenan et al., 1992, p. 2027)
Being their own boss	"...ability to organise their own workload ("you are your own boss")" (Green, 1993, p. 608) "Purchasing equipment, finding a partner, doing the book-keeping, hiring a secretary, a cleaning lady, sorting out pay slips..." (Beaulieu et al., 2006, p. 178)
Use of information technology for billing, consultation, and performance management	"The provision of a computer program was seen as a potentially useful aid, enabling GPs to refer only those eligible for some type of intervention." (Watson et al., 1999, p. 424) "All four internal [Quality and Outcomes Framework] teams included administrative staff, although their roles varied considerably between practices. IT managers or computer operators had been recently employed in all four practices, reflecting a growing need in practices to incorporate QOF-compliant information technology into their appointment, recall and consulting room systems." (Grant et al., 2009, p. 237)

In addition to the set of tasks to "cure" patients through drugs, treatment, or referral, family physicians work to "care" for patients. The caring aspect of the family medicine involves helping patients and families deal with the psychosocial complexities of health and illness (Hansson et al., 2007), supporting and reassuring their patients (Tabenkin et al., 2001), and helping patients and families manage their complex medical and emotional needs (Stange, 2009). The caring tasks are more intangible and tacit than the curing tasks, and both are critical to maintain a family physician's work. When compared to other health professionals, especially with other physician specialities, family physicians tend to distinguish themselves by the caring and relational aspects of their work (this theme will continue in the discussion on relational and object-related boundaries).

In Hughes and McCann's (2003) study on the inter-professional barriers to extending prescribing rights to community pharmacists in Northern Ireland, family physicians described prescribing as a clinical task and thus should remain the work of family physicians not pharmacists. Family physicians in the focus group pointed out continuity of care would suffer with pharmacists prescribing: "a lot of repeat prescribing is not clinical. You are not seeing the patient, you are merely sorting out prescriptions" (Hughes & McCann, 2003, p. 603). Pharmacists are clearly qualified to accomplish the task of prescribing – they have the medical knowledge to advise the patient about drug interactions, dosage, etc. But family physicians defended retaining the task of prescribing by distinguishing that the task of prescribing is not just medical. They drew on the caring and relational aspect of their work to defend their professional boundaries; here "clinical" implies family physicians are able to draw from their patient knowledge, from "seeing the patient".

Family physicians' day-to-day experiences of running a practice also shape their professional boundaries. The *business side of a practice* involves managing an office and practice management. Physicians interested in practicing family medicine can do so by being a locum[14], setting up their own practice from scratch, joining a group practice, or buying an existing practice from a retiring physician. In Beaulieu et al.'s (2009) study, focus groups of trainees in Europe and in Canada expressed disinterest and anxiety over the administrative aspect of traditional fee-for-service practice. As one participant expressed:

[14] Locums are hired physician consultants in part-time or contract basis.

> "I think starting from scratch would be incredibly difficult. Where I'm working now, they mentioned hiring me on as I end and there are a lot of advantages to that because then you don't have to worry about the overhead starting-up costs, which are huge, not knowing if you're in a good location or not … all those sort of business-oriented aspects." (p. 18)

It is often overlooked that in being their own boss, family physicians have on-going administrative tasks of running a business such as paying rent and utilities, bookkeeping, staffing, and finding a replacement for time off (i.e., finding a locum) (Green, 1993). There are also administrative tasks related to their professional duties. Family physicians need to build relationships with other health providers, for example, with team-based care and specialist colleagues; and they need to handle and coordinate patient information like writing, reviewing, receiving, and sending paperwork, for example, diagnostics reports and referrals to services; they need to maintain up to speed with social and medical services that are available in their community (Norfolk & Siriwardena, 2009; Samoil, 2008). The fact that family physicians are business owners and have administrative responsibilities is often obscured, that is, administrative responsibilities are implicit when we describe family physicians and their professional roles and boundaries.

2.1.1.2. Relational Boundaries

Family physicians' relationship with their *patients* greatly contributes to the physicians' professional boundary definition. "The College of Family Physicians of Canada has long listed the centrality of the doctor-patient relationship as one the principles of family medicine" (Wilson, 2008, p. 1103), and the doctor-patient relationship distinguishes family

physicians from any other physician specialities. Family physicians consider a basic characteristic of their profession to be their relationships with their patients (Beaulieu et al. 2008, p. 1158):

> "The most exciting thing is being able to practise medicine one on one, being able to have a patient of my own, who I follow and get attached to, and he gets attached to me.'' (Resident in family medicine)
>
> ''I think that's part of why you choose family medicine, as opposed to people who choose gynecology or surgery. We love to be near people and then seeing tangible small-scale results. There's a relationship, a bond, and that's probably important to us.'' (Resident in family medicine)

The commitment to patients is continual, gratifying, and demanding (Beaulieu et al., 2006). When assessing the obstacles and motivations of solo GPs who work in a group practice setting in Belgium, Feron et al. (2003) found GP participants describing a dyadic "one patient one doctor" relationship: "If you were to ask my patients what they thought of me joining a group practice, they would answer that it would be all right as long as it remained in the waiting room" (p. 169). Once a patient comes under the care of a family physician, the doctor-patient relationship solidifies the role the physician will play in the patient's care and is a long-term commitment. As a resident in family medicine from Beaulieu et al.'s (2008) study explain: "I think one thing about family medicine is that you have long-term commitments to your patients, which can be scary as well, because you're worried about picking on patients you may not like." (p. 1158).

Jang and his associates (2007) found family physicians expressed concerns about damaging the doctor-patient relationship:

> The majority feel that reporting patients who are unsafe to drive to the licensing authorities puts them in a conflict of interest and has negative consequences for patients, patients' families, and the patient–doctor relationship. Despite these misgivings, almost three quarters agree that physicians should be legally required to report unsafe drivers. (p. 535)

Family physician might go out of their way to maintain their doctor-patient relationship. de Stampa and his associates (2009) found physicians were willing to participate in the integrated service network in order to maintain relationships with patients; one participant explained the reason for joining was "by necessity, but not willingly; I didn't want to abandon my patients. (...) As I said, it was out of necessity; I did it for the patient." (p. 52). Given the value family physicians place on the relationships with their patients, physicians should be inclined to draw on the doctor-patient relationship to facilitate the creation, maintenance, and disruption of GP professional boundaries.

Interactions with *peer family physicians, specialist colleagues, other health care providers, and administrators* should also have an impact on family physician's professional boundaries. Relationships with other providers are necessary in order to provide continuity of care and are based on "mutual recognition by professionals of their interdependence" (San Martin-Rodriguez et al., 2005, p. 136). Family physicians seek expertise from other health care providers – "we are the generalist that is why they call us GPs. For us, dieticians are very useful people, we can reinforce their recommendations" (Pomeroy et al., 2008, p. il27) – and other providers rely on family physicians for the "day-to-day general medical

concerns" (Wilson, 2008, p. 1101). de Stampa et al. (2009) found, requisite communication with community case managers about patients can foster positive working relationships:

> "Active GP18: It was easy to work with the case managers. They were nurses from community services who knew the condition of my patients very well. I developed really good relationships with some of them, because they had to call me often for the complex cases." (p. 52)

Even though these professional relationships are necessary they are challenged by interpersonal competition, perceptions of clinical hierarchies, and issues of control. In a fee-for-service environment, family physicians are used to competing against each other for patients – "historically there was a thing about practices being very competitive" (Walther & Mathers, 2004, p. 556). Competition between family practices only subsided because there are more patients looking for family doctors (physicians no longer need to worry about building and maintaining a patient roster). Professional boundaries and clinical hierarchies remain stuck with family physicians still having the "final say" despite delegating more of the work to nurses and other health professionals as redesign in primary care becomes more multi-disciplinary and team-based. It is more common to see the routine, task-based, and protocol-based clinical work be assigned to nurses; "nurses are very good at doing things and at following criteria and they will run the clinics, but the overall medical control will always come back to us" (Grant et al., 2009, p. 238). Hughes and McCann (2003) found GP participants were reluctant to relinquish control of prescribing to pharmacists: pharmacists were perceived to be outsiders, and they were seen to a certain extent as a threat to the GPs (p. 603). On the other end of the spectrum, family physicians perceive a lack of respect by some specialists (Manca et al., 2008).

Family physicians have become more isolated as more choose to relinquish their hospital privileges. There is no place for family physicians to intermingle with their peer and specialist colleagues (GP practices are dispersed in the community). The perception amongst their specialist colleagues is that there is less appreciation for the role of family physicians (Manca et al. 2008, p. 1435.e2):

> "In the past, before regionalization, family doctors and specialists had more opportunities to meet and work together. The days when family doctors met each morning with specialists and subspecialists in the coffee room are gone, and this kind of interaction has not been replaced. Our relationships have suffered."

The collegial rapport with their colleagues has been severely diminished as more family physicians give up their hospital privileges; nevertheless, family physicians do value the opportunities to exchange practical experiences in a group setting (Walker & Mathers, 2004). The degree of peer and inter-professional collegial interactions should have an impact on GP professionalization (i.e., how cohesive the profession of family medicine is and how it interacts with other professions).

Historically family physicians have little direct interactions with administrators and policy makers[15]. Remuneration negotiations are done by the professional association (e.g., in British Columbia it is the BC Medical Association, the BCMA, which conduct all physician

[15]Interactions with hospital administration exist for family physicians that have retained their hospital privileges. For family physicians that still work in the hospital, they would be in a Department of Family Practice and be involved in the organizational functioning in the hospital. They might even hold administrative positions (e.g., Member of the Medical Council, the Medical Director, or the Head of the Department of Family Practice).

negotiations with the provincial government). Family physicians are disconnected with the system level discussions about primary care design and delivery unless they are involved with the professional association. Often experiences with primary care redesign and change practice initiatives feel like an imposition (i.e., it is imposed on them without consultation). Suggs and her associates (2009) reported GP participants often used words like "red tape", "hoops", "barriers", and "bureaucracy" to describe their experience with the Ontario Drug Benefit Program in the focus group sessions they held, and some participants "saw themselves being used as free watchdog gate-keepers to monitor drug costs" (p.73). Again when we examine the relational features of family practice, the "business" side is less apparent. It would seem family physicians draw more upon the doctor-patient and professional relationships when defining their professional boundaries (e.g., Stange, 2009).

2.1.1.3. Object-related Boundaries

As mentioned in the introduction, object-related boundaries relate to what actors perceive to have ownership and control over. Objects can be conceptual or physical in nature. The perception of control over these objects facilitates the creation and maintenance of the family physician's professional boundaries.

Family physicians are responsible for their patients' health, and they have *ownership towards their patients* ("she is my patient"), regardless of whether they are comfortable with such a high level of responsibility. Historically, family physicians were available to their patients 24/7, that is, they were on-call after-hours and had shifts in the emergency department. In

Beaulieu et al.'s (2008) case study of family medicine professional identity in Canada, participants had mixed comments about the level of responsibilities family physicians have to shoulder:

> "...It's a very high level of responsibility to feel that you are responsible for all aspects of your patient's health and that you will be held responsible for it... I think people are feeling that it's not appropriate to shoulder that kind of responsibility, and they don't want to." (Family medicine program director) (p. 1158)

It is acknowledged amongst other actors that overall patient responsibilities lie with the family physician (Beaulieu et al., 2008):

> ''The family doctor is, from my angle, a primary health care provider who looks after all the primary health care needs of his or her patients...The family doctor controls the overall care of the patient. In other words, he may receive expert advice from a consultant or whatever, but I'm talking about the 'ownership' of that patient, the primary care provider, the person who coordinates all the health care provided to an individual: it's the family doctor.'' (Internal medicine program director) (p. 1159)

However some participants didn't feel the level of responsibilities should fall wholly to family physicians (Beaulieu et al., 2008):

> ''I don't think everybody should be doing everything. So I don't think the physician should be delivering babies, seeing children, looking after an infarctus, going to assist surgery. I think that family practice trainees should gear their practice, to a large extent, around their interests.'' (Specialist in internal medicine)
>
> ''I see family medicine as quite beleaguered. We have become more and more sub-specialized. And so the practice of family medicine in an urban center consists mostly of doing assessments and dispatching, which I think is not as rewarding to physicians. In the rural areas, we have the opposite problem. The specialists aren't available, so family physicians are burdened with having to do too much because they don't have access to the many levels of specialties.'' (Vice-Dean) (p.1160)

As mentioned before, the different facets of GP professional boundaries are interrelated; the same concept can contribute to different facets of professional boundaries. While I found the concept of patients inform relational boundaries (in the doctor-patient relationship), it also had a role in shaping object-related boundaries (in the ownership of patients).

Family physicians have a breath and depth of *knowledge of their patients* that is unique. The generalist nature of family physicians means they have a whole picture of the patient and are keepers of the patient's history. They are the professionals that are "best placed to know which patients need to be registered" for a specific service (de Stampa et al., 2009, p. 52). "They [GPs] understand where the patient is going through all sorts ..., how their heart failure is getting on, how their diabetes is being managed, and take the patients who may have 3 or 4 illnesses…" (Moffat et al. 2006, p. 64).

As a participant in Beaulieu et al.'s (2008) study described the breadth of the family physician's knowledge base:

> ''I have always said that I have great admiration for family physicians, because in order to do what we ask of them, they must retain an enormous amount of knowledge. You have to be good in cardiology, in pneumology, in gastroenterology, in obstetrics, in infertility, in this, in that. It's incredible! In fact, the scope of medical knowledge has become enormous. And we are asking people to master it all.'' (Vice-Dean) (p. 1159)

As the primary care provider, family physicians are asked to be responsible for many things. Family physicians feel a great deal of pressure on their time with the demands and scope of a

busy clinical practice (Aluise et al., 1994; Beaulieu et al., 2008; Beaulieu et al., 2009; Hogarth-Scott & Wright, 1997; Keenan et al., 1992; Porche & Margolis, 2006; Samoil, 2008; Watson et al., 1999). Being someone's family doctor is a time consuming job: "committing to a patient's case is time consuming over the long and short haul, and requires tenacity and a conviction..." as a GP participant describes the family physician's advocacy role for patients (Suggs et al., 2009, p. 73). It is not surprising that family physicians control and highly protect their *time* in order to manage their workload.

Financial remuneration also affects how physicians manage their time and define their professional boundaries. Those who are paid by fee-for-service will allocate their time to see as many patients as possible to maximize their billing; non-billable work is less of a priority. "One of the main difficulties participants saw with increasing involvement of primary care [in genetic services] was the potential time involved, and how this would fit in with current GP remuneration methods which do not encourage [genetic services] discussion and counselling." (Watson et al., 1999, p. 422). Time is perceived to be a precious resource, and there is often a gatekeeper which regulates access to the physician. In Hughes and McCann's (2003) study on inter-professional barriers between pharmacists and GPs, a pharmacist participant recounted "sometimes once you get the doctor they are very receptive, but it is getting past whoever is in between you and the doctor, be it a receptionist or whoever." (p. 603). But probably the most vital thing professionals, like family physicians, control is their right to organize themselves and their affairs (i.e., professional autonomy).

According to the Oxford English Dictionary, *autonomy* is defined as "the condition or right of a state, institution, group, etc., to make its own laws or rules and administer its own affairs" (OED, n.d.). When GP trainees were asked about the roles and career trajectory of general practitioners in Beaulieu et al.'s (2006) study, trainees saw the career of being a GP as a flexible one: "there are as many ways of being a GP [as] there are GPs because each individual doctor has his own patient-base and his way of working depending on who he is'' (p. 177); "general practice [is] a career that could evolve over time and be adapted to one's interests and abilities" (Beaulieu et al., 2009, p. e18). Like many other professionals, family physicians have the autonomy to decide what is within their professional boundaries, that is, their jurisdiction is recognized by the public and the legal system (Abbott, 1988). They have the ability to define their roles and consequently also other health professionals (Brooks, 1998; Carlsen et al., 2007; Grant et al., 2009; Hughes & McCann, 2003; Walker & Mathers, 2004; Watson et al., 1999).

Lastly, family physicians have control over their *office practice*. As an entrepreneur, the physician is responsible for her practice. She sets up how the office is run, her office hours, what kind of patients she wants to see, what filing system she uses, etc. Family physicians do not have that level of control when they are practicing outside their practice setting (e.g., in the hospital).

The GP professional boundaries are constructed by a combination of the family physician's relationships with other social actors, her perceived ownership of objects, and her clinical and administrative tasks (Figure 2.1). The family physician's sustained connection with the

patient is what sets her apart from other health care providers. The family physician exerts a tremendous amount of effort to maintain the knowledge of and relationship with her patients. She has to always be available for her patients; she has to keep up with an array of tasks in order to consider herself as the "first contact" and the "coordinator" of patient care. Time with patient is the key. It allows the family physician to claim contextual in-depth knowledge about her patients and to develop trustworthy longitudinal doctor-patient relationships. Through examining the multiple aspects that contribute to GP professional boundaries, one begins to realize that family physicians have a large and hard-to-manage set of professional boundaries.

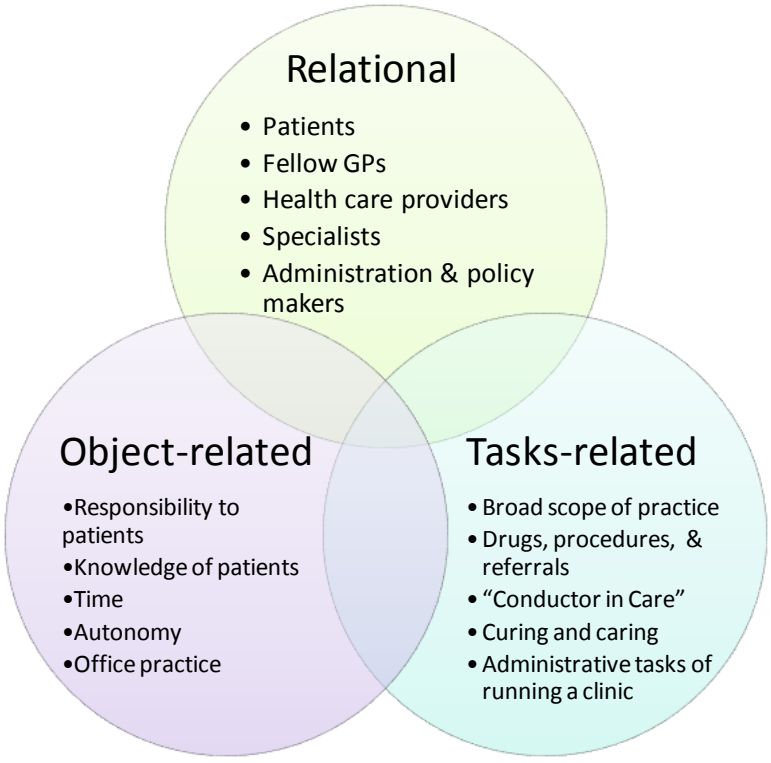


Figure 2.1: The Construction of GP Professional Boundaries

Since the 1990's the professional boundaries of family physicians have been *narrowing*. There are a number of reasons why the boundaries are shifting. Firstly, family physicians found they had too much on their plate due to their expansive professional boundaries. This had a negative impact on their quality of life (Feron et al., 2003) and led to burnout (Loxterkamp, 2009b). As one resident in family medicine explains, "it is a huge scope of practice. Which is one of its biggest advantages, but, at the same time, it's always possible to do a little too much. Divide yourself in too many different ways that sacrifice your personal life, aside from medicine..." (Beaulieu et al., 2008, p. 1157). It seems the traditional form of family practice (i.e., solo practice) is no longer perceived to be sustainable (Beaulieu et al., 2009). Physicians sought to be in a group practice (Feron et al., 2003) or to practice as a locum (Beaulieu et al., 2006) so as to minimize the administrative responsibilities of owning a family practice. Their claim as autonomous entrepreneurs allowed family physicians to manage their clinical workload by *1) selecting clientele* (Beaulieu et al., 2009; Keenan et al., 1992), *2) choosing to specialize* (Beaulieu et al., 2006; Beaulieu et al., 2008; Beaulieu et al., 2009; Checkland et al., 2008; Samoil, 2008), or *3) limiting /prioritizing their tasks* (Loxterkamp, 2009b; McDonald et al., 2009; Mirand et al., 2003; Watson et al., 1999). Increasingly, family physicians are choosing to give up providing services like maternity care (i.e., selecting clientele) and home visits (i.e., limiting tasks), or choosing to specialize in a specific area of primary care like maternity.

Secondly, the medical culture values specialists, and there exists a clinical hierarchy between specialist physicians and family physicians. Family physicians do not feel they get the respect they should from their specialists colleagues (Manca et al., 2008). Family physicians

want to be valued and recognized for their expertise. Grant et al. (2009) found family physicians employed inclusionary strategies to expand their prestige and area of control by claiming the uniqueness of providing the "generalist" aspect of care[16]. At the same time, family physicians rationalized to delegate the "routine" and "task-focused" work to nurses – a "downward exclusion" strategy employed by family physicians to maintain their status over the nurses (Grant et al., 2009, p. 240). It is also becoming more common to see "general practitioner with special interests" (Moffat et al., 2006), with family physicians focusing on specific types of patient or care.

Lastly, health care services are evolving to adopt a more corporate-management discourse (i.e., managerialism) (Scott, 2000). As corporate-management discourse permeates the health care sector, the physician institution is increasingly challenged and being less taken for granted. It is more likely to observe strategic actions by family physicians and other institutional actors that provoke the institutional environment, for example the movement towards accountability and transparency in quality patient care and with that the management of professional work. "Quality of care" is prompted, tracked, and measured with management tools such as performance indicators and utilization reviews; family practices are incentivized to implement electronic patient records. New forms of remuneration have been introduced like pay for performance. All of this had an impact on family physicians' professional work and boundaries. For example, the incorporation of information technology in family practices not only changed the way physicians chart, but it also affected the nature of the office visit and has a potential of weakening the doctor-patient relationship. "The

[16] Witz (1992) proposed professionals employ demarcation strategies to best-position themselves in clinical hierarchies: "upward usurpation" strategies to gain control and privileges and "downward exclusion" strategies to maintain on top of other clinical hierarchies (as cited in Grant et al., 2009, p. 231).

requirement to enter data into the electronic medical record to respond to the large number of targets was described as reducing eye contact, increasing time spent on data collection in the office visit, and potentially crowding out the patient's agenda" (McDonald, 2009, p. 123). The physician autonomy is being challenged. Responsibility for the patient and knowledge about the patient is shifting away from the family physician to these system management tools and processes.

2.1.2. Boundary Work by Family Physicians

The organizational environments are collective and interconnected (Meyer & Rowan, 1977; Oliver, 1991). Organizations and organizational actors are continuously exposed to external demands (e.g., managerialism is challenging the way health services are being delivered). The range of response to the environment depends on the "assumptions about the degree of choice, awareness, and self-interest that organizations possess for handling external constraints" (Oliver, 1991, p. 148), from blind adherence to taken-for-granted rules and values to actively shaping and contesting values and requirements. Regardless of the motive or the context of the response to external pressures, actors play a role in maintaining or transforming existing institutions. In this study, boundary work involves the purposive actions (actions such as discursive practices) by individuals or organizations to create, maintain, or disrupt institutional boundaries.

The maintenance of institutional boundaries involves supporting, repairing, or recreating the social mechanisms to ensure compliance (Lawrence & Suddaby, 2006, p. 36). Lawrence and

Suddaby (2006) proposed the maintenance (or enforcement) of boundaries can be achieved either through ensuring adherence to rule systems or reproducing existing norms of belief systems. For example, actors might draw on functional or historical accounts of why the practice exists (Jepperson, 1991). The disruption of boundaries involves disconnecting with, disrupting, and undermining those very same rule and belief systems (Lawrence & Suddaby, 2006, p.47-56).

Even though I will present the beliefs/concepts to illustrate either maintenance or disruptive boundary work, the same concepts can be used for either purposes (e.g., the lack of time could be used as a reason for not taking on new work, but it can also be the reason to stop doing an existing task). Table 2.2 presents the concepts employed to enforce and/or disrupt GP professional boundaries.

Enforcing Boundaries

Strategies used to enforce institutional boundaries continue to draw from taken-for-granted values and beliefs about family physicians. Rhetoric such as "holistic", "bio-psychosocial" or "patient-centred" care reinforces the norm that family medicine is a specific model of medicine and family physicians have claim over "an area of professional knowledge of their own, distinct from both the dominance of their hospital colleagues and the claims of population-based approaches" (Checkland et al., 2008, p. 791). Unlike other health care providers, family physicians hold a unique claim to knowledge about their patients, both in terms of breadth (a comprehensive picture of the patient) and depth (details and background

stories about a patient). The continual connection with patients is highlighted as a reason why family physicians are able to gain this level of knowledge about their patients. Family physicians consistently draw on their knowledge of and relationship with the patient for identity and boundary maintenance. In the rest of this section, I will present strategies used by family physicians to enforce their professional boundaries.

Carlsen, Glenton, and Pope (2007) conducted a systematic review of qualitative studies about GPs' attitudes to and experiences with clinical practice guidelines. They found six thematic reasons for family physicians to not follow clinical practice guidelines. Three of the six themes involved concerns related to the effect on patients and on the doctor-patient relationship[17]. Family physicians claimed they hold the responsibility for the patient; they found guidelines were not flexible enough to meet the complex needs of the patients (Carlsen et al, 2007, p. 973). They had reservations about using clinical practice guidelines, especially if they perceived the guidelines would affect their relationship with their patients. Family physicians saw that proscriptive guidelines might "entail rationing and denial of patients' requests, thereby jeopardising the doctor–patient relationship." (Carlsen et al., 2007, p. 976). Family physicians used especially negative (or especially positive) examples of patient outcome as a reason for rejecting (or accepting) new tasks. Lawrence and Suddaby (2006) proposed ***valorizing or demonizing the normative foundations of an institution as a way to maintain institution*** (p. 41).

Even though many family physicians are no longer practicing in the hospital or providing the "generalist" breadth of care, family physicians still see themselves as the coordinator of

[17] The other three were related to the nature of evidence and the ease of use.

patient care. Beliefs such as "the coordinator of care" and "physician's professional autonomy" are ***mythologized***. Hansson and his associates (2009) found family physicians do not perceive a positive attitude towards collaboration as a part of their professional role to the same extent as nurses do (p. 78). Despite clashing with the evidence-based and corporate-management discourses where shared patient care is recommended to improve quality of care and to meet health human resources shortages (Hansson et al., 2009; San Martin-Rodriguez et al., 2005), some family physicians remain resistant to change. Physicians claim it is because they are socialized to "be in charge". "We're not comfortable being part of a team. We're comfortable being the one in charge..." (Mirand et al., 2003, p. 17). A family physician described the discomfort with sharing clinical responsibility with a specialist consultant (de Stampa et al., 2009):

> "At one point, the patient had two physicians, because over time the SIPA [System of Integrated Care for Older Persons] physician began to take care of our patients, even though we had been recruited to take care of them and we had been working with them from the start (...)" (p. 53)

Table 2.2: Boundary Work by Family Physicians

Boundary Work - Themes	Selected Passages
Doctor-patient relationship *(belief system)*	"It was felt that lifestyle advice often annoyed patients and affected the doctor–patient relationship. This was especially so when advice was given unrelated to the patient's presenting complaint." (Lawlor et al., 2000, p. 457) "The majority feel that reporting patients who are unsafe to drive to the licensing authorities puts them in a conflict of interest and has negative consequences for patients, patients' families, and the patient-doctor relationship. Despite these misgivings, almost three quarters agree that physicians should be legally required to report unsafe drivers." (Jang et al., 2007, p. 535)

Boundary Work - Themes	Selected Passages
	"The other issue is the issue of confidentiality. When I am writing in patient records, the understanding has been between myself and the patient that these are confidential records." (Hughes & McCann, 2003, p. 603)
Time *(belief system)*	"Physicians who did not make home visits, on the other hand, were more likely to report being too busy to personally make house calls (P<.0001)" (Keenan et al., 1992, p. 2029) "They could not address nutrition in the present system of consultation. The lack of consultation time, patients presenting to the consultation with lists of two or three problems and heavy workloads influenced the doctors' approach to nutrition care." (Pomeroy et al., 2008, p. il25) The increased travel time "from my office to the hospital...there was less time in a day to make it to the hospital for rounds...as a result of these and other changes, my colleagues began to resign their hospital privileges ..." (Samoil, 2008, p. 1100)
Financial incentives *(rule system)*	"When we asked our first panel of respondents what would keep them from assuming additional leadership roles, some salient factors were... Lack of support from colleagues, including financial remuneration for managing or leading." (Aluise et al., 1994, p. 5) "Several authors emphasize the need for adequate financial investments in order to promote the development of collaborative practice" (San Martin-Rodriguez et al., 2005, p. 139) "Primary care can be much better than it is in Canada...The level of respect can be determined by the level of underfunding." (Manca et al., 2008, p.1435.e3)
Control & responsibility *(belief system)*	"Only 46% of all survey participants indicated that they would increase home visiting if reimbursement were improved. This finding underscores the fact that physician home visiting, though perhaps most affected by reimbursement, is not simply a decision driven by economics. For example, it is clear from the logistic regression (Table 4) that some physicians continue to provide home visits as indicated – most likely on the basis of their professional values and commitment to patients – despite poor reimbursement." (Keenan et al., 1992, p. 2031) "So, in our mindset we think that, you know, it is a one- stop-shop, it's all up to us, and that's how we operate. I think that

Boundary Work - Themes	Selected Passages
	creates a big barrier to getting into a lot of things that were kind of hinted at. We're not comfortable being part of a team. We're comfortable being the one in charge, and I think that's a big barrier." (Mirand et al., 2003, p. 17)
Nature of Support *(belief system)*	"...the pressure exerted by the culture of evidence-based medicine on the notion of expert knowledge and expertise, and how this culture challenges family medicine in the professional system." (Beaulieu et al., 2008, p. 1160) "The fact that I knew it was temporary, that bugged me (...). From the start we thought that it wouldn't last..." (de Stampa et al., 2009, p. 53)
Communication & Engagement *(rule system)*	"Most of the non-active GPs said that they regretted the lack of information provided at the outset on their specific role in the [System for Integrated Care for Older Person] experiment... "It was confusing for me at the beginning. And afterwards, too. I didn't receive clear information about what I was supposed to do"" (de Stampa et al., 2009, p. 53) "They didn't keep me in the loop when it came to issues beyond the patient's problems, but I didn't make an effort to find out, either." (de Stampa et al., 2009, p. 53) "...you need a doctor's voice as well.....that is why a lot of initiatives have failed in primary care because there hadn't been that ground swell from within..." (Moffat et al., 2006, p. 65)
Relationship with others *(belief system)*	"But the advantage of being in a [Primary Care Group], if you agree a framework, you've got your automatic … support." (Walker and Mathers, 2004, p. 556) "Nine of the partners had at some point in their career been singlehanded. None of them reported that they would currently prefer to work as a singlehanded practitioner, citing team working and the clinical, *practical, and emotional support* of other doctors as the major incentives for remaining in partnerships." (my emphasis) (Green, 1993, p. 606)

*Themes are categorized as either involving the belief system or the rule system.

The concept of time (e.g., the lack of, the efficient use of) is often used to repel new tasks from coming into practice. Family physicians emphasize they do not have time to do more

work or incorporate new tasks into their already busy practice, ***embedding "time" as a limited resource***. In a study done by Porche and Margolis (2006) examining the role of a GP in rural mental health units in Australia, the majority of the GP respondents believed a significant amount of patients with mental illnesses would benefit from the contribution of a GP. However, the issue of time was one of their top concerns: "mental health care consumes a considerable amount of time and in a busy, often already over-booked general practice, it may be very difficult to allocate sufficient time to provide the appropriate care" (Porche & Margolis, 2006, p. 569). Family physicians will also question whether the disputed task, intervention, or practice is an effective use of their time. Family physicians in Mirand et al.'s study (2003) were asked about their views on the definition, goals, and clinical delivery of preventive care; the authors found "spending time to discuss prevention with a patient was perceived by some physicians as not being a prominent element in the role of doctor nor an effective use of physician time" (p. 17).

Finally professional boundaries are enforced by the ***creation of rules that facilitate and support professional work***. Family physicians expect to be financially remunerated for taking on out-of-bound tasks/roles. For example, many researchers offer family physicians a financial stipend to participate in their study (e.g., de Stampa et al., 2009). This can be seen as an economic coercion tactic to regulate their professional boundaries (family physicians will not take on new work unless they perceive they are properly compensated). There are also organizational processes family physicians see as necessary for being and staying involved in change initiatives. Physicians expect to be informed and engaged when introducing new work into their profession. Loxterkamp (2009a) used the analogy of family

physician as an agent of change for his patient and his community to describe the potential role for family physicians in primary health care change. He suggested patients need to see the potential benefit from changing. And in the same vein, family physicians need a similar type of reassurance when they are asked to change their practice: "they need assurance that the shift is not only possible but worth the effort." (p. 263).

When defending their professional boundaries, family physicians are not really using any new concepts outside of what they have traditionally used to distinguish themselves from other actors. Family physicians continue to use and propagate core concepts like "doctor-patient relationship", "time", "control & responsibility" in their professional boundary work. Enforcement of boundaries utilized belief-based mechanisms – played on normative foundations of an institution – or rule-based mechanisms – created rules or developed coercions – to deter institutional change.

Reshaping Boundaries

Lawrence and Suddaby (2006) assert that "institutional work aimed at disrupting institutions involves attacking or undermining the mechanisms that lead members to comply with institutions" (p. 47). The authors suggested the emergence of new institutions might not be the only or even the dominant way to disrupt existing institutions (and to initiate institutional change) (p. 48). My findings would suggest the same. Take for example the movement towards evidence-based medicine in primary care. While the "scientific-bureaucratic" discourse promotes the use of scientific knowledge to inform clinical practice (Checkland et

al., 2008), actors fight back and raise their concerns about the generalizability of evidence. An issue that has long been recognised: "population-based trial results are difficult to transfer to the individual patient and this reflects the inherent uncertainty of medical evidence" (Carlsen et al., 2007, p. 976). The attempts to disrupt boundaries by the new institution might lead actors to reemphasize their core institutional attributes (i.e., activate maintenance boundary work).

The literature review did not yield a definitive mechanism for disrupting boundaries; however, I speculate there is an alternative approach that can be thought of as *reshaping* boundaries[18]. Institutional boundaries might be reshaped through ***modifying existing assumptions and beliefs*** on "fuzzy" attributes. Fuzzy attributes are those characteristics that are more peripheral (less central) in the professional boundary definition[19]. An example of this is in Walker and Mathers' (2004) study on GPs' experiences of a group prescribing initiative. About half of the participants came out of the initiative feeling the "most valued outcomes were process oriented: increased interaction between practices and a greater sense of group cohesion" (p. 552). "Group cohesion" amongst family physicians, as a professional attribute, was never a big part of the physician identity. It is not an attribute that is frequently used in maintenance boundary work (e.g., family physicians would not say they were forgoing something because it didn't give them an opportunity to interact with their colleagues). For some participants, the process of the initiative led them to recognize the value of collegial support from their colleagues: "by discussing issues together and

[18] I am using *reshape* rather than *disrupt* because I see the process as more incremental and less aggressive.
[19] As boundaries become narrow, actors will use particular institutional attributes inconsistently for boundary definitions. Pockets of these attributes/characteristics will develop.

discovering that their similarities outweighed their differences, their feeling of group cohesion increased" (Walker & Mathers, 2004, p. 555).

Empirically, scholars have found relational and systemic factors to encourage inter-professional collaboration (see review by San Martin-Rodriquez et al., 2005). I assume some of these factors, for example the understanding of other professional practices, are more flexible (and can lead to institutional change) because they are not core attributes used in maintenance boundary work. They do not trigger enforcement of boundary as readily as some other concepts.

2.2. Discussion

I was able to identify a list of attributes that make up GP professional boundaries, but I was unable to find a consistently accepted definition for "what is a family physician" (e.g., Beaulieu et al., 2006). There were discrepancies in the way GP professional boundaries are constructed. The findings did show that the connection with the patient is still a legitimate, core attribute of the GP professional boundaries.

The GP professional boundaries were clearer and better defined historically; more recently the boundaries have been shifting and narrowing. Previously legitimate or taken-for-granted actions were no longer accepted to be the norm (Oliver, 1992). Family physicians are doing less (through strategic choice). Competing logics (e.g., the power dynamics and the corporate-management discourse) are shaping family practice: family physicians are

specializing in disease and population specific areas; many are incorporating management requirements into their work. In attempting to control the large and expansive set of professional boundaries, family physicians are managing their professional boundaries separately. They are not all choosing the same thing to maintain or limit. Boundary shifts are occurring in different areas, and subsequently family practice holds multiple organizational forms (e.g., solo practice, group practice, walk-in clinic, maternity clinic, etc.).

Because family physicians practice in (semi-)isolation in the community, each actor has the flexibility to decide how they want to manage their professional boundaries[20]. Boundary shifts are happening independently. They are occurring at a micro and meso level (individual and group level). As a result, GP professional boundaries have a quality of "fuzziness" when examined at the macro level. Core assumptions and beliefs about some professional tasks and activities are being broken. What is interesting is that different physicians chose different things to discard and keep within their professional boundaries. Particular attributes are retained by some family physicians while other attributes are no longer credible. The result is GP professional boundaries cannot be precisely defined and have a blurred and indistinct – a "fuzzy" – quality (OED, n.d.)**.** Fuzzy professional (institutional) boundaries are acceptable because there is no strong means to enforce conformity. The opportunity for social interaction, imitation, and observation between family physicians has been reduced since family physicians have given up hospital privileges. Geographic dispersion is one of the many social pressures for deinstitutionalization (Oliver, 1992, p. 577).

[20] Even though their professional autonomy has eroded with the introduction of the management discourse in health care, family physicians (and physicians in general) still hold an enormous amount of power to self-govern.

Deinstitutionalization is the discontinuity of institutionalized activities or practices (Oliver, 1992) and practices are abandoned because they no longer hold their original meaning (Maguire & Hardy, 2009). Based on previous studies, deinstitutionalization is a key to introducing radical organizational change (Greenwood, Suddaby, & Hinings, 2002; Maguire & Hardy, 2009).

Does the Characteristic of Professional Boundary Affect Boundary Work?

From the selected HSR articles, I was able to delineate potential mechanisms for the enforcement of boundaries but had limited success on discovering possible mechanisms to disrupt boundaries. The fact that GP professional boundaries have been shifting and become less distinct has not changed the way boundaries are enforced. Family physicians are still able to effectively defend their professional boundaries. Attempts to disrupt boundary thus do not necessarily lead to change (this is seen as a resistance to change). Enforcement of professional boundaries is done by selectively using core attributes to distinguish their profession from other attacking institutions. The obvious rival institutions are the nursing, the corporate-management, and the scientific institutions (e.g., Aluise et al., 1994; Carlsen et al., 2007; Grant et al, 2009).

Key beliefs and concepts are used to enforce and disrupt GP professional boundaries by family physicians (Table 2.2). Out of a host of beliefs and concepts used to define (what is) the family physician, only some are readily employed in the boundary work of GP professional boundaries. Other concepts are more obscure and not often activated for

boundary work. Perhaps institutional elements are not all created equal. There are strong to weak (central to peripheral) institutional elements, and they do not contribute equally to the creation and maintenance of the institution. The implication to boundary work is *what gets selected* to create a distinction between the focal institution and other institutions. Actors are more likely to draw from the core attributes in maintenance-type of boundary work. Peripheral attributes can play a role in boundary work (i.e., reshaping boundaries) as they are less likely to trigger enforcement of boundaries, more subject to be redefined, and more flexible for redefinition.

Family physicians have slowly been surrendering what they considered to be peripheral parts of their service. They are increasingly seeing the administrative tasks of running a clinic to be burdensome and choosing to practice as a locum or in a group setting (Beaulieu et al., 2006). It is more acceptable to alter work roles and routines from the margin than to make changes to more central roles like giving up the decision-making authority (de Stampa et al., 2009).

Based on the territoriality literature (Brown, Lawrence, & Robinson, 2005), the likelihood of infringement is higher when the target's boundaries are difficult to demarcate or other members do not recognize the boundary marking (boundaries are more subjected to be redefined). The frequency of attempts to disrupt professional boundaries might increase when the professional boundaries are less coherent (fuzzier). However, it is unknown if attempts to disrupt boundaries would be a success (leading to institutional change). Is there a

difference between fuzzy versus well-demarcated professional boundaries in terms of its ability to withstand attacks from rival institutions?

The process of deinstitutionalization and reinstitutionalization is incremental; Greenwood, Suddaby, and Hinings (2002) proposed stages in institutional change. Boundary work might be more successful in introducing change to (i.e., disrupt) existing institutions if the work is focused on weakened institutional elements: it might be easier to disrupt an existing institution by modifying the assumptions and beliefs on its non-core attributes. I will attempt to extend this idea and go on to explore potential mechanisms for reshaping boundary with the case study of the Division of Family Practice in the next chapter.

Chapter 3 – The Case Study

The case study is set within the context of primary health care reform in British Columbia (BC), Canada. Primary care is typically provided by family physicians running solo or group practices. These practices are generally privately-operated enterprises. McKendry, Goertzen, Reid, Mooney, & Peterson (2006) reported over 80 percent of GPs practice in community settings in groups with other GPs or solo practices in BC during 2000/2001. Physicians running, and working in, these private practices have the dual responsibilities of being community-based medical professionals as well as a small business entrepreneurs. In Canada, family practices are generally paid for by public and private insurances under a fee-for-service mechanism.

The provision of health care is a provincial mandate, and the Province has delegated the administration of most of the services to the regional health authorities. The only exception is the services provided by physicians, which are managed by contracts negotiated between the Ministry of Health Services and the physician association, i.e., the BC Medical Association (BCMA) in British Columbia.

Primary health care plays a central role in the prevention of illness and promotion of population health. The provision of primary health care involves services that promote health, prevent disease, and provide diagnostic, curative, rehabilitative, supportive, and palliative services, and as a result engages a range of health care providers (e.g., physicians, nurses, nurse practitioners, occupational therapists, physiotherapists, and dieticians) (Lamarche et al., 2003). Primary care is a "level of a health services system that provides

entry into the system for all new needs and problems, provides person-focused (not-diseased oriented) care over time, provides care for all but very uncommon or unusual conditions, and coordinates or integrates care provided elsewhere by others" (Starfield, 1998). Primary care continues to be provided by family physicians and often is the first point of entry into the health care system for patients (Canadian Health Services Research Foundation [CHSRF], 2005; Doctor Sadok Besrour Chair in Family Medicine, 2003). Since family physicians play such an integral role in primary health care, their engagement and participation is critical to the success of any primary health care reform and renewal.

One of the principal goals of primary health care reform in BC is to cultivate a continuum of care (Primary Health Care Charter, 2007). A continuum of care relies on health providers and services from different levels of care to work together (Barr et al., 2003). Reid, Haggerty, and Mckendry (2002) proposed there are three types of continuity of care that are important in care delivery: continuity of information, of personal relationships and of clinical management. Team work between health care providers is central to all three types of continuity of care. In addition, collaborative relationships need to span health care organizations. Collaborations between organizations are necessary since no single organizational form provides all levels of health care services (in BC and in most jurisdictions in Canada).

Family physicians have been historically reluctant to be involved with other health service providers/agencies in collaborations. This type of physician resistance to change is cited as one of the major barriers to innovations in health care (Bhattacherjee & Hikmet, 2007;

Fottler, Gibson, & Pinchoff, 1980; Letourneau & Minnesota, 2004; Morris, 1998). The historical, cultural, and social aspects of how physicians are trained, organized, and remunerated greatly inform why there is such resistance to change (Abbott, 1988; Becker, 1977; 1961; Scott, 2000).

From my interviews with participants, health service providers in BC were increasingly practicing in silos beginning in the 1990's. The level of collaboration between family physicians and other health care agencies was diminishing. A growing number of family physicians were pulling away from providing services in hospitals and community care settings across the province, for example, fewer physicians maintained their hospital admitting rights, some limited their out-of-hour coverage, others left their practice (Watson & Wong, 2005, p.5). Family physicians were increasing isolated in their community practices. Through a province-wide consultation with family physicians, concerns were voiced by the profession about decreasing morale among those GPs providing continuous comprehensive care (British Columbia General Practice Services Committee [BCGPSC], 2007). The coordination with other levels of care and service providers had become less essential in defining family practices and identities. It is therefore of utmost interest that cooperative interorganizational relationships involving family physicians, the Ministry of Health Services, and the regional health authorities have started to emerge in BC.

The Division of Family Practice is a new and unique organizational form in British Columbia that brings together community-based family physicians who have historically practiced in isolated settings. Family physicians within the same geographic area with common health

care goals can form a Division of Family Practice in their community. Divisions of Family Practice are being created across the province. They are funded by the Ministry of Health Services and supported by the BCMA (Physician Master Agreement, 2007). For the first time, family physicians have a formal setting in which to raise their concerns about the "system" directly with the health authority (the other major service provider in the community) and the Ministry of Health Services. The Division of Family Practice serves as a platform for the theorization of change (Greenwood et al., 2002). By studying the Division of Family Practice as a case study of interorganizational collaboration, I am able to contribute to a deeper understanding of how the agentic process is involved in the de-institutionalization and re-institutionalization during radical organizational change, specifically via the negotiation of professional boundaries.

The purpose of this case study is: 1) to examine how the new organizational form, the Division of Family Practice, enables change in GP professional boundaries, and 2) to unpack the role of social boundaries in practice change. In order to provide a more comprehensive picture of the role of social boundaries in practice change, the findings from the case study will be summarized in the final chapter along with the findings from the examination of the HSR literature from Chapter 2.

3.1. Methodology

3.1.1. Sampling

The case involves a specific primary care redesign initiative in BC. The Division of Family Practice *is a non-profit organization through which family physicians with common health care goals and/or in the same geographic area in BC can be affiliated.* The Division of Family Practice works with the local health authority and the Ministry of Health Services (MOHS) to integrate health care in that community[21]. The purpose is to give "physicians a stronger collective voice and more impact in their community while helping them work together to improve their clinical practices, offer comprehensive patient services, and influence health service decision-making in their community" (Divisions of Family Practice [DFP], 2009).

As a non-profit society, the Division of Family Practice has a formal structure and defined stakeholder involvement. The types of collaborative projects are unique to each of the Divisions of Family Practice and are based on the priority issues facing that health service delivery area.

> "A Division of Family Practice will work with its local health authority [HA] and community agencies through a Collaborative Services Committee (CSC), co-chaired by both a Division and an HA representative. The CSC will develop and implement solutions to issues facing the delivery of health services at the community level across the continuum of care. Any initiatives requiring additional funding will require the support of the Division, local HA and the [Ministry of Health Services]." (DFP, 2009)

[21] In the case study, the local health authority is the Fraser Health Authority, FHA.

The single case study is on the Division of Family Practice in White Rock/South Surrey (WRSS). The WRSS Division of Family Practice was chosen because it was one of the first in BC. As one of three prototype Divisions, its relationship building and collaborations with its partners were further developed than those in other Divisions[22]. There were a greater number of projects initiated and more potential areas of collaboration for me to observe (e.g., documentation from the Division was available since fall of 2008 and from the CSC since April 2010).

The case-study approach facilitates the descriptive study of the recursive relationship between collaborative relationships and boundary work (i.e. *how* these concepts interrelate), and the inspiration of new ideas and theoretical development in the agentic process involved in the negotiation of professional boundaries (Siggelkow, 2007). The case-study approach also brings focus to contemporary events in primary care redesign in BC.

3.1.2. Data Generation

The study examines how inter-subjectivity, social interactions, and communication between the Division of Family Practice members facilitated and supported the redefinition of professional boundaries for the family physicians involved at the planning and operational level (Emirbayer & Mische, 1998; Zilber, 2002). To obtain rich and useful data, diversity in the data will be attained through 1) interview texts, 2) fieldnotes from participant

[22] The other two prototype Divisions are in Prince George and Abbotsford.

observations, and 3) texts from organizational and governmental documents related to the Division of Family Practice.

Interviews: Participants were purposefully recruited from the GP working group and health service providers who have been/are actively involved with the Division of Family Practice in WRSS. All family physicians who were involved in the initial development of the Division of Family Practice in WRSS were asked to participate in the study (i.e., physicians that were in the GP working group). Other stakeholder participants must have been involved since the development of the Document of Intent for the Division of Family Practice WRSS or have held an official role with the Division of Family Practice for six months at the time of the interview process. There were no exclusion criteria.

The initial GP working group that helped form the Division of Family Practice consisted of twelve (12) GPs from the WRSS community[23]. The twelve GPs from the initial working group and two other GPs who are current Members-at-Large were asked to participate in the project (n=14). Nine GPs agreed to participate in the study. Representatives from each of the health care stakeholders involved in the Division of Family Practice (BCMA, GPSC, MOHS, and FHA) were also asked to participate in the study[24]. Additional information from these stakeholders allowed me to gain other perspectives on the collaborative relationships and actions by the GPs. Six administrative participants were interviewed (1 – GPSC, 1 – BCMA, 2 – FHA, 1 – MOHS, and 1 – WRSS DFP).

[23] With the exception of one GP, all of the GPs from the initial working group are still involved at the planning level of the WRSS Division of Family Practice.
[24] The General Practice Services Committee (GPSC) is a committee formed by representatives from the BCMA and the MOHS to implement programs that improve health care for patients and job satisfaction for family physicians.

The final number of participants was determined during the data collection/analysis phase of the study. The sampling size was based on "the basis of the evolving theoretical relevance of concepts" (Strauss & Corbin, 1990, p. 179). During the interview transcription process, I felt that additional information about 1) the historical context of primary care in BC, and 2) the functioning of a specific collaborative project was necessary, therefore a second wave of GP interviews was conducted. Three more GPs were recruited to add to the understanding in these areas. In the end, 18 interviews were conducted (12 GPs and 6 stakeholders). To ensure anonymity, participants were randomly assigned a number that is cited instead of their name when they are being quoted.

Semi-structured interviews were based on an interview guide[25]. Interviews aim to draw out what the GPs' involvement with the Division of Family Practice is and how their interactions with the other actors in the Division of Family Practice (BCMA, GPSC, MOHS, and FHA) shape GP professional boundaries and identities. Each interview lasted approximately one hour. Interviews were digitally recorded and transcribed verbatim.

Participant observation of the monthly meetings held by the Division of Family Practice board and the Collaborative Services Committee provided further information on the nature of the collaborative relationships between the GPs and the health care stakeholders. An overview of the study was provided to the WRSS Division of Family Practice board and the WRSS Collaborative Services Committee. Both committees provided consent to participant

[25] The interview guide was revised and informed by the data from the interviews and participant observation throughout the data collection phase.

observation. I was introduced as a PhD student doing research on physician engagement and inter-organizational collaborations (and that I was sitting in on meetings as an observer) at the first set of meetings I attended. I participated as an observer in the Divisional board meetings and the CSC meetings from November 2010 to March 2011. I took hand-written notes during each meeting which were transcribed into fieldnotes at a later time. As an observer, I would sometimes ask meeting members for clarification of a certain topic, but I was never an active participant in these meetings.

During my field work, there was also an update and brainstorming session on a Division initiative with the greater membership of the WRSS Division of Family Practice (January 2011). I was allowed to observe this meeting which was attended by 31 Division members and a number of partner stakeholders.

Organizational and governmental documents helped inform the historical context, the macro-system context, and the structures and processes related to the Division of Family Practice. The documents were selected based on their ability to inform the case study, and they dated back to 2007. Appendix B lists the organizational and governmental documents used in the analysis.

I wrote fieldnotes and memos to document my personal reflections, insights, and ideas related to the study. After each interview, I wrote fieldnotes based on my observations about the interview (e.g., description of the setting of the interview, things I noticed about the participant, linkages to other pieces of information, ideas to follow up on). I wrote memos

throughout the data collection and analysis process as a consideration that I, as the researcher, am active in the research process. These documents also contributed to the data.

3.1.3. Data Analysis

The examination of texts (talk and written) is a method to study how historical, cultural, political, and social factors (i.e., institutionalization) shape actors' beliefs and practices (Phillips & Hardy, 2002). By examining the texts involved in the creation of social reality there is the potential to effect attitudinal and behavioural change (Tsoukas, 2005).

An interpretive thematic analysis was used (e.g., Braun & Clarke, 2006). One of the strengths of this form of thematic analysis is that it enabled me to summarize key features (themes) of a large body of data, highlighting similarities and differences across a dataset, while still being able to provide a detailed narrative (Braun & Clarke, 2006, p. 97). To begin the analysis, I reviewed the data to develop a general familiarity with the texts. I systematically examined and coded texts from the interviews, the participant observation fieldnotes, and the governmental and organizational documents. Initial coding consisted of reviewing text line-by-line and then identifying features of the data that appeared to be of interest and reflecting important ideas and examples. To ensure that context was preserved in the code, some surrounding data were included in the data extract (i.e., the individual coded chunk of data). The Atlas.ti 6.2 software was used to code and analyse the data.

Through an iterative process, initial codes were reviewed, refined, and collated to develop initial themes. Ideas from the data that had similarities or conceptual patterns became initial themes (conceptual groupings). I looked for processes, event series, connections to the big picture, and/or interactions between concepts to further refine the themes and provide contextualization (Miles & Huberman, 1994, p. 147). The emerging themes drew attention to specific parts of the data that exemplify how institutional elements and agentic processes are involved in the shaping of professional boundaries. The findings informed how the organizational form, that is, the Division of Family Practice, enables change in GP professional boundaries, and the role of collaborative relationships between GPs and other health services agencies in reshaping GP professional boundaries. My goal was to examine the interplay between meanings, actors, and actions.

3.1.4. Establish Trustworthiness

The study was approved by University of British Columbia Behavioural Research Ethics Board. Participant recruitment was through an introductory email by the President of the WRSS Division of Family Practice. The email provided an overview of the study - a brief description and the rationale - and a short biography of the researcher. The overview noted the researcher would contact participants directly to provide more information and to confirm participation in the study. Before each interview, the informed consent information was reviewed with the participant and informed consent was obtained. A copy of the consent form was provided to the participant.

Each participant had an opportunity to review writing excerpts where they were quoted and the written sections around the quote were appended to provide context for the quote. If there were disagreements in interpretation, the differing parties discussed the areas of disagreement and attempted to reach a consensus. If after discussion the disagreement remained, the various interpretations were presented and published (i.e., the parties agreed to disagree). The researcher held the right to comment on the various interpretations (i.e., to provide her perspective and context). The participants and/or executive sponsor had the right to withdraw from parts of the project and/or the entire project at any time by formally informing the researcher. No participants withdrew from the study.

3.2. Findings

The findings are organized into three sections. The first section is an account of GP professional boundaries as conceived by the family physicians who participated in the study[26]. Interview texts from the GP participants received the same analytical treatment as the HSR literature in Chapter 2. The analysis helps us appreciate how GP professional boundaries are represented by the GP participants in WRSS. Laying out the conceptions of GP professional boundaries for our GP participants is significant to setting the social and historical context in the case study. The second section is a historical account of events leading up to the creation of the Division of Family Practice in WRSS. The focus on the historical processes is to understand how things came to be the way they are (Phillips &

[26] Of the twelve family physicians who participated in the study, all except one practiced in WRSS at the time of the interviews. The one GP who worked outside of WRSS was interviewed to provide historical context to the case, and the interview text from that participant was included only in that section.

Hardy, 2002) and to locate where the social problem lay (Fairclough, 2001). The last section explores how collaborative relationships are being fostered by the Division of Family Practice and how the Division of Family Practice influences the professional boundaries of family physicians in WRSS.

3.2.1. Conceptions of Professional Boundaries from GP participants

In the qualitative examination of the HSR literature (Chapter 2), I found the demarcation of GP professional boundaries to be shifting. Many once-taken-for-granted tasks, activities, and values are no longer being used to define and maintain GP professional boundaries. Actors are drawing on different aspects of their work to define who they are as family physicians, resulting in a fuzzy GP professional boundary on a macro level. Despite a consistent call to be a "full-service family practice" community in WRSS, the representations of GP professional boundaries are more complex and conflicting upon a closer look. I found intrapersonal and interpersonal variations on meaning and interpretation attached to professional tasks and activities.

There are three cohorts of GP participants: those who practiced for over 30 years, those who practiced for 10-25 years, and those who practiced for less than 10 years[27]. Most of the board and the working group members of the Division of Family Practice in WRSS are family physicians that graduated during the 1980s. The family physicians from this cohort have a

[27] There was only one GP participant who was in the category of less than 10 years in the community.

substantial amount of experience in primary care delivery and are in a position to dedicate time to work outside their clinical practice.

> "So initially [I worked part-time] because I was very focused on my young family, and as the years have evolved I have maintained part-time clinical but then filled up with other things, more administrative. So overall I work full-time plus now [laughs]" (GP 76)

> "I saw myself as somebody who had quite a bit of experience in primary care and had a vision of potential for primary care. I saw that I could help shape the direction that things were going. I saw I could play a significant and positive role and that's one of the things that motivated me to be part of it [the Division of Family Practice]." (GP 81)

The concept of "full-service family practice" was inevitably brought up in the interviews as a core feature of being a family physician in WRSS. Most of the participants mentioned they were in a full-service family practice when asked to describe their practice and related tasks. When prompted to expand on the idea, participants referred back to the concept of **continuity of care**. Continuity of care is seen to be either caring for patients in multiple locations or through time – the same physician is engaging with the patient over time. Full-service means "you do maintain affiliation with a hospital" (GP 78) that means having **hospital privileges**. The family physician is the **coordinator of care** and is responsible for a **broad range of problems**.

> "To me that means, continuity of care, having a physician who will follow their results...basically be the quarterback in their care from cradle to grave, and without disjointed care." (GP 79)

> "Full-service means in the broadest term in my mind, a willingness to see the same people over time, ideally in different setting, but in this community it would mean involved in, involvement with the hospital practice. And seeing your own patients rather than say a walk-in setting or a temporary locum setting, where you're not engaged over time with a practice that gets to know you." (GP 77)

> "I have a full service family practice...and it includes hospital work, and nursing homes. So my day involves starting my day usually at 7 at the hospital, doing rounds for an hour and then coming to the office, seeing patients. And during that day I see a variety of patients of ages and problems, may have to deal with faxes from nursing homes or extended care facilities, pharmacies, or patients with urgent problems that can't be seen that day and want to know [what] they should do. As well as dealing with patients that are there to be seen for all their problems." (GP 80)

It is the **traditional model** of family practice and the concept of full-service family practice is used to contrast against the practice of walk-in clinics (i.e., **not a walk-in clinic**). It is fuller in scope and serves a full age spectrum.

> "So, full service is the, I guess, the traditional model of family doc and that... it's not boutique in a sense, it's not walk-in in a sense, so it complies to full service. Now full service is a bit broad in its scope. Full service as you see the full age spectrum, it might include obstetrics but it doesn't necessarily have to include obstetrics as part of the scope of full service. So it's the old traditional family doc who has hospital privileges, has a community practice. And that's really the full service concept." (GP 75)

The term full-service family practice is a succinct way for the GP participants to illustrate their professional boundaries. Unlike some communities, in WRSS it is important for family physicians to retain hospital privileges. This is reflected in the understanding of the term full-service family practice.

> "Well, in this community [full-service family practice] means we provide both office-based care, as well as hospital care, as well as care in nursing homes, and usually care at home...[our hospital] is one of the few remaining hospitals where family doctors still have privileges. In most other communities that's not even an option. So if you work in Vancouver as a family doctor, they don't have admitting privileges at [the tertiary hospitals] anymore. They have, at best, a few doctors having social admitting privileges." (GP 80)

GP participants' accounts of the full-service family practice concept *seem* consistent and coherent; however, variations start to emerge when the accounts are compared against the physicians' individual practices. Many participants provided caveats to their depiction of full-service family practice:

> "So the full-service is the full spectrum. Historically I've done, [I] used to do emerg, which I'd stopped two years ago; [I] used to do obstetrics, which I stopped about 10 years ago. Again it's just the time demand." (GP 75)

> "Full service in my mind usually means it's not just the patients that walk into your office you're looking after, you are also caring for them at home or in a nursing home or in the hospice or in the hospital, and that you're providing call for those places as well. And for some doctors, that might also include obstetrical care. So that you do your patient's delivery as well but for me that doesn't include that." (GP 80)

> "Full-service means that you do maintain affiliation with a hospital. And that you do provide some of the aspects of primary care that many GPs have perhaps let go such as maternity care. When I started practice I used to do emergency medicine as well, but emergency is now attended by emergency specialty-trained physicians. So I think full-service means that you do provide that continuum of care, right from community into hospital and that whole spectrum of care from newborn to end-of-life care including palliative care, including home visits. And so that's what I provide for my practice." (GP 78)

Rhetorically, family physicians still assume they are full-service family physicians providing "full spectrum" care despite having carved off certain pieces to other providers (intrapersonal variation). Many older physicians have given up emergency and maternity services which used to be part of their work; newer family physicians can choose not to take on emergency and maternity work. Emergency physicians and obstetricians have taken over the work in emergency and maternity services respectively. Interpersonal variations emerge as individual family physicians selectively choose how they practice, and put limitations on the tasks and activities they will perform.

GP participants have continually managed their professional boundaries during their medical career (i.e., they have shifting professional boundaries). Similar to what I found in the HSR literature, the GP participants are managing their professional boundaries by choosing to *limit tasks, specialize, and select clientele*. Specialization is based on a physician's areas of interest, and it may be in areas not closely associated with family medicine. For example, one of the physicians in WRSS has a unique interest in sports medicine.

> "General practice is half of what I do. So I'm here two and a half days a week. My general practice work is typical GP work [which] includes hospital practice. I am here all day Mondays and Thursdays, half day on Tuesdays. The rest of my practice time is spent doing musculoskeletal assessment. I have my subspecialty in sports medicine so I work at a separate facility...one and a half [to] two days a week. That's how my week is split up." (GP 79)

Family physicians are selective about who they will see. Coverage in the office setting of group practices is varied. Most family physicians will try to stick to seeing their own patients but there is some flexibility:

> "So there' maybe about eleven soon to be twelve of us here and we each have our own individual practice. We don't see each other's patients unless one of us is away. But we do have a rotating walk-in clinic here so every afternoon one of us is on call to see urgent care visits for all the doctors' patients. That's the one time we will see each other's patients, when we are covering the afternoon walk in." (GP 79)

> "Yes, our mandate is to try and see our own patients predominantly [but] if somebody is away, or if I'm in on an evening, or my partner's patients need to be seen, well, we'll certainly try to fit them in. The benefit of that is of course they are not completely strangers as they would be in a walk-in clinic necessarily because we have the whole EMR [electronic medical record] to fall back on." (GP 85)

Hospital work poses another challenge. Although GP participants work in a group-practice setting, it is not the norm for them to round on their partner's patients. The care for unattached hospital patients is highly undesirable[28].

> "The physician who doesn't do hospital [in our group], his patients are orphan patients. And we decided to do that because we didn't want any animosity because it is actually more difficult to do hospital work and office work then doing just office work. So when he joined, we decided we wouldn't cover his patients, but right now we're looking at [another doctor] taking them on as his orphan patients. So he would be, get credit for, seeing those patients, but they would be considered orphan patients." (GP 84)

Another conception of professional work and boundaries that was of interest is the idea of an atypical family practice. During the interviews, a number of GP participants considered themselves to be "atypical" family physicians. Participants claimed they are exceptions because they do not work as GPs on a full-time basis. Of the eleven GP participants interviewed from WRSS, only two participants work five-days a week in a family practice[29]. For the rest of the time, these family physicians work in other areas, such as a specialized service, administration, or another geographic location: "my practice is quite varied. I split my work between primary care [as a] general practitioner... [and a] certain proportion of my practice, a disproportionate amount of it, is involved with palliative care" (GP 77). Upon closer examination, it seems *typical* for family physicians to choose part-time work or some other alternative work arrangement. It seems like they are mythologizing what they do in

[28] Unattached patients are patients who are not considered to be patients of the physician in questions, or in some instances, patients who do not have a family physician altogether. Unattached patients are also referred as orphan patients.
[29] And of those two GPs, one works a 4-day week on alternating weeks.

order to rationalize the differences between their actual practice and their definition of family practice.

Family physicians are free to choose how they want to work. The autonomous nature of being a family physician allows them that flexibility. The community of WRSS envisions a single, unified vision of full-service family practice for the community. In order to accomplish this, family physicians have to identify with the full-service practice model and choose to practice full-service family practice. The challenge is dealing with the work realities, individual preferences, and the autonomous nature of being family physicians.

3.2.2. The Historical Context

> "Every time I have been involved with primary care [initiatives] before, it was much more adversarial. So one would have a good idea and they have to work very hard to sell that to the Ministry or to the Health Authority. And there was much more of a turf-protection. So everyone would protect their own turf and advocate for their department. At this time for whatever reason there was much more of a collaborative atmosphere in place. Both the Ministry of Health and the Health Authority, and BCMA and the physicians all wanted to work in the same direction on the same sorts of things. So that sense of collaboration was terrific and that's when I realized [the Division of Family Practice] has a high chance of succeeding." (GP 81)

Before the Division of Family Practice

The working atmosphere in the primary care sector in BC has gone through a major shift over the past decade. Previously isolated and sceptical actors are now working together to transform the delivery of primary care. The provincial government of BC and the BCMA recognized that the morale in primary care was at an all-time low and something needed to

be done to retain and expand the number of family physicians working in the province. The creation of Divisions of Family Practice was the latest in a series of initiatives to support and engage family physicians in BC[30].

Historically, the relationships between the various actors (i.e., family physicians in BC, the BCMA, the MOHS, and the health authorities) were defined strictly by service contracts. In order to develop service contracts, actors come together to ensure things that are specified in the contracts, such as services and remuneration, are delivered. Each set of actors was looking to maximize their own benefit. That is, the family physicians seek to be fully compensated for all aspects of their work (which is increasing in complexity and hours), and the Ministry's goal was to draw up a compensation package that is within its service parameters (to purchase affordable, cost-effective physician service). The relationships are mostly transactional and exchange focused (e.g., who is providing the service/who gets paid; how do they get paid; how much services are being delivered/what do they get paid for).

As the funder, the government does not actually deal with the family physicians directly[31]. The BCMA is the intermediary to negotiate "for and on behalf of physicians for their compensation". The medical association is also responsible for setting medical service fee schedules and negotiating the schedule of benefits paid by the Medical Services Plan, as well as representing sessional, salaried, and other alternative payment physicians" (BCMA, n.d.). The BCMA represents *all* physicians in British Columbia. Organizationally, the BCMA have to manage the range of demands and concerns from different medical disciplines and

[30] The other initiatives are all under the umbrella of the General Practice Services Committee (GPSC), see footnote 31.
[31] Whereas in the delivery of hospital care, the government deals directly with the regional health authorities.

geographic regions (16 districts). The economic and political interests of the General and Family Physicians are represented by the Society of General Practice (SGP) while the Specialists and Surgeons are represented by the Society of Specialist Physicians and Surgeons (SSPS). The BCMA is responsible for negotiating with the MOHS to develop an agreement that is then voted upon by the BCMA members.

The principal service contract for physicians in BC is the Physician Master Agreement. The Physician Master Agreement is more than just a financial agreement between the physicians and the MOHS; it circumscribes the interactions between actors (the funder, the service provider, the intermediary, the service partners). For example, different committees are set up in the process of the development of the Agreement: the Physician Service Committee is "to serve as the senior body overseeing the *relationship* between the Government and the BCMA and the implementation and administration of this Agreement and the Physician Master Subsidiary Agreements", and the Collaboration Committee is there "to *facilitate the involvement of physicians* in identifying and implementing cost-effective and sustainable innovation and constructive change throughout the health care system…" [emphases added] (Physician Master Agreement, 2007, p.15 and 19). These committees facilitate various aspects of work in order to deliver a Physician Master Agreement that can be approved by all parties. There are prescriptive steps and expected conduct for negotiations and resolutions. Teams, committees, and sub-committees, such as the Share Care Committee, Conflict Resolution Team, and Patterns of Practice Committee, dictate how actors interact and work with each other. The exchange-based interactions used in contract negotiations drive

participants' behaviours. Actions by actors are formalized, positionally-oriented, and top-down.

The quality of the relationships between the different actors was historically quite negative accordingly. There was a great deal of mistrust between the BCMA and the government.

> "People were often reactive working on the government side. We got past the stage of mutual adversariality and hyper-defensiveness [now]. In the past, I would say both sides of the negotiations, the BCMA and the Ministry, were devoid of trust in each other and were somewhat defensive." (Admin 71)

> "We actually, at the time, had a war-like relationship between government and the BCMA and doctors. Doctors were the enemy. And obviously the result of that was very poor patient care, with no sustainability, and we were [at risk of] losing the most critical part of the physician services, the family doctors. And it was out of that environment that it was decided to change and negotiate practice [change] and experiment with this committee, a joint committee between the BCMA and the government, to see if we could do interest-based negotiations." (Admin 73)

The family physicians felt disengaged and frustrated with what was happening in primary care. GPs felt left out of the policy development process in primary care, despite having the SGP representing them at the collective table. They felt like they were blamed for poor patient care, but yet had little input in the system. It felt like the BCMA and the Ministry making these decisions for them.

> "I think in the past the problem has been there hasn't been great communication between one side and the other, and that has lead to feelings of frustrations from both sides." (GP 80)

> "I think physician organizations have let down primary care terribly up to this point. I think the lack of over-sight and control of the way walk-in clinics [have] developed over the number of years and the huge variations in quality of care that comes out of them has been a major failure of the BCMA and the College of Physicians. [They were] not scrutinizing more closely, making more careful demands on what happens [because] although much of the care is very competent and appropriate, some of it is pathetic and inappropriate." (GP 77)
>
> "You may have heard other physicians talk about the old days. Family practice was not at all a pleasant place to be in the 1980s and 1990s. We were viewed as the enemies of government and the enemies of health care. And we were basically the people who cost a lot of money to health care. It was a very unhealthy environment and a lot of physicians left because of it." (GP 79)
>
> "…if you went to a dinner certainly 5-7 years ago of doctors, and they had a glass of wine each and you had them talking about the administrators. The vitriol and the contempt you would have heard would explain the isolation and the absence of clinical input into building a health care system." (Admin 71)

It is in this environment that the Ministry and BCMA realized they needed to develop solutions to not only improve health care for patients, but they needed to find "new ways to address the mounting problems of low morale and decreasing professional satisfaction among BC's full-service family practice physicians" (BCGPSC, 2009a). The General Practice Steering Committee (GPSC) was formed through the 2002 Physician Master Agreement[32]. The GPSC has representatives from the BCMA and the MOHS, and its purpose is to support "general practice physicians by developing and implementing programs that improve health care for patients and job satisfaction for physicians" (BCGPSC, 2009b).

The creation of the GPSC was referred to by some of the GP participants as one of the first signs of positive change in the primary care environment in BC. A major consultative

[32] The Specialist Services Committee (SSC) was created for the specialists and surgeons. The GPSC and the SSC were part of the wave of changes happening in the BC health care environment as a result of the 2002 Physician Master Agreement. The Medical On-Call Availability Program (MOCAP) was another initiative from the 2002 agreement.

process, the Professional Quality Improvement Days (PQIDs), was carried out from the fall of 2004 to the summer of 2005. The Government and the BCMA agreed to fund this series of consultations around the province to hear what family physicians had to say.

> "The biggest thing I think that over the past I am going to say five years that has really impacted us is the GPSC. So the GPSC has identified through these PQIDs and discussion with the government that there has to be a change. And for the reasons I mentioned earlier: aging population, complexity, time involved and so on, and we don't have time. And there's an exodus of GPs out of doing full scope family practice." (GP 75)

> "We went out and asked doctors, primary care doctors, what was wrong with their lives, in the professional lives and quite frankly it has some affect significantly in their personal lives… they were [also] attended by health authorities, Ministry of Health folks, and by BCMA folks. Most of them just listened and what they listened to was very vituperative on some occasion. It was very strong; it was very angry; it was very alienated. It had a lot of much needed venting, but we tried to also take from it the suggestions, the constructive suggestions for improvement. And to identify what family physicians felt were the needs in order to get out of the morass…that they found themselves in. And the existence of which is recognized by all the players. And they told us the four things they needed was - pay us, value us, train us, and support us." (Admin 71)

The PQIDs was not only a place for family physicians to voice their frustrations and ideas, but more importantly, it was an event that engaged previously disinterested physicians.

> "What happened was there was the first GPSC proposal, right. And there was the PQIDs 2005 I think? 2004? And it was all about... It was the beginning of the primary care renewal agenda. And I know I went to the big meeting and I had for like 20 years thrown everything in the garbage or maybe 15 years thrown everything in the garbage from the medical association or from, I just didn't pay any attention. It wasn't that I was angry or anything. I was just busy with small kids, and medical politics, whatever, you know. But it was clear as well, family practice is going down. My partner is retiring; there's nobody new coming into this. I'm not going to get somebody to replace her. Nobody is valuing… I went to that big meeting… All I knew was none of this has anything to do with the core values of what I do in my work… I was shocked like none of this is going to help. I actually remembered thinking… Who so missed the message of what primary care is about? Was it the government; was it my medical association; was it the health region? ... How did what matters get so lost in this? I'm going to pay attention from now on." (GP 83)

The diabetes collaborative was the first pilot project that the GPSC worked on (2002). The GPSC was "...working with doctors to identify how better to serve their patients with diabetes through more of a population health lens" (Admin 68). The collaborative was based on the Expanded Chronic Disease Model (Barr et al., 2003), and guided by the Institute of Health Improvement's (IHI) quality improvement framework. The diabetes collaborative's success led to collaboratives being set up in other chronic diseases (i.e., congestive heart failure, hypertension)[33]. Following the chronic disease collaboratives, the Practice Support Program (PSP) was set up in 2007. The program offers "focused training sessions for physicians and their medical office assistants (MOAs) to help improve practice efficiency and to support enhanced delivery of patient care" (BCMA, 2007). As of January 2011, the GPSC has fifteen initiatives under four work streams: "and while doing that work, we [the GPSC] have 15 different initiatives" (Admin 73).

[33] This set of chronic disease collaboratives would become part of the Full Service Family Practice Incentive Program (FSFPIP), one of the four streams of work for the GPSC (BCGPSC, 2009a). The four work streams are: FSFPIP, Practice Support Program, Divisions of Family Practice, and the Community Healthcare and Resource Directory (CHARD).

The Creation of the Divisions of Family Practice

The Division of Family Practice is another one of the work streams for the GPSC. The Divisions of Family Practice are "affiliations of family physicians (FPs) with common health care goals and/or in the same geographic area of BC" (DFP, 2009). The Divisions of Family Practice have three distinct features: they are non-profit societies; they are locally-based organizations; and they are setup and run by family physicians. Family physicians at the community level self-organize to work with their Health Authority, the GPSC, and the Ministry of Health Services *as partners in order to make changes at both the practice level and the health system level* (DFP, n.d.).

One piece of feedback from the PQIDs is that family physicians want to be involved in health system planning and management (British Columbia Medical Association [BCMA], 2004). The Divisions of Family Practice provide the organizational support to make this possible.

> "So there were two drivers. One, we [the GPSC] were looking at in-hospital care … but the working group was struck … we were going in circles, we could not see a better way of approaching in-hospital care. We knew the present situation was in disarray because family doctors were contacting us and telling us…So that was one driver - in-hospital care was disintegrating… And the second thing was the voice and influence [of family physicians]. Doctors were saying generally through the PQIDs and through many other venues: 'We are frustrated. We see inefficiencies in the system. We see ridiculous things in the system and we are absolutely powerless to solve them.'" (Admin 73)

> "So when it finally came time to look at the next thing the General Practice Services Committee wants to work on, they realized they pretty much maxed out on the number of process-related activities they can do. So there was diminishing return on investment. So it was time to try something that was more of a structure. Now the structure was about how to put into place ways for groups of family doctors in a local area to build, that they have a sense of community; that it is cohesive; that they knew each other. When it came time for discussion about things that couldn't get resolved unless a majority of doctors can get together to resolve it with their partners, there would be a system to actually bring them together." (Admin 68)

The Divisions of Family Practice are meant to "give physicians a stronger collective voice and more impact in their community while helping them work together to improve their clinical practices, offer comprehensive patient services, and influence health service decision-making in their community" (DFP, 2009).

The physician organization (i.e., Division of Family Practice) as an organizational form for family physicians is not new. Other jurisdictions such as the United Kingdom, New Zealand, Australia, and Alberta all have similar models for family physicians to work together and network; however, there are distinctions between the other physician organizations and the BC version:

> "The [other] FP organizations did not include improved patient access, health outcomes and physician professional satisfaction among its ultimate goals. They operated in competition, rather than in alignment, with the regional health authority delivery system. They did not consider their community and local government as partners." (DFP, 2009)

> "We looked at an entity that would provide that voice and influence in the system. And we ended up by identifying Divisions of Family Practice. We looked at networks; we looked at Divisions of Family Practice; we looked in Australia, New Zealand, the UK, Alberta, and Ontario. And we preferred a BC-made Divisions of Family Practice." (Admin 73)

In creating Divisions of Family Practice, the government of British Columbia started with three community prototypes: Abbotsford, Prince George, and White Rock/South Surrey. The White Rock/South Surrey GP community was the last of the prototypes to come on board. The initial discussions with the GPs at White Rock/South Surrey happened in January 2008.

The Community of White Rock/South Surrey

The community of White Rock/South Surrey (WRSS) is a suburban community with a population of 18,250 in the southwest corner of the Lower Mainland in British Columbia (City of White Rock, n.d.). The community hospital is the Peace Arch Hospital and is administered by the Fraser Health Authority. The hospital relies on the family physicians to be the most responsible physician (MRP) for all of the patients in the medical, palliative, sub-acute, and the geriatric assessment and treatment units. Maternity care is provided by the Peace Arch Maternity Clinic, which is mostly staffed by family physicians. The family physicians act as consultants for the surgical and the psychiatric units, and some family physicians provide surgical assists for patients from their own practices as well as for patients admitted as orphan patients. The Department of Family Practice oversees and represents the family physicians working in the hospital.

It is a close community with a manageable group of family physicians working in a small geographic area (less than 100 GPs in the community). There are two large group practices, and the rest are small group practices or solo practices. Relationships between physicians in

WRSS have always been good: “White Rock is a pretty close medical community and we have a history of getting along well with everybody, and we’re all friends” (GP 74). The physicians in the community have a history of developing system-level solutions. The creation of the community walk-in clinic is one example of that.

About 20 years ago, walk-in clinics started to emerge in WRSS. The family physicians were frustrated with the lack of continuity of care when their patients would go to the walk-in clinics. Information from the patient’s visit at the walk-in clinic did not go back to the patient’s family physician.

> “There had been two walk-in clinics come to the area and the doctors were slightly frustrated with, I guess, communication that was coming from them because their patients, if they needed to go somewhere else or went somewhere else, the doctor would never be made aware that this patient had gone somewhere different, much less if any medications had been changed or, you know, modes of treatments had been altered.” (Admin 72)

Family physicians also perceived that they were left with treating the complex cases while the walk-in clinics were dealing with the quick urgent cases. So in 1993, a group decided they would open up a walk-in clinic of their own and ensure documentation from patient visits was reliably forwarded to the family physician. The community walk-in clinic is still operating today with about 40 physician shareholders and 35 physicians working shifts.

> "We felt the pressure of walk-in clinics and they were seeing patients, sort of the quick urgent patients, and we were defaulted to seeing the sort of more complex patients. So that was our, sort of, built-in locums in the community. So if I am not here on a certain day I would send my patients to our [community walk-in] clinic. We would receive information back as to what happened the next day for my patients. So essentially I had sort of a locum in the community that would look after my patients." (GP 75)

The WRSS GP community spearheaded the creation of other services such as the maternity clinic and the youth clinic when the perceived need came up. It is an active physician community that seeks to work with their community partners (e.g., the local hospital foundation) and the local health authority. These initiatives not only demonstrate a community approach to solving issues of patient care and physician coverage, they demonstrate the WRSS GP community is willing to come together beyond the walls of individual practices (refer to Chapter 2 on the notions of GP professional boundary) to solve collective problems.

Unattached Patients - The Issue that Led the WRSS to Become a Prototype Division

The WRSS GP community historically has worked well with the local health authority to provide hospital care services for the community. However, by the mid-2000s, the ongoing provision of hospital care services by family physicians was under threat in WRSS. The number of unattached patients was increasing. Patients were presenting with complex conditions, and inpatients had high acuity. The volume of patients was also rising (Proposal for enhanced GP services at Peach Arch Hospital, March 2008). Family physicians were experiencing mounting workloads at the hospital in addition to their office practices.

There were approximately 55 family physicians in the community at that time, and of those, over 50 had admitting privileges (White Rock/South Surrey Family Practice Group [WRSSPG], 2008). Questionnaires distributed to the family physicians who had admitting privileges indicated that 9 of the 16 respondents had considered "dropping out of the unattached patient roster over the preceding few months" with 5 of the 16 respondents considering giving up their hospital privileges (White Rock/South Surrey Division of Family Practice [WRSSDFP], 2009, p. 121). "Physicians were leaving or threatening to leave the active staff of the hospital because of the extra burden of looking after patients that weren't their own." (GP 77)

Around the province, communities were seeing family physicians give up their hospital privileges for a number of reasons: "getting too many orphan patients, can't park, parking is expensive, it takes time out of my day, I get calls through the day, all that sort of stuff. I don't need this, this is a headache" (GP 75). Hospitalists replaced family physicians and took over the duties as the MRP of medical patients. A group of concerned WRSS family physicians was trying to find a way to keep family physicians providing hospital care services in WRSS.

> "We as a community felt that better care for the patients would be to have the GPs maintain hospital privileges, so they can follow them in and out of hospital. But we wanted to find a way that can be doable that we would be able to spend the time with them in the hospital to do a good job and be able to get back to our own offices." (GP 78)

> "So it was around that time that we were really struggling here. The load of the unattached patients was getting more and more. We didn't feel supported by the health authority... There was starting to be a concern that family doctors would stop, start dropping out of hospital work. And that we might end up with hospitalists here in the way other communities had. And by watching the evolutions in other communities, we could see that would really erode the community vision of full service family practice. So we had formed a steering committee, I think it was as far back as the summer of 2006 actually, looking at basically the issue of GPs in the hospital. (GP 76)

By having hospital privileges, the family physician is accepting the responsibility of being the MRP for medical patients in the community hospital. The "privilege" of hospital care adds substantially to the physician workload, but it is also rewarding.

> "So I think there's a huge [in]convenience to being to have hospital privileges. You've got to do your charts, you're supposed to go to medical rounds, being called, call from patients that are in your call group that you've rounded on and so on." (GP 75)

> "I think it's really important to keep physicians engaged in the hospital. I think educational value, communication value, relationships with colleagues and so on. I mean there's lots of thing that are, I think, important to maintain the docs, GPs, in the hospital. I think if you just work here [in an office practice], you shorten your life expectancy [laughs]. I think you just don't learn as just [much] and you're just not as involved. So I think it's important to be part of that, personally." (GP 75)

The additional pressure of caring for unattached patients might be the straw that broke the camel's back. Unattached patients get assigned a family physician to be their most responsible physician when they are admitted to the hospital. The patient assignment is from a roster of family physicians that are willing to take unattached patients (i.e., the Doctor of the Day program). In general, unattached patients are more time consuming and resource intensive to care for because physicians lack information about the patient's history. Family

physicians also prefer to take care of their own patients (as opposed to another GP's patients). With the number of unattached patients growing, family physicians were spending more time at the hospital while having to still keep up their office practices.

> "So then there is the model where the GP would traditionally came in and see patients, right, [we all] got a whole bunch of orphan patients, you know, and they, there was a wave of discontentment about getting all these orphan patients and I really should be looking after my patients in the hospital. And I am just getting overloaded and I don't want to do this." (GP 75)

> "We had a lot of patients coming into the hospital whose GPs were outside of our community and we were taking turns looking after these people, but it seemed that their care was not optimal because we were very busy. GPs were having to do rounds in the hospital and then going back to our office. And in order to provide comprehensive care, you really need to contact their GPs, get their medical history and figure out what's happening with them, do their acute care investigation and what not, and then help them to discharge back [to their own GPs]. And that was very time consuming. So we had a lot of difficulty maintaining that kind of work." (GP 78)

The cost of running a clinic is also a factor:

> "So we were looking for a way to get some funding that would allow physicians to take time out of their offices and pay their overheads and spend a number of hours in the hospital, maybe on rotation basis to look after the hospitalized patients." (GP 78)

It was the unattended patient issue that brought the WRSS GP community to look beyond their community for a solution[34]. In 2008, the executive director of primary care at the local

[34] Prior to the formation of the Division, the WRSS GP community and the local health authority did put together a proposal for the MOHS (2006), where the GPs in the community would be the hospitalists. It was called the GP hospitalist program. The program never got going because of funding problems – the MOHS claimed it was the HA's responsibility to fund the program, and the local HA argued that funding should come from the MOHS.

HA set up a meeting where the WRSS family physicians met with representatives from the MOHS and the GPSC (Figure 3.1). One of the participants described the event:

> "I could see that the BCMA and the Ministry of Health were both starting to speak the same language, or I was hearing from both organizations about the importance of family practice. So the representatives from the Ministry and GPSC came to that meeting and we were presenting at that time our frustrations with this whole hospital issue…the Assistant Deputy Minister at that meeting said, 'we know you have a problem and we want to work with you to fix that problem, but actually we would like you to work with us to look at the deeper issues of supporting family practice and as part of that we would find a solution to your hospital work. But would you be willing to have us come back and have a workshop with you, a half day workshop, where we really look at these issues.' And we said yes we would." (GP 76)

A working group made up of twelve local GPs was struck to look to define and articulate clearly the issues and challenges from the GP perspective to help with launching the conversations with the MOHS. The group was tasked with the development of a document outlining the background, the current concerns, and the scope of services in the WRSS GP community, and a proposal for enhanced services. A series of meetings between the GP working group from WRSS, the MOHS, the GPSC, the BCMA, and the FHA explored reasons for developing a collaborative relationship between the concerned parties and culminated in the formation of the White Rock/South Surrey Division of Family Practice. A "Document of Intent" (DOI) was formulated and signed by all the partners involved in and supporting this process. By winter of 2008, the Division of Family Practice in WRSS launched their first service-priority program in the Peace Arch Hospital (the Family Physician Hospital Care Program).

That was the genesis of the Division of Family Practice in WRSS. Prior to this series of events, the working relationship between family physicians and health care agencies (the FHA, the BCMA, and the MOHS) were more or less transactional, exchange-based interactions. The Divisions of Family Practice are reshaping how the organizations interact – less market-based and rule-based interactions (Ouchi, 1980) and increasingly towards interactions based on "sympathetic understanding" of each other's goals, interests, and limitations. Family physicians were willing to work with health authority administrators to figure out the care of the unattached patients.

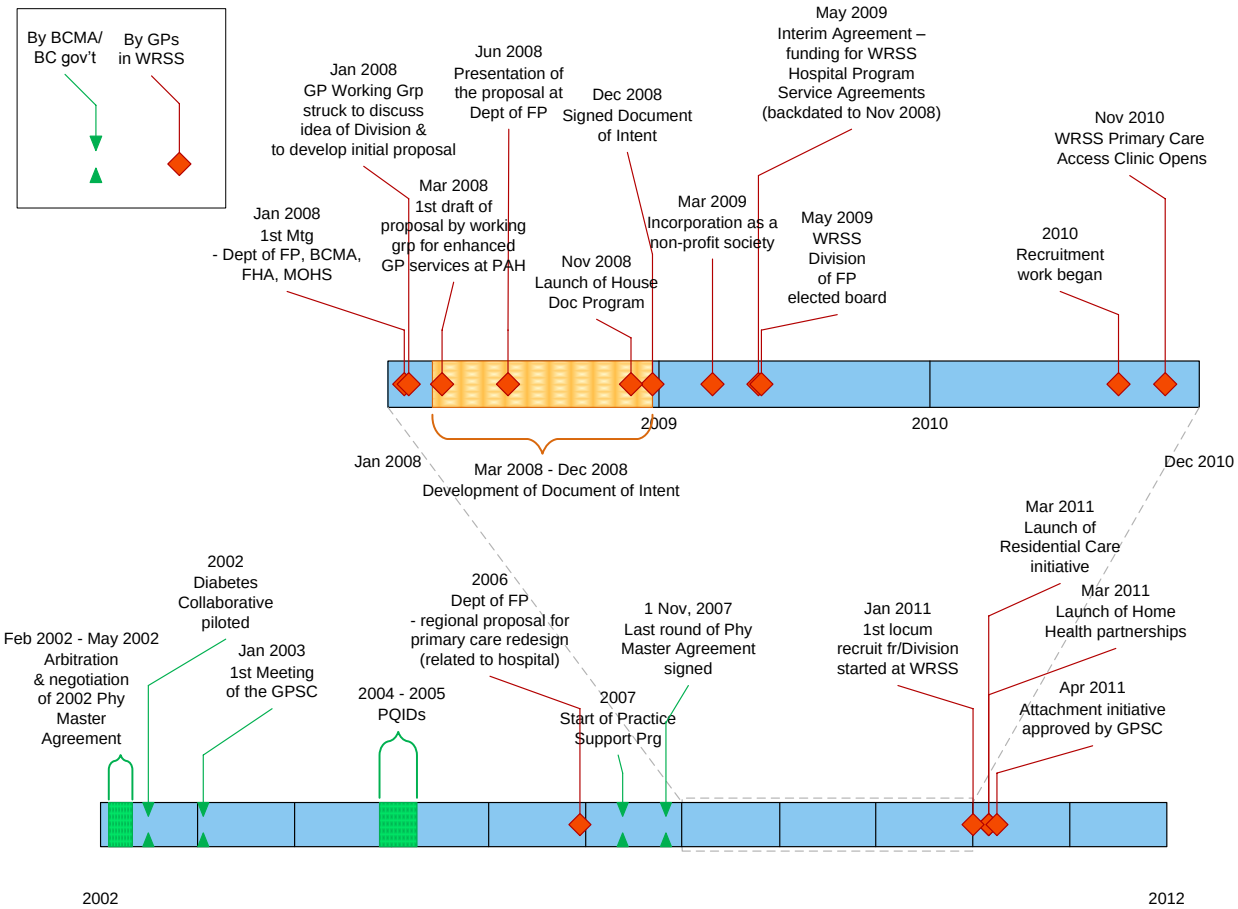


Figure 3.1: Timeline for the Formation of the Division of Family Practice in WRSS

3.2.3. Division of Family Practice Encourages Collaborative Relationships

The Division of Family Practice is a new organizational form in the health services landscape of BC. Since the formation of the Division of Family Practice and the Collaborative Services Committee (CSC), interactions between the family physicians in WRSS and other health care agencies are more collaborative than they have been before. Two new sets of linkages have emerged through having the Division of Family Practice in the community and the Collaborative Services Committee (Table 3.1).

	Within Same Profession	**Between Different Professions**
Within Same Organization	Family physicians are partners in a group practice	Family physician is a provider in multidisciplinary care in the hospital
Between Different Organizations (interorganizational)	Family physicians are members in the **Division of Family Practice**	Division of Family Practice is a partner in the **Collaborative Services Committee** (CSC)

Table 3.1: Types of Collaborative Relationships

The Division of Family Practice is welcoming to all family physicians. The physician-to-physician interactions in WRSS have broadened as a result of the Division of Family Practice. Previously, opportunities to interact with other family physicians came predominantly through the hospital (e.g., medical staff meetings, the Department of Family Practice meetings) or being in the same call group. Physicians cooperated as a result of their obligations in the hospital. Informal social interactions exist with some family physicians in

the community. In contrast, membership to the Division of Family Practice is open to any family physician in the geographic area. The Division serves as a bridge to connect with the community-based family physicians that do not have hospital privileges and who have not been actively engaged in the GP community in the past.

The Division of Family Practice is a partner in the CSC where they sit with the MOHS, the BCMA, the FHA, and the GPSC. The function of the CSC is to bring partners together to "present clinical issues of concern for patient care outcomes, co-determine priorities and co-design solutions, calling on additional voices from patients and the community" (WRSS Collaborative Services Committee [WRSSCSC], n.d.). And according to the terms of reference, the WRSS CSC "embodies the collaborative working relationship among the Partners" and has a collaborative process that "is not intended to mirror traditional negotiations".

It is the collaborative nature of the Division of Family Practice that facilitates the (re)shaping of GP professional boundaries. Partners of the CSC gain an appreciation for each other's goals, values, and limitations through the interest-based negotiation process; **sympathetic understanding** for their partner's circumstance develops. The Division of Family Practice and the CSC are seen to be **"helping" structures**. Divisional programs and initiatives have brought, or are seen to be bringing, relief of the administrative burden for the family physicians. The partners are viewed to be genuinely supportive of family physicians. Family physicians in WRSS are taking **ownership and accountability** for things that were never accepted to be in their jurisdiction in the past, the largest endeavour being the operation of

the Division of Family Practice. Over the rest of this section I will elaborate on the mechanisms and agentic processes that enable change in the GP professional boundaries.

Sympathetic Understanding

Both the Board of the Division of Family Practice and the CSC have monthly meetings. These face-to-face meetings are meant to update members on the Divisional initiatives and activities/events in the community. Physician issues are brought to the Division first; the Division also canvasses for practice-level and service delivery issues within their membership. Matters that can be dealt with by the Division, for example, locum placement and physician recruitment, stay with the Division while the CSC is where the Division and the local health authority "bring forward issues that they both actually want to work on" (Admin 68). Projects are developed through an interest-based process. The CSC will only invest in:

> "…initiatives that were only mutually desired. So that if the health authority wants to do one thing and the doctors in the Divisions weren't particularly interested, it died. If the doctors wanted to do something and the health authority didn't want to do it, it died. And funding kept being withheld until they can come up with something that's of mutual and common interest." (Admin 71)

The MOHS, the GPSC, and the BCMA representatives are at the meetings to provide planning and policy support to the projects (e.g., funding, administrative and accounting, communication). The CSC meetings are co-chaired by representatives of the health authority and the Division of Family Practice. Either the health authority or the Division can put

forward a problem they want the other partners to help with. The issue is put on the agenda of the monthly meeting, and it is discussed. Unresolved issues are followed up on in subsequent meetings. During the time of my field work, the monthly agendas were quite consistent. A project idea was under discussion for months as the problem was (re)defined, constraints and benefits were identified, and a service agreement was spelled out. Issues with implementation are brought up. The CSC partners are able to provide the political and organizational context from each of their perspectives; solutions and workarounds are offered to the collective table.

> "I think there are things even with residential care, like at the last meeting [a GP board member] was like, 'we're afraid this whole residential care proposal is falling apart. Like we're not getting any answers, the Ministry seems silent and the partners seem discouraged.' And [the MOHS representative] said 'no, no, no, no, someone's been sick; we've been short staffed; and it's still viable; it's there; you know, give the partners hope.' And within three days, we have the formal agreement ready to go. [I] was like, okay, this is good. I think we can hear each other; there's an avenue for way more progress or for at least an understanding if there can't be progress. You understand why or the constraints that, cuz I've heard a couple of the people from Fraser Health going, oh yeah if we give you this, we can see that, and in turn you'll have to prove it was worth it, so you have to show us how that saved a million dollars. Okay, fair enough. You're under the gun to have to prove that what you're doing is worth it, and we're part of the reporting structure that says this is how you saved the money. And so yeah, *you get that they are under just as much pressure being able to do their job as you want doing yours. So I think it's healthy. It's new. It's not even a year old yet, but I think it's good.*" (Admin 72), [emphasis added]

> "You've only been to one CSC so far I think. But, it's completely changed the way we interact with the health authority. Part of that are the personalities around the table and commitment to the process as a whole, but what you find now is there are no secrets. So this is a huge change for all parties. So the cards are [on] the table, people understand what the others' limitations are. And you don't always agree necessarily, but at least we have an understanding of where people are coming from and what's possible and what's not. So, I think it's profoundly changed how we interacted." (GP 76)

Relations between the different partners have been altered. For family physicians in WRSS, their relational boundaries have expanded. They have a more intimate relationship with the GPSC and the BCMA, and have made new connections with the MOHS. Relationships with the health authority are being restored. Family physicians have a more equitable relationship with the local health authority.

> "The biggest shift that I can see in that environment was creating a new environment where the family doctors weren't simply...part of the Health Authority and having to follow the rules of the Health Authority, like being placed on a committee that the Health Authority controlled...Now with the Division of Family Practice, the shift is the group of doctors still have a good relationship with the Health Authority, but that there's a relational power shift. So the doctors come to the table with the Health Authority in an equal partnership rather than invited inside the Health Authority and the Health Authority [is no longer] setting the parameters of the relationship." (Admin 68)

Family physicians are sensing that they have a voice at this collective table. Things that were perceived to be institutionalized are open to examination and have a potential for change for every partner. A number of GP participants spoke about how the Division is the catalyst for moving ahead with changes at the health authority.

> "Whereas I find with the Division, there's a lot that we've been given the ability to change...things that we have felt were written in stone. Things like home health or mental health which are institutions that have almost been viewed as archaic and that they have been run in a certain way for a long, long time. And people there don't like change. It's scary." (GP 80)

> "So that [financial incentive policy] was an absolutely ingrained policy that hadn't changed for years no matter how the GPs might have complained about it, but this Division structure and the inter-divisional counsel lead to [the HA executive] advocating for change and it happened." (GP 76)

From the health authority's perspective, before the Division of Family Practice there was no meaningful way for the health authority to relate to the family physicians, or for the health authority to involve family physicians in how primary health care was delivered. Because family physicians are in independent practices, it was difficult to solicit input or collaborate with the whole community. The Division of Family Practice is the entity that brings together the family physicians in the community (Figure 3.2).

> "We had no way, we would have had to link with hundreds of individual physicians and see what they want because there was no co-ordinated voice or collective structure that brought all of those physicians together. So same way if we look at how we want to redesign home health services, we had no entity that we can sit down with, meaningful table, and have collaborative discussions on how we wanted to redefine the system. Because we would have had to have it with Doctor Jones, Doctor Smith, Doctor…now Doctor Jones said I don't agree with Doctor…it just became impossible. And health authorities sometimes try and you'd find ten doctors that would kind of agree that this is what we'd do, while, another ten docs say 'well, we totally don't agree. Sorry we're not going to do it.' To me it comes down to a basic element of all partnerships, if the health authority is being seen as one entity, it becomes almost impossible to develop a partnership with nine hundred individual people." (Admin 69)

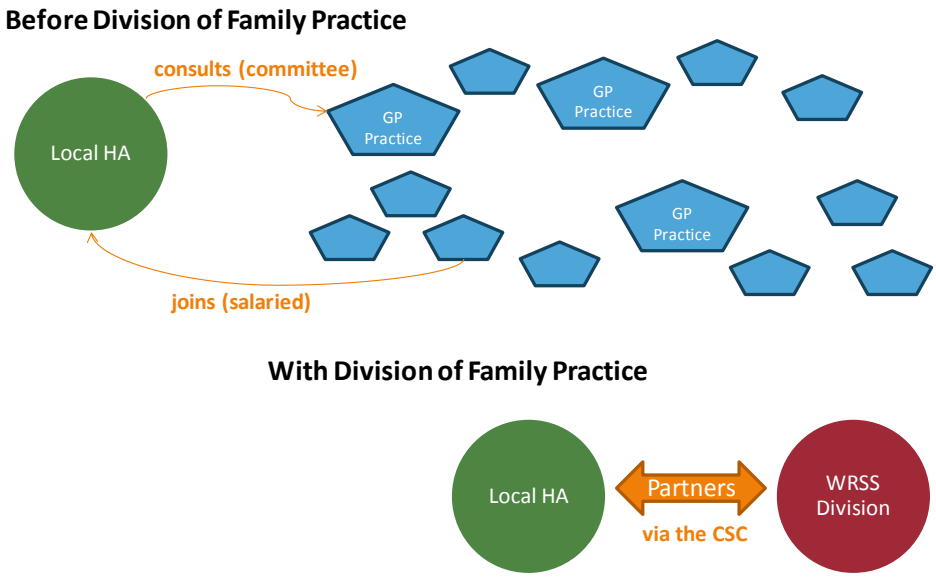


Figure 3.2: GP Relationships with the Local Health Authority

Before the formation of the Divisions, the relationship between family physicians and the MOHS was less than significant, with minimal interactions. The government might become aware of a local regional concern if a physician group took up a local contract dispute or a local quality of care issue during contract negotiation (Physician Master Agreement, 2007). Now, family physicians in WRSS recognize staff from the Ministry working with the Division. Board members with the Division have close contact with the MOHS because of the Division's initiatives. The MOHS is often criticized for developing blanket, high-level policies that miss the nuances of the different communities. Since the MOHS now has a more direct relationship with the family physicians working in the province, they are more apt to appreciate community variations. This connection might have influence over policy development, for example, the MOHS recognizing the different constraints of an

urban/suburban area versus a rural area and its impact on funding the Divisions of Family Practice:

> "[The financial formulations] work well when you have 30 doctors or more but not when you have less than 30 doctors. So those things are just being worked through now, and we've got a number of flexible models. And the doctors are going to sort of practice with them and see what works." (Admin 73)

Many participants felt the Division of Family Practice is a vehicle for engaging all family physicians in the community. Staying connected is why the WRSS GP community is seen to be a cohesive group. The hospital practice was pivotal in that.

> "I think that's one of the reasons this community has remained so active and engaged is that we have those regular meetings and we stay in touch with one another. I think when you lose that, people tend to drift and disconnect from things because they just get into their routine of going to work every day and coming home every day. And they don't go to the hospital and they don't see other people doing things. They lose touch with fresh ideas or change. And they come to their office and they go home. And I think it is a lot harder to stay abreast of changes and be interested in change [because] you become a bit insulated. And I think it makes it harder for other communities. My hope is the Divisions will help that. Maybe to give them a place to reconnect or to disseminate ideas, but I think it's been easier for us to keep, to maintain the courage to keep making the changes and try new things because we have those connections already, haven't lost them yet." (GP 80)

The medical staff composition has changed over the years and not every family physician retained her hospital privileges. These physicians do not have the same social or professional support as their colleagues who work at the hospital. The Division of Family Practice can bring the family physicians that are not doing hospital work back into the fold. Every family

physician in the community now has the opportunity to participate in primary care renewal discussions and initiatives through the Divisional structure.

> "I think it's really important for the community health and those physicians' health [the non-hospital based family physicians] that we have a vehicle, a mechanism, to bring them under the fold. Because it used to be the hospital was the fold, and either you were in that game or you were out of that game. If you weren't, you were almost deemed as a lesser physician. [In] this day and age, that doesn't cut it. I think we all make choices in terms of the type of practice we pursue based on our interests, our family situation and what not, and I think to have a vehicle where all physicians can be supported, not just the hospital-based physicians, that's a the key piece. That's what the Division adds over and above what we could have done before." (GP 79)

> "I think the purpose of the Division, at least as I thought, the purpose of the Division was to provide incentives for physicians to come into family practice and remain in family practice in the community. And to provide an organizational structure that would involve physicians who didn't participate in the hospital in the community as well." (GP 74)

The Division of Family Practice has facilitated these relational changes for family physicians in WRSS through building new relationships and reinforcing/repairing existing ones (a shift in relational professional boundaries).

A "Helping" Structure

The Division of Family Practice gives family physicians a physical home in their community. It is a non-profit entity that resulted from "a formation of some sort of a relationship between groups of family physicians that practice in a geographic area that are looking for mutual interests to reform how primary care...is delivered, offered" (Admin 69). A number of family physicians have taken on additional responsibilities to run this

organization in the WRSS community (Figure 3.3) (refer to the next section on ownership & responsibility). Membership is at 98 percent of total family physicians in the community (WRSSDFP, 2010a). It is not only about the money[35]. Family physicians in WRSS are engaging with the Division because they see this is an opportunity to provide input – to "improve primary care in our area, improve the delivery service and improve the working conditions of the physicians" (GP 82). It is about being heard, being recognized, and being supported; "pay us, value us, train us, and support us" was the takeaway from the PQIDs.

> "I think the climate for a very long time, [because] I've been practicing for 15 or 16 years, it's been one that's very hopeless. You know, for the first 10 years I've practiced I think the atmosphere in medicine was very much, at least from the doctors' point of view, feeling as though they weren't heard, that there were very significant gaps in their ability to provide care and limited resources. And they were trying to communicate that need somewhere and they weren't heard, or they were ignored or told they were wrong or not listened to. And it wasn't as though they were saying we want more money. It was they were saying we need more nurses, we need more social workers, we need more beds, and being told no, you don't know what you are talking about. Now that might not have been the case, but that's what doctors felt. And I suspect from the other side, there were also similar frustrations with, you know, from their point of view. And I think that was because people weren't necessarily talking to one another." (GP 80)

> "And as a Division, all of a sudden we have a collective voice that we never had before… As a collective voice of 70 physicians going to the Health Authority [and the Ministry of Health] to try and figure out how we can improve those networks and things to try and get better care for our patients. That has been hugely satisfying... So I think the physicians involved feel that, the ones [who] have been doing the work, is that we are finally making a difference to the way we are practicing medicine and how care is being delivered." (GP 78)

[35] The other initiatives from the GPSC more directly deal with the financial compensation aspect; however, family physicians are remunerated for some of the Division initiatives (e.g., participation in brainstorming sessions, the hospital care program).

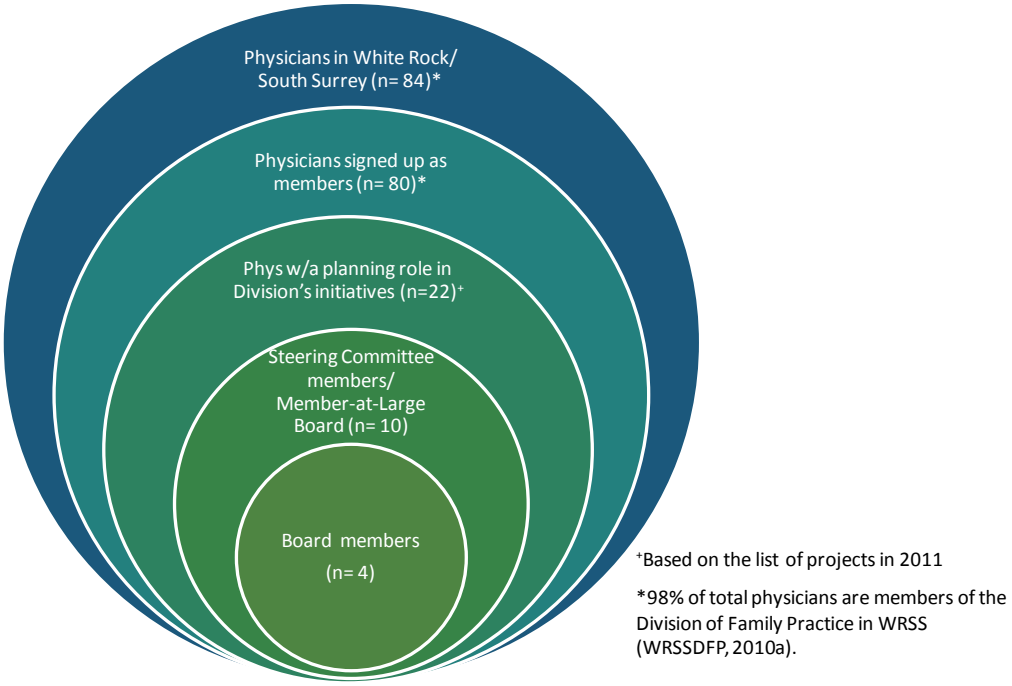


Figure 3.3: Division of Family Practice in WRSS – Physician Involvement

Divisional projects are self-identified by family physicians to meet practice challenges in the WRSS community (Figure 3.4). The Division of Family Practice "is an entirely voluntary strategy. If doctors don't see value or don't want to participate in it, they don't have to. So it's always got to be meaningful" (Admin 68). Communication and engagement are fundamental to the subsistence of the organization. The WRSS Divisional Board and working groups meet on a regular basis, and the greater membership is being engaged judiciously through surveys, Division bulletins, social events, and informational and brainstorming meetings. The Divisional meeting is a generative environment where participating physician members work out what is important and necessary for the community. A parallel process exists with the partners at the CSC. The dealings at the

Division and the CSC, however, are not completely straightforward and unchallenged: tensions and collaborations coexist. Members are working together as a collective, but contestation remains – the idea of symbiotic and competitive interdependences (Burns & Muller, 2008).

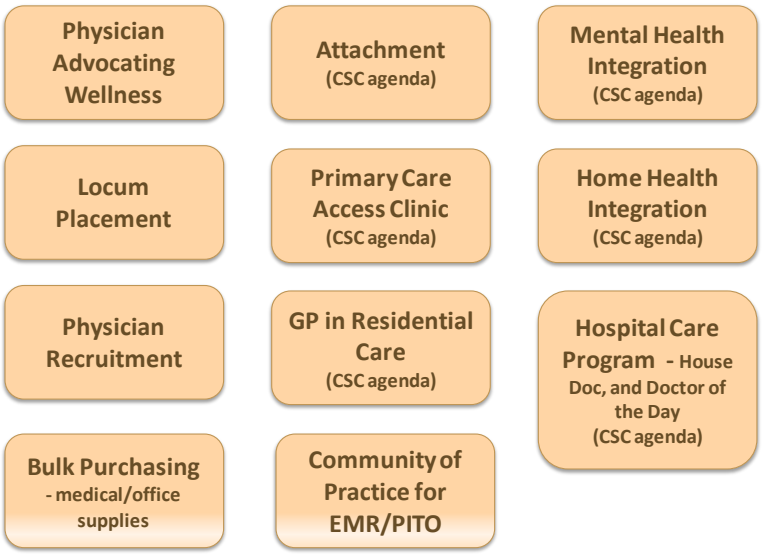


Figure 3.4: The List of Current Projects in the WRSS Division of Family Practice, 2011
* Programs that are regularly on the CSC meeting agenda are denoted by "CSC agenda".

Through the interviews with family physicians, a commonly relatable problem of physician and locum recruitment was identified[36]. From an individual physician's perspective, it is extremely time intensive to look for physician locum and replacement. WRSS had no organizational body to ensure there was sufficient physician capacity in their community[37].

[36] A locum is a family physician who substitutes for another family physician during a break. Physician recruitment for the WRSS community is done to increase the capacity of the community and to replace physician colleagues who are retiring.
[37] It was left to market forces to determine where family physicians worked. Governmental provisions and incentives are only available for rural communities (e.g., the Rural Practice Subsidiary Agreement under the Physician Master Agreement).

Family physicians managed the demand by having closed practices, that is, they did not take on new patients. The WRSS Division of Family Practice has taken the administrative burden from the independent practices and is responsible for a community recruitment strategy for locums and physicians[38].

> "So it's really would be hugely important [because], particularly in a small office like mine, if one or two docs need to take a holiday when spring break comes – all my partners have little kids you know, so you want to be off around spring break, or Christmas, or summer holidays or when you want to take holidays – and you can't get a locum. And if you spend half the year looking and advertising and answering the phone, or not answering the phone [because] nobody calls, it's really a stressful thing. And then when the docs do go away, the rest of you have to sort of carry on seeing extra people in the middle of a beautiful summer day, wishing you could have a little break yourself. Working for two docs or three docs instead of just [for] yourself. It's pretty frustrating if you do that year after year. So imagine there's actually a shared group of locums that's out there that would be more available. And you don't have to spend your after-hours just seeking, would be a great relief, a great help, if it works." (GP 77)

At Divisional meetings, physician members are put in a place to think of a collective solution and not just about their practice. The discussions often involve sharing personal experiences and considerations. The group generally strives to find a consensus position (and most of the time they succeed), but in some instances the group is less cohesive. This is evident when a prized resource is being discussed (e.g., locums). During the time of my fieldwork, the locum and physician recruitment program was an on-going agenda item at the WRSS Division board meetings. There was on-going discussion about the role of locums and locum remuneration, placement, and incentive mechanisms. At one meeting the project coordinator raised this question: for locums who do not want to do hospital work, should they be

[38] The Division has hired a project consultant to help with this initiative.

included in the locum program pool? Some members thought the Division should set a good example and insist locums do hospital work in this community as this would demonstrate the Division of Family Practice is committed to its vision of being a "full-service family practice" community. Other members did not want to deter locums to come to the WRSS area. "Competition for locums among Fraser Health and other health authorities is intense. Summer and spring break are particularly competitive" (WRSSDFP, 2011). The Division thus should take any locums interested to work in WRSS.

Competition for resources resulted in the Division devising a point system to prioritize requests for locums in their community locum program. Consideration is based on time of the request (the time of the year), previous access to a community locum, and the physician's scope of practice. With respect to the physician's scope of practice, more points are given to physicians doing full-time work, those that are full-service family physicians in the community, and those who are participating in Divisional programs (e.g., on the rota to take care of unattached patients). Physician members are incentivized to participate in Divisional work; they are also encouraged to become more "full-service" oriented. Physician members that do not have hospital privileges will not get the same level of support as other members in the community local program. Even though all family physicians are encouraged to join the Division of Family Practice in WRSS, not every family physician will find value from the Division of Family Practice.

Physician members have diverse practices, views, and experiences. Conflicts and tensions are part of the search for meaning and value for the group, and are part of the collaborative

process. The range of positions further complicates the collaborative process: physicians would like to help themselves (individual reward), help their colleagues (group – colleagues they identify with), and help the community (system - the greater good).

> "[The Division of Family Practice in WRSS] is so new, once it starts making big differences, like I think the House Doc program has helped in a lot of ways, but there's a lot of physicians that don't call the House Doc [because] they're just not used to that. That's not the way they've done things. I think the residential care program has now got to a point where it's going to be making a difference. So that's good, but I don't do that much residential care. So from a personal perspective, it hasn't helped me that much. But I think as a health care thing it is very important. And the people that do a lot of residential care, I think that's very important for them." (GP 84)

Ownership & Responsibility

Despite the challenges of collaboration, family physicians are getting involved with the Division of Family Practice (some more so than others). In a certain respect, physicians are giving away some of their autonomy and expanding their level of responsibility to gain benefits from a community strategy. The Division of Family Practice challenges family physicians in the WRSS to negotiate what they are willing to allow the community to decide on and what control they would retain. One can start to see task-related and object-related professional boundaries being reshaped for GP participants involved with the Division of Family Practice in WRSS.

It requires a tremendous amount of personal commitment from the family physicians at the board and the working-group level to operationalize and run the Division of Family Practice.

The GPSC provides support to set up the Division of Family Practice and to look after the administration and financial management of the Division until a community is ready to be independent. The WRSS Division of Family Practice runs as a non-profit society with a constitution, a set of by-laws, a privacy policy, and a board of directors. The board meets monthly "to discuss strategies and initiatives that match the priorities of our membership" (WRSSDFP, 2010b). The Division is legally responsible to hold and distribute sessional monies for physicians meeting and planning participation and clinical payments from the Division's service agreements. The WRSS Division has three staff members to support the various projects and to help with the administration and financial management of the Division.

Family physicians involved with the WRSS Division do not take the responsibility lightly. The GP participants are taking ownership of the organization and its job to serve the WRSS physician and patient communities (shift in object-related professional boundaries).

> "And I think my sense is that there's a little more hope now. But I think being responsible for that, too, is one that you can't just sort of say, 'we need this, this, and this'... willing to stand behind it and be willing to be efficient and organized, and be responsible for the resources you get and that you use them properly. And you don't waste money and you don't use things inefficiently. And so I think it's a responsibility as well, which is why it's helpful to say, this is how much money you have, you decide how you want to spend it, but that's it. Then you have to be careful with how you spend it. And it does mean making decisions." (GP 80)

Having a Division of Family Practice makes family physicians accountable for identifying the practice issues they want to see changed in their community, and for developing initiatives that can address the issues (primary care renewal). Physician members spend a lot

of time discussing projects. Rationales and assumptions are revisited to make sure the initiatives are sustainable and cost-efficient. The monthly board meetings and the CSC meetings are normally scheduled in the evening for two and a half hours, but often these discussions run over time. For most physician members this is on top of a full day of clinical practice.

Physicians involved at the board level and in working groups are also responsible to perform management tasks, tasks such as coordinating and attending meetings, preparing reports and documents, and collecting and analyzing data. They are involved in strategic planning and engagement and leadership activities. Some family physicians have more familiarity or training in administration, but there are others who are less administratively inclined or interested[39].

> "You're paying doctors to spend all this time to decide how to set it up and how to do this and how to do that. But maybe if you hired a really good office manager, they could have done that very effectively and for half the cost? I just think that the more that you can get people that know how to do that, it might be much more effective than paying doctors and taking time away from doctors [laughs] to do those things. And I know a lot of [the work], it has to be doctors because you have to know, you know, the residential care thing you can't pay someone else to do that, but you know a lot of things I think you could...
>
> like for instance, you know, the first year we ran an [activity] which I helped put together with [the Division coordinator]. But there really must be people that, you know, organize those things that you don't have to have, you know: a) a doctor – you're paying them... it's a lot of money to pay a doctor to do that – and b) if that's not something they're necessarily good at or trained to do, it could take you longer to do it, and c) if you don't really have the time to do it, if there's someone that's more appropriately educated to do that [laughs], yeah." (GP 84)

[39] The GPSC is providing training for interested physicians through the Leadership and Management Development Program offered at Simon Fraser University.

Notwithstanding its challenges, the Division of Family Practice in WRSS have ten committee members and members-at-large on their board and twenty two family physicians involved in a planning role in Divisional programs (WRSSDFP, 2010a). These family physicians are taking on new and non-clinical tasks as part of the Division of Family Practice (shift in task-related professional boundaries).

Finally, family physicians involved with the Division of Family Practice are assuming a community/system level perspective on problem solving. The WRSS Division of Family practice approaches problem identification and solutions from a community perspective, beyond the traditional bounds of the physician's office practice. Through looking at medical supplies for its Primary Care Access Clinic, the WRSS Division of Family Practice was able to obtain a medical and office supplies bid that was substantially lower than what most practices are paying in the community. The potential savings from using this new supplier can be up to fifteen percent in some cases. The Division was able to offer and coordinate bulk purchasing of the supplies so that all the clinics in the community can enjoy the savings. The Division is also trying to address other practice problems in a more global way such as improving physician mental health through its Physician Advocating Wellness program, and supporting information technology usage through bringing information back from the Physician Information Technology Office via the Community of Practice initiative.

Spread of Divisions

Every community in BC now has a Division of Family Practice or one in development. At the time of the field work, the Fraser HA had nine Divisions with the last one forming. There is an inter-divisional council within the health authority where the representatives from the various Divisions gather to discuss how Divisions can collaborate with the health authority. The Division and the local HA are collaborating to redesign and integrate health services.

3.3. Discussion

In this case study, the role of the WRSS Division of Family Practice in reshaping GP professional boundaries was examined. For GP participants involved with this Division of Family Practice, I was able to identify shifts in their relational, task-related, and object-related professional boundaries. Their relationships with peers, government/policymakers, and other providers have altered. What were once less important relationships have grown stronger and more prominent: with their colleagues who do not have hospital privileges, with the local health authority, and with the BCMA. The CSC gave rise to a new bond between the Division of Family Practice and the provincial government. The GP participants acquired a sense of ownership for the Division of Family Practice and what it is trying to achieve; they took time to work on and participate in Divisional projects. The GP participants took on new and non-clinical tasks to run the non-profit organization, to engage in strategic planning, and to implement projects for the community.

The shifts in professional boundaries for family physicians were not occurring at the core. Relationships, tasks, and objects that were central to their definition as family physicians remained intact: the boundary shifts did not have significant effects on the doctor-patient relationship; physicians remained responsible for coordination of care for their patients; and their practices remained independently owned and operated. The areas where GP professional boundaries were being reshaped were more peripheral (i.e., those relationships, tasks, and objects that were less prominently used to define themselves and to enforce boundaries). The relationships that were reshaped were ones that were less central in role and boundary definition. Administrative duties like locum recruitment and negotiating medical supply purchasing for their office are less essential in defining family physicians. Nonetheless, as a trade off, physician members did have to give up part of their autonomy to have the Division of Family Practice take on work and responsibility on their behalf. Physician members had to be open to collective rather than individualistic solutions, and not all physician members were ready to make that shift. Some family physicians in WRSS were reluctant to use the House Doc Program; for them it was preferable to maintain patients as "their own" and manage without utilizing the House Doc[40]. The division coordinator saw variable up take of the program by physician members.

[40] Family physicians sign up to be House Docs. He is on a paid schedule to be on-site, as the "House Doc", to help other family physicians with their admitted patients in the local hospital.

> "In the early days you could go the whole shift and no one will call you and you're thinking what am I doing and you'll be looking for work. That's not so much now. The pager rings all the time. But then there's maybe another group of physicians that have never tried to work one of those [House Doc] shifts. They have no interest; they have no time. And it may be a little bit harder for some of them to actually call. I know a few people have said it makes me feel like I am incompetent or I am not managing my time properly if I have to rely on someone else for my patients. I should be able to do it all. And I don't think it's a right philosophy but they've been so used to doing that for 20 or 30 years that I think it just a whole different shift in perspective that some of them if they haven't used it or tried it that they don't. It's not their first thought. But it's becoming much more popular when you look at the notes that the people are making." (Admin 72)

The Division of Family Practice is a structure where GP professional boundaries are able to be renegotiated, but not every family physician will choose to be associated with the organization. Participation in the Division is voluntary. Family physicians' engagement with the Division of Family Practice is dependent on physicians seeing the actions and the structure of the Division as meaningful and valuable. Initial engagement might be for pragmatic reasons (e.g., specific gains), but continued association will allow physician members to develop a feeling of ownership towards the Division, i.e., psychological ownership (Pierce et al., 2003). The feelings of psychological ownership can lead to perceived usefulness and a positive attitude towards the Division (Paré et al., 2006), and a perception that the Division is more credible (Suchman, 1995). The engagement of family physicians with the Division of Family Practice in WRSS is a process (rather than an event). As psychological ties to the Division of Family Practice grow, physician members will be more active in boundary work.

The Division of Family Practice in WRSS has been successful at disrupting the physician institution and reshaping GP professional boundaries for family physicians who have been

involved, because 1) it was able to disturb and reformulate the reward and sanction mechanisms for them, and 2) it has enabled core assumptions and beliefs about GP practice to be broken down and redefined (Lawrence & Suddaby, 2006).

In a strong institutional environment one expects institutional isomorphism of family practices (homogeneity of practices) (DiMaggio & Powell, 1983). Practice and behaviour persist because existing practice is obvious and proper. Actors cannot comprehend a viable alternative[41]. The case study illustrates that the physician institution is perhaps not as strong as it once was. GP participants professed to working in "full-service family practice", but it became apparent that family physicians in WRSS provide "full-service" care in a variety of ways. GP participants continue to view hospital privileges as a vital part of their role, but the perceived importance of doing maternity and emergency work is becoming less wide-spread. Most of the family physicians I interviewed have given up maternity and emergency care in their practice. What were once role-defining tasks are now elective. Family physicians are no longer consistently drawing on the same things (objects, tasks, relationships) to define their practice. The institutional meaning of family practice differed between subgroups, which suggests weakened institutional elements (Zilber, 2002). Variations in family practice, such as walk-in clinics, group practices, part-time practices, and GP specialists, exist in WRSS. Oliver (1992) suggested a weakened institutional environment is more susceptible to deinstitutionalization.

[41] Suchman (1995) referred to this as cognitive legitimacy.

3.3.1. Disruption and Reformulation of the Reward and Sanction Mechanisms

In a weakened institutional environment, organizations and organizational actors are more able to respond strategically to political, functional, and institutional pressures (Oliver 1991, 1992). The partners' involvement with the Division of Family Practice and the CSC might have been to actively control perceived external pressures; the aim was to influence and shape institutional processes in order to maintain organizational stability (Oliver, 1991). The government and the BCMA needed the support of the family physicians in order to restore and strengthen the primary health care system. The FHA was trying to mitigate functional pressures from increasing acute care demand. Family physicians in WRSS were looking for a local solution to their unattached patient problem in the hospital. The family physicians in WRSS agreed to be a prototype Division of Family Practice because they wanted to have a voice in identifying the practice issues and solutions for their community.

The Division of Family Practice in WRSS is seen to be a vehicle to support and engage family physicians (a "helping" structure). Because it is a physician-run organization, it has given physician members an opportunity to provide input to the primary health care renewal agenda. It reconnected the family physicians without hospital privileges to the GP community in WRSS. The GP participants were starting to see Divisional initiatives helping to reduce the complexity of their daily GP life. For example some GP participants pointed out the Hospital Service Program has eased the stress of hospital work for them, and they were anticipating the administrative burden of finding a locum would be reduced by the community locum program. Family physicians want to be supported and valued for

practicing primary care and not just in financial terms[42]. The Division of Family Practice is an initiative that contributes to moving the reward mechanism from providing strictly financial reward to including social rewards such as reduced social isolation, increased job satisfaction.

> "I think that's medicine, medicine can be a little bit isolated. I think you do medicine: you go home; you have your social life and so on. But I think it's important to have that sort of cross-pollination sort of that connectivity with each other. So I think it's been helpful. You can't put a value on that in terms of dollar value, nor should you, but I think in terms of your satisfaction in medicine and so on. Knowing that there's people out there that's kind of are helpful and we've kind of grown in our own community apart from Divisions so we've been [a] very, very, fortunate community that we've always been this way. Division has sort of just expanded that particular role I suppose, or that involvement." (GP 75)

3.3.2. Redefinition and Reinterpretation of Core Assumptions and Beliefs

The working environment of the Division of Family Practice in WRSS and the CSC allowed organizational actors (physician members in the Division and CSC partners) to negotiate meanings and revisit assumptions and beliefs. Reshaping of GP professional boundaries was possible because the Division of Family Practice and the CSC permit collaborations and oppositions.

The Division of Family Practice and the CSC in WRSS have brought diverse groups together: physician members who are practicing differently in the Division of Family Practice and multi-level partners at the CSC (the MOHS, the BCMA, the local health

[42] The PQIDs finding was "pay us, value us, support us, and train us".

authority, the GPSC, and the Division of Family Practice)[43]. Prior to the formation of the Division of Family Practice, the WRSS GP community was fragmented. Despite having a strong Department of Family Practice, the Department's jurisdiction only covered the local hospital. Family practices worked independently. Family physicians that did not hold hospital privileges had few interactions with other GPs. The family physicians in WRSS did not have a mechanism for coming together as a professional group outside of the hospital. In addition, the Division rebuilt existing and created new relationships between family physicians in WRSS and other health care providers/stakeholders. Oliver (1992) suggested increasing workforce diversity to facilitate deinstitutionalization. The diversity of actors also contributed to the possibility of change – the possibility of reshaping GP professional boundaries.

The WRSS Division of Family Practice pulls together issues and improvement ideas from its physician members. Member-identified issues are then brought to the collective table of the CSC where the partners co-determine priorities and co-design solutions. The CSC is where potential projects find their legs (i.e., obtain funding and support). Determining what to support at the Divisional and CSC meetings is not straight forward, and is at times fraught with tension.

Physician members participating in Divisional and CSC meetings offer multiple perspectives; groups go through a "storming" stage as individuals attempt to determine

[43]Membership in the Division of Family Practice and the CSC in WRSS is frequently being revisited. The WRSS Division of Family Practice had been considering expanding membership to emergency physicians and GPs specializing in obstetrics. The WRSS CSC was looking for a community representative at the time of the study.

priorities (Tuckman, 1965, 1977). Disagreements and different points of view exist between physician members in WRSS Division of Family Practice despite being a seemingly cohesive group from a macro perspective. Tension is especially evident when discussing the distribution of a prized resource (e.g., financial allocation, and placement of residents and locums). As suggested by Gergen, Gergen, & Barrett (2004), the generative potential of dialogue that can affirm, construct productive differences, create coherence, and facilitate narrative and temporal integration (as cited in Lawrence & Suddaby, 2006, p. 63).

Professional associations, such as the Division of Family Practice, facilitate change because they enable theorization (Greenwood et al., 2002). The Division of Family Practice and the CSC provide the space for physician members and the CSC partners to review their differences and similarities on a sustained basis. The act of conversation between organizational actors is a chance for assumptions to be examined, development of a common language, and creation of a shared context between participants (Ford & Ford, 1995). It is when actors are dealing with inconsistencies that they have the ability to redefine roles and relations and attempt to negotiate past conflicting views (Clark & Jennings, 1997). In trying to work through the tensions and conflicts, physician members are reshaping their professional boundaries.

Change constitutes and is constituted by communication. “The basis of thinking is concepts, and concepts are expressed in words which derive their meaning from the way they are used in specific language games, which are located in distinct forms of life. Thinking is not an exclusively private affair: in so far as it makes use of concepts, as it must, it is necessarily, to

some extent at least, public" (Tsouka, 2005, p. 98). Language is fundamental to institutionalization as talk is involved in the social construction of reality (Phillips et al., 2004).

Unlike observations in previous studies, tensions and power dynamics did not pitch organizational actors against each other: disruption of the institution did not involve professionals and the state working against each other (e.g., Lawrence & Suddaby, 2006); change was not premised on professional groups fighting for jurisdiction (e.g., Greenwood et al., 2002) or a struggle for/use of power within an organizational field (e.g., Rao, Monin, & Durand, 2005; Maguire, Hardy, & Lawrence, 2004)[44]. The environment of the Division of Family Practice and the CSC in WRSS is comparatively collaborative. The WRSS Divisional members and the partners in the CSC are working *together* to bring about changes in primary care. Working together has fostered sympathetic understandings between those involved and promoted a growing sense of symbiotic interdependence.

[44] Power dynamics will always exist but in this case it played out in the discussions and interactions (at the level of talk).

Chapter 4 - Conclusion

In the introductory chapter I posed two research questions to be examined in this dissertation.

> RQ1: How do interorganizational collaborative relationships enable family physicians to redefine their professional boundaries?
>
> RQ2: What is the role of professional boundaries in practice change for family physicians?

I will apply the findings from the case study to describe how interorganizational collaborative relationships can enable family physicians to redefine their professional boundaries (to address the first research question). Findings from the analysis of the HSR literature will inform the scope condition of the findings; I believe the GP professional boundaries have been weakening and that is what facilitates their reshaping. To answer the second research question I will review the qualities of professional boundaries I identified in the HSR literature and the case study. Selected qualities such as clarity and layers of boundaries may play a role in promoting practice change.

4.1. Research Significance

4.1.1. Collaborative Relationships and Reshaping of GP Professional Boundaries

Through the Division of Family Practice in WRSS, family physicians are collaborating among themselves (the GP professionals) and with other health services agencies such as the MOHS, the BCMA, and the local health authority. As a new organizational entity, the

Division of Family Practice brought family physicians in WRSS with common health care goals together to partner with health services agencies in order to make changes at the practice and health system level. The Division of Family Practice provided the social and physical space where collaborations could exist. Interactions between partners allowed for reshaping of professional boundaries for those family physicians involved.

A Place to Collaborate and Work Out Differences

The Divisions of Family Practice in BC were not built in a competitive environment, unlike other models of physician organization (e.g., models in the United Kingdom, New Zealand, and Alberta, which all have physician organizations in primary care) [45]. In the BC model, the Divisions of Family Practice are founded by geographic regions. The regional focus means partners have some common ground; the family physicians and the local government work together to solve locally identified problems. With the assistance of the GPSC, the Divisions of Family Practice also have the opportunity to collaborate inter-divisionally. The Divisions share experiences of developing and implementing local projects, and bring back shared learnings to their own community. The work between separate Divisions of Family Practice is one of many examples of the collaborative nature of the Division of Family Practice model that facilitates the reshaping of GP professional boundaries.

[45] In New Zealand the Primary Health Organizations are responsible for an enrolled population rather than a geographically defined population (Smith & Cumming, 2009). A more competitive environment rather than a collaborative one exists because the multiple Primary Health Organizations in the same community vie for the same patient population for enrollment.

Another way the Division of Family Practice promotes collaborative relationships is by providing the space for actors to intermingle. Prior to the Division of Family Practice, family physicians worked in isolation in the community in either a solo practice or in a group practice. The main place where family physicians could interact with other family physicians in the community was at the local hospital where GPs had hospital privileges. Socially, the hospital was a place for family physicians to gather and become informed of practice-related and community news. Formally, family physicians were there to provide medical care to their patients who had been admitted to the hospital. They belonged to the Department of Family Practice, which organized and represented family physicians in the hospital. The hospital provided a social and physical space where the family physicians interacted. With decreasing numbers of family physicians maintaining hospital privileges, the hospital's role as the central place where physicians in the community could intermingle was lost.

The Division of Family Practice provides an alternate "space" where family physicians can come together. The Division is where family physicians and health care agencies go if they want to connect with family physicians in the community. But unlike the hospital, the Division has a wider jurisdiction to engage in a range of health care matters: from integration between primary care and acute care, to issues at a clinical/practice-level, to population health-level projects[46]. Family physicians can bring their practice issues to the Division of Family Practice for potential solutions (e.g., the Division has a subgroup working to support their members with using the electronic medical record system). It is also the organization that represents the family physicians in the community. If the City of White Rock wants feedback on their health promotion programming from the family physicians in the

[46] Projects based in the hospital however will strictly be centered around acute care delivery.

community, they will go to the Division. The Division of Family Practice is a hub where family physicians and health care administrators can gather and dialogue about issues and changes at the practice and health system level.

The reshaping of GP professional boundaries was possible because actors had opportunities to work collaboratively in and with the Division of Family Practice. The Division of Family Practice provided the structure for family physicians to realize change because physicians were able to participate in theorization as a *diverse* group. Through involvement in divisional work, family physicians were able to reinterpret core assumptions and beliefs about themselves and their partners, and reformulate reward and sanction mechanisms. Dissimilar views were challenged, and through on-going dialogue, actors were able to form sympathetic understandings of each other's perspectives, values, and limitations. In their study of the forestry industry, Zietsma and Lawrence (2010) found conflict to be a key piece of the cycle of institutional stability or change, which involved institutional stability, institutional conflict, institutional innovation, and institutional re-stabilization. In order to innovate, conflict involving boundary breaching and bolstering, and practice disrupting and defending must occur.

As described in the case study, relationships between the family physicians, the local health authority, the medical association, and the government were strengthened with the creation of the Division of Family Practice and the Collaborative Services Committee (CSC). Each of the partners brought their unique perspective to the collective table. Inevitably, tensions and inconsistencies arose during the process of issue and solution identification. Frequently,

meetings and dialogues about the various primary care projects provided opportunities for partners to work out these differences in meanings and goals. Language matters in the construction of organizational stability and change (Tsoukas, 2005; Tsoukas & Chia 2002). Through interactions and dialogue, a sympathetic understanding of each other's perspectives and objectives evolved. San Martin-Rodriguez et al. (2005) cited the socialization of profession as a determinant for inter-professional collaboration; that is, if professionals understood the practice of the others, it was more likely to see a positive impact on inter-professional collaboration (Arslanian-Engoren, 1995, as cited in San Martin-Rodriguez et al., 2005, p. 136).

Changes in GP professional boundaries for the family physicians in WRSS depended on the level of engagement with the Division of Family Practice. Family physicians who were highly engaged with the Division of Family Practice in WRSS developed ownership and accountability for things they never cared much about previously. Family physicians were much more focused on their own practice before; they did not want to be involved with health care delivery at a system level. With being involved with the Division of Family Practice, family physicians were less inclined to defer to the Ministry, the medical association, and the local health authority to fix system problems. The WRSS Division of Family Practice has developed and signed service agreements for service delivery in redesign projects, many of which are tackling system level change. For the most part, the redesigned solutions are facilitating integration of care. The family physicians engaged with the Division appreciate the symbiotic interdependence between the work of family physicians and other health care clinicians and organizations.

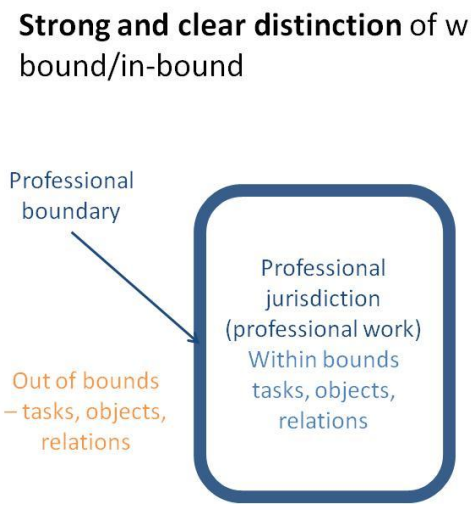
Physician members are beginning to invest themselves in the Division and its initiatives. Those physicians who were part of the Board or a project team dedicated time outside of their busy clinical practice and family responsibilities to be involved with planning and implementing divisional projects. They took on more non-clinical tasks and responsibilities. Physicians took on leadership roles in the Division and worked with their partners at the CSC to make changes happen in their community. On behalf of the community of family physicians, the board members have taken on fiscal and performance accountability for the projects out of the Division of Family Practice in WRSS. One of the routes to psychological ownership is the investment of self into the target. Investment of self can come in many forms such as investment of one's time, ideas, skills, and physical, psychological, and intellectual energies (Pierce, Kostova, & Dirks, 2001). Some studies suggest psychological ownership for organization (or organizational object) to be associated with extra-role behaviour and positive orientation towards organizational change (e.g., Valdewalle, van Dyne, & Kostova, 1995; van Dyne & Pierce, 2004), which is precisely what occurred among the family physicians involved in the Division.

In return for their involvement, physician members in WRSS receive support from the Division of Family Practice with things such as bulk purchasing of medical supplies and locum recruitment. Some of the most valued outcomes from the family physicians' perspective were initiatives that helped them with the time and resource constraints of their for day-to-day practices. The Division of Family Practice in WRSS is seen as a helping structure for the family physicians in the community. The Division is a place where family

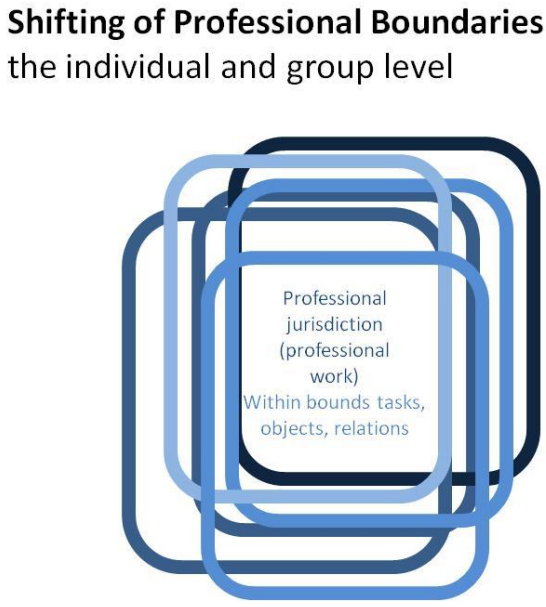
physicians can go with their problems to seek potential solutions. It is part of the larger infrastructure of the GPSC to support their practice and systematic redesign of primary health care.

Fuzzy GP Professional Boundaries

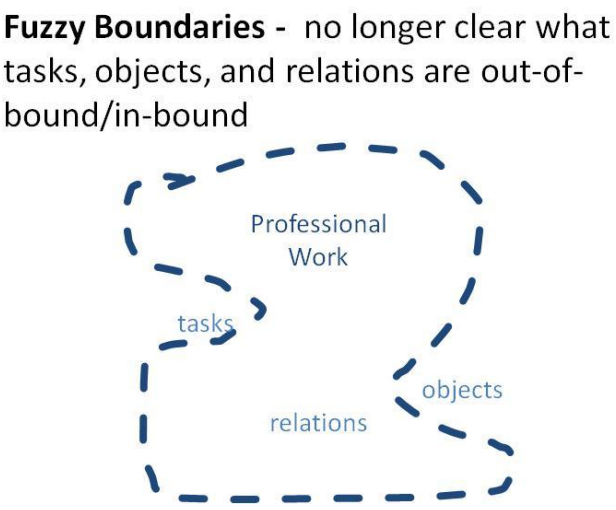
The family physician profession has been undergoing a process of deinstitutionalization. There has been an erosion of legitimacy of institutionalized practice and a growing failure to reproduce previously-taken-for-granted organizational actions (Oliver, 1992). Family physicians do not have consistent views of what defines their practices anymore; their practices are no longer replications of the traditional form of family practice such as being on call for their patients 24/7, delivering babies, etc. I found this trend of variations in practice in the case study and in the HSR literature. GP professional boundaries have been shifting and narrowing, though not all in the same direction. The result is that GP professional boundaries are not as clear and distinct as they once were, and they have become a weakened institutional element (Figure 4.1).



4.1.a. In a strong institutional environment, professional boundaries are clearly defined.



4.1.b. During deinstitutionalization, mimetic action/practice decreases. Professional boundaries are shifting at an individual and group level creating a "fuzzy" boundary.



4.1.c. From a macro perspective, the professional boundary is not as distinct as it once was.
Figure 4.1: Changes in GP Professional Boundaries

Family physicians are more susceptible to a reshaping of their professional boundaries (and more open to practice change) when distinctions are not well demarcated. In a strong institutional environment, making any change to professional boundaries would be inconceivable (DiMaggio & Powell, 1983) or would be deterred; that is, the onset of changes would be subject to defensive boundary work (Gieryn, 1983). And even if family physicians were able to disassociate with a selected task, object, or relationship, the physicians would be reproached for the decision to "break away" from the traditions of family practice. However, the findings in this dissertation show disruption of professional boundaries is possible when those boundaries are less distinct[47]. I found the family physicians involved with the Division of Family Practice in WRSS were able to redefine their professional boundaries when it did not affect their core professional attributes. The more involved family physicians have expanded their non-clinical work and gained management and leadership skills. The WRSS

[47]Actions assume a neo-institutional perspective where actors are culturally competent to navigate and work with institutionally defined logics (Lawrence & Suddaby, 2006). As active institutional interpreters (Zilber, 2002), the family physicians in WRSS are continually associating and disassociating actions, objects, and relationships with the meaning of being a family physician.

family physicians were willing to give up some control over the business aspect of their practices, allowing the Division of Family Practice to coordinate the locum placements and bulk purchasing of clinic supplies for the community. The family physicians, however, still retain their core attributes. They have kept the responsibility for their patients, their role as the coordinator of care, and the doctor-patient relationship intact. These core attributes were readily used to maintain professional identity, jurisdiction, and boundaries.

4.1.2. The Role of Professional Boundaries in Practice Change for Family Physicians

The concept of GP professional boundaries was conceived to encompass the objects, people, practices, and spaces that are associated with the work of a family physician. Task-related, object-related, and relational boundaries offer a multi-faceted approach to describing how family physicians choose to distinguish themselves and their work. The three forms of professional boundaries inform and reinforce one another. A family physician over time may develop a relationship with the patients she has seen for many years from the community. Because of the doctor-patient bond, she has the trust of her patients. She has gained the knowledge of the social context of her patients which helps her with diagnosing and treating them. She feels ownership towards her patients and will follow her patients to a variety of locations to coordinate their care.

These modes of professional boundaries serve as goal posts for family physicians to make out what they would or would not do. A change in practice would mean the family physician has to accept something that was formerly outside of her professional boundaries into her

work and/or identity (or discard something that was inside the boundaries). The findings from this dissertation suggest the qualities, the nature, and the structure of boundaries can play a role in facilitating practice change.

The **clarity** of the boundary describes how apparent the demarcation is. Having clear professional boundaries means actors can precisely and consistently recognize what is to be in or out of bounds (i.e., consensus on institutional logic) (Scott, 2001). For example, physicians have a professional relationship with their patients but not a social one. Ethical codes regulate professional conduct around patients. The doctor-patient relationship is kept intact by regulative and cultural assumptions. Instead of a clear boundary, I found the professional boundaries of family physicians to be less distinct than they once were. There were aspects of their professional boundaries with imprecise definitions. The family physicians I interviewed in WRSS did not have a consistent understanding of what "full service family practice" was, despite claiming to practice full service family medicine. They identified themselves as "atypical" in the way they practice. In the context of facilitating practice change, it is harder to disrupt boundaries if they are more distinct, persistent, and widely recognized. To put it another way, it is easier to defend professional boundaries if the boundaries are more distinct. If the professional boundaries are fuzzy and less distinct, the boundaries should be more permeable and flexible. There is a better chance of making practice change with ambiguous professional boundaries.

Professional boundaries are not one dimensional. There are **layers** to boundaries consisting of core and peripheral elements. The core elements in GP professional boundaries are tasks,

objects, and relationships that family physicians readily draw on to demarcate their jurisdiction and identity. They are the elements used for the maintenance and enforcement of their professional boundaries. The peripheral elements are more obscure and are not often used for demarcation purposes. For example, I found in the case study and the qualitative analysis of the HSR literature that owning one's practice is no longer a core feature of what defines a family physician. There are more family physicians choosing to practice as locums or work as salaried physicians (e.g., hospitalists) than there were two decades ago. There are two important implications to having a set of core and peripheral elements in professional boundaries. First, when making practice change, the peripheral elements of the GP professional boundaries are more susceptible to redefinition. It is more likely to redefine a peripheral element such as the business aspect of the family practice. For example, the family physicians in WRSS were eager to have the support of the Division of Family Practice in non-clinical tasks. Secondly, resistance to change is greater and it may require more effort to make change in the area where a core element is invoked (e.g., the notion of patient). The relationship with a patient is greatly drawn upon for the enforcement of boundaries by family physicians (i.e., the doctor-patient relationship is a core boundary element).

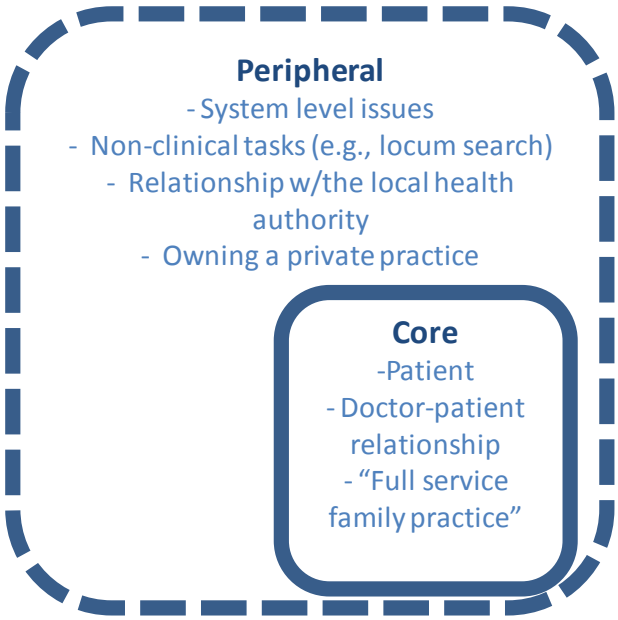


Figure 4.2: Example of Core versus Periphery Elements in GP Professional Boundaries

Boundary movement – Boundary expansion and contraction do not necessarily happen in unison. I saw pockets of change as individuals and groups of family physicians decided to limit their practices. When movements are asynchronous they can lead to fuzzy and more flexible boundaries. Changes in boundaries are dynamic and occur over time. The various aspects of GP professional boundaries are interrelated; a shift in one aspect affects the other aspects of professional boundaries. I saw the sense of responsibility towards community solutions become more significant as the relationships between physician members, their physician colleagues, and the partners in the CSC evolved. Family physicians involved with the Division of Family Practice in WRSS became increasingly interested in taking part in solving system-level problems.

4.2. Limitations & Potential Future Research Directions

The case study of the WRSS Division of Family Practice was an observational study. My interest was in how collaborative efforts can support practice change for family physicians (via change in GP professional boundaries). I was able to find emerging collaborative relationships between the involved actors and a reshaping of professional boundaries for family physicians. Through these observations, a set of mechanisms that explains how collaborative relationships enabled family physicians to redefine their professional boundaries was proposed. However, I believe the two constructs are inter-related and reinforcing. That is, in addition to collaborations supporting the reshaping of GP professional boundaries, the strength of professional boundaries will affect the ability of family physicians to develop collaborative relationships. Other health services researchers have looked at professional boundaries as a barrier to interdisciplinary collaborations (e.g., San Martin-Rodriguez et al., 2005); therefore, I decided to focus my dissertation elsewhere. But by choosing to examine only one side of the relationship, I may have underplayed the inter-relatedness and the reinforcing nature of the two constructs (Figure 4.3). There is potential for future research to look at the bi-directionality of the association between collaborations and boundaries, especially the give-and-take that is necessary for organizational or professional change.

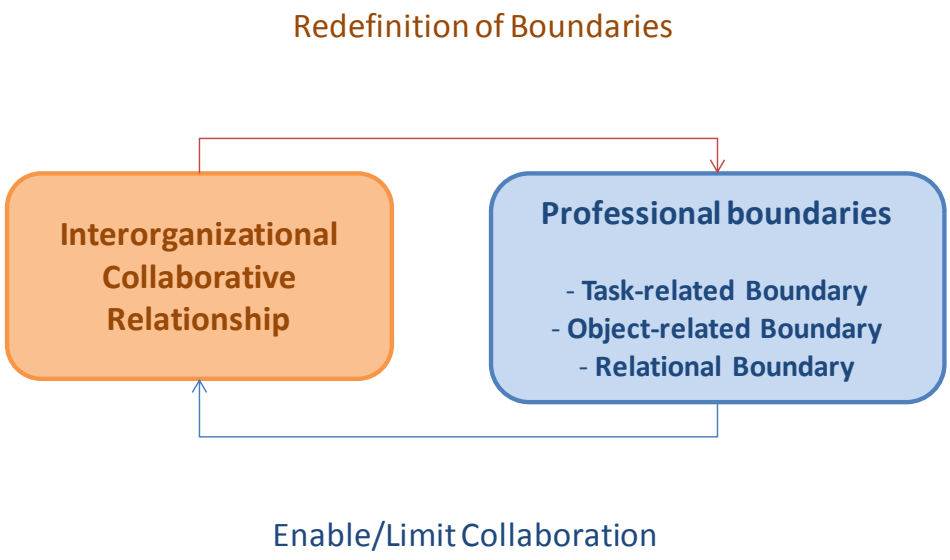


Figure 4.3: The Inter-related Association between the Two Constructs

Having only observed a window on the event, I cannot parse out other factors and events in the past, nor anticipate future events, that might influence or alter my findings. For example, the Division of Family Practice is just one of a series of initiatives from the General Practice Services Committee (see Chapter 3, footnote 31). Perhaps too much emphasis was placed on the contribution the Division of Family Practice made to the change; perhaps the relationships with the family physicians and their partners were already improving when the Division of Family Practice was formed. I began my study of the WRSS Division of Family Practice two years into their collaborative relationship (their first meeting was in January 2008). I cannot factor in the changes in professional boundaries that may have taken place before the start of my observation; however, I can confirm the Division of Family Practice is a new organizational form that allows actors to interact more directly. The Division of Family Practice is unique from any other GPSC initiatives as it has changed the way family

physicians are organized in the community. Although I cannot measure the size of the impact the Division of Family Practice has had on reshaping professional boundaries, I can conclude the Division of Family Practice has had a role in reshaping professional boundaries of family physicians.

The generalizability of the findings from the case study might be questioned because it they are drawn from a single-case. Due to the sampling and data gathering methodology, the findings from the case study might be seen as idiosyncratic. The physician community in WRSS is a cohesive group. They have demonstrated in the past that they are a high-functioning group of family physicians who can come together to solve community problems. However, the way the Division of Family Practice works is not unique to the WRSS community. The other two prototype communities that started their Division of Family Practice at the same time as WRSS had very different physician dynamics (e.g., one of the communities had a hostile physician environment where family physicians were not often communicating before the start of the Division), but these prototype communities all had success in fostering collaborative relationships with their partners through the mechanisms of the Division of Family Practice. These communities were able to create divisional projects to help primary care delivery in their region despite having dissimilar starting points.

Another sampling decision I made was selecting family physicians who were highly involved with the Division of Family Practice as my participants. I purposively selected family physicians that were highly involved with the Division of Family Practice so I could answer

my research question around how the reshaping of professional boundaries worked: I needed a positive case study in order to describe the phenomenon of interest. That said, the mechanisms delineated from this study may be less appropriate for family physicians who are late adopters (i.e., those who are less involved with the Division). Future studies would need to validate the proposed mechanisms (explain how collaborative relationships enabled the reshaping of GP professional boundaries) with late adopters.

Another potential issue with generalizability relates to whether the multi-faceted dimensions (task-related, object-related, and relational) used to describe the professional boundaries of family physicians apply to other professions. My concept of multi-faceted qualities of professional boundaries was inspired by the work done on institutional carriers (Jepperson, 1991; Scott, 2001). Future research should test if the multi-faceted construction of professional boundaries would hold with other types of professions.

The findings of this dissertation are guided by a neo-institutional lens. I assume the conduct of individual actors reproduces the structural properties of social life, and the same actors are involved to bring about changes that are beyond isomorphic changes. Changes in habitualized action and meaning are dependent on the transformation of social structures and interactions. Other theoretical perspectives might provide different interpretations than mine. From an exchange-based perspective, the collaboration and practice change in the case study could be seen as financially motivated. The Ministry of Health Services provided funds for the running of the Division of Family Practice and for new service contracts. Family physicians were financially compensated when they participated in Division of Family

Practice events, and indeed, the study participants spoke of a sense of recognition when they were remunerated. However, if physicians' motivation to take part in the Division of Family Practice was solely driven by money, it cannot wholly account for the increased level of ownership and responsibility the family physicians felt for the Division and its initiatives. From a power perspective, the collaborative relationships between the family physicians and their partners could be interpreted as more strategic and interest-based than I have painted. Strategically, family physicians are getting more involved in primary care service planning at a system-level because they want to reassert their power and maintain their status at the top of the health care hierarchy (e.g., Hotho, 2009). The wider scope of influence assigned to the Division might provide family physicians with more power and control in their community and the health care system. My point is, the conclusion drawn from this dissertation is one of many possible interpretations of the phenomenon. The reading of the results will vary depending on the researcher's theoretical frame. Each theoretical perspective will highlight a different consideration for achieving organizational change for the profession of family physicians.

Lastly, the findings in the dissertation may not have significantly contributed to the institutional work literature on the disruption of professional boundaries. Taking direction from Lawrence and Suddaby's (2006) list of purposive actions, I was able to flesh out how reshaping of professional boundaries might have taken place in the case study. The findings of the case study also illustrated the use of dialogue in reshaping professional boundaries. I demonstrated how creative conflicts through inconsistencies and differing perspectives promoted change in GP professional boundaries. As pioneer work from an interdisciplinary

perspective, a full exploration of the area of generative dialogue and institutional work is beyond the scope of this dissertation. Future research is encouraged to delve deeper into the production of generative dialogue and its ability to reshape institutions.

4.3 Theoretical Implications

Related to the Field of Implementation Science

The nature of collaborations in health care - earlier health services research literature often viewed collaborations from a team perspective. Organizational- and institutional-level factors were less explored. This dissertation examined a new organizational form and its features that facilitated collaborations and practice change (e.g., one of the features is the flexible nature of the Division of Family Practice). According to San Martin-Rodriquez et al.'s literature review (2005), there were few empirical studies which explored the role of decentralized and flexible structures in fostering collaborative practices (p. 139). The case study of the WRSS Division of Family Practice partly addressed this gap. Most interview participants commented on the flexible nature of the Division of Family Practice and the CSC and its ability to promote collaborative relationships between the partners. There were a number of factors that enabled flexibility. Firstly, the age of the initiative and the organization – WRSS was one of the Division of Family Practice prototypes in British Columbia. Because it was such a new endeavour, there were no clear roadmaps and nothing was set in stone. The partners were open to a trial-and-error approach (and were not expecting to get everything right the first time). Secondly, the process that the Division of Family Practice engaged in was centred on the tenets of interest-based negotiation. Family

physicians were ready for a change from the status quo, and the government and the BCMA were willing to play supportive roles. Lastly, manageralism has permeated the health care sector. Large health care organizations like the National Health Service in the United Kingdom and the Institute for Healthcare Improvement in the United States have adopted manufacturing process improvement techniques in their change management strategies. For the most part, this brand of change management has been embraced worldwide. Physicians and health care administrators are increasingly comfortable with methods such as the "plan-do-study-act" cycle to make incremental changes. The case study illustrates how a flexible structure encourages collaborative relationships between organizations; however, the flexibility in the structure might be difficult to maintain. For example, once the Division of Family Practice as an organizational entity matures, its structure and processes will become persistent and routinized.

Another implication of the findings relates to physician engagement and the perception of ownership by the partners in the collaboration. The sense of being "partnered with" rather than "partnered at" can shape the success of the collaboration. Collaborative initiatives traditionally invited family physicians to join the local health authority's planning group. Family physicians were encouraged to participate in the redesign work and get "plugged in", but the accountability for the project rarely fell to the physicians. They were never truly an equal partner in the process. In addition, the size of the collaboration and the group composition has to be balanced so the group can work together without feeling alienated or drowned out by their partners. A family physician from the case study described how reorganization at the medical advisory committee level affected family physicians' voice in

the hospital: a restructuring of their local health authority meant the Local Medical Advisory Committee was abolished, and it was replaced by an Inter-regional Medical Advisory Committee. At a regional level, the Inter-regional Medical Advisory Committee has to deal with medical staff issues from twelve acute care hospitals and a range of specialities. Medical staff issues from the WRSS hospital now have to compete for time on the Inter-regional Medical Advisory Committee's agenda. There is a feeling of being drowned out by the bigger acute hospitals and losing their voice in the system. In the case of the Division of Family Practice and the CSC, the feeling of ownership of the process and the outcome only came when 1) family physicians believed they had a voice in the endeavour and 2) they perceived they were equal partners in the collaboration. By focusing the case study on the process of collaborations, I demonstrate that attributes of the collaboration such as size, rigidity, and composition can play a role in shaping physician engagement with the collaboration (and ultimately in the success of practice change).

Finally, this dissertation aligns well with an "appreciative" mode of inquiry and allows the reader to see how the social system works (rather than how it fails by focusing on the barriers and flaws). By valuing what is positive in the system one can imagine how change is possible. Like the appreciative inquiry research tradition, which is "uniquely intended for discovering, understanding, and fostering innovations in social-organizational arrangements and processes" (Cooperrider & Srivastva, 1987, p. 152), the research lens that I applied in this dissertation focused on the constructive elements that are more fruitful in bringing about organizational change, rather than on the deficiencies.

Related to the Study of Boundary

In this dissertation I offered an alternative classification scheme for defining boundaries. Guided by the literature on institutional carriers, I assumed a range of carriers codify and form the "boundary" concept. Professional boundaries are not one-dimensional, but multi-faceted. The three modes of boundaries (i.e., task-related, object-related, and relational boundaries) form the professional boundaries concept for family physicians. I was able to map the characteristics of and claims about family physicians into the three modes of professional boundaries. The proposed classification scheme connects actors, objects, actions, and meanings to the social construction of the professional boundary construct. It offered a novel approach to the operationalization of the construct that expanded the conception of boundaries from previous literature (e.g., Lamont & Molnar, 2002; Montgomery & Oliver, 2007; Ziesmas & Lawrence, 2010).

In addition to the classification scheme, I found that the success of boundary work may lie in the attributes/structure of the boundary that is being created, maintained, or disrupted. Similar to what other researchers have found, qualities such as strength and durability (Ferlie et al., 2005), rigidity and permeability (Ellis & Ybema, 2010), and movement of boundaries (Zietsma & Lawrence, 2010) shape and promote boundary work. More importantly they affect organizational stability and change. The idea that there are core and periphery elements to professional boundaries is a contribution to the boundary work literature. The findings illustrate that enforcement of boundaries was accomplished by using core elements, and the disruption of boundaries was more viable when peripheral elements were attacked/challenged. Enforcement and disruption of boundaries most likely employ different

mechanisms and draw on different attributes of the boundary. Future research on boundary work needs to answer questions such as: how do elements develop into core and peripheral elements; and what is the opportunity for elements to strengthen (and become core elements) or weaken (and become peripheral elements)?

Bridging Research Disciplines

The dissertation brought together a collection of theoretical and methodological notions from the health services and organizational studies research domains in an attempt to understand changes in professionals. The case study draws attention to how agency and organizational form can bring about institutional change in professionals. The case study was able to illustrate how family physicians are involved in reorganizing their own professional work. Physicians are utilizing alternative strategies and tactics to deal with changes in professionalism (Muniz & Kirkpatrick, 2011). The Division of Family Practice was an example of an organizational form that did not set managers up against professionals, but that connected "managerial, professional and other fields in order to generate services that are viable and accepted" (Noordegraaf, 2011, p. 1364). The interdisciplinary approach of this dissertation provided some fruitful insights for the study of health services collaboration and boundary work. It should encourage similar bridging of other research disciplines, for example, bridging of the gap between the professionalism and the organization studies literature on professionals and organizational change (Suddaby & Viale, 2011).

4.4 Practical Implications

Physicians as highly trained and powerful actors in core health care activities at times adopt or reject initiatives. It is especially challenging to get physicians on board with redesign initiatives that involve collaborations with other health care professionals or organizations. The Division of Family Practice as a new organizational form has positively engaged family physicians in the primary care redesign efforts in British Columbia. Collaborative relationships between family physicians and their health care partners have thrived under the Division of Family Practice in the study of the WRSS community; through the CSC, family physicians and their local health authority are tackling system-level problems such as unattached patients and service integration. However, the sustainability of such collaborations is uncertain. There are three practical implications for decision makers evaluating the merits of using a collaborative framework to promote change in health services delivery. I discuss each in turn below.

Collaborative Decision Making

Decision making at the Division of Family Practice and the CSC was based on an interest-based process; only the initiatives that were mutually desired by the members/partners went ahead. Taking an interest-based approach to negotiation takes time, and time might not be afforded to many Divisional projects. Projects are tracked against time: funding cycles usually have fixed timelines; projects need to demonstrate they have the desired effect and provide a return on the investment; project evaluations are deliberate and planned. It might not be practical, or even feasible, for the actors in the collaboration to work out every aspect

of the project (from conception to implementation) until a common interest or understanding is formed. During my observation of the Division of Family Practice board meetings there was a tangible tension from trying to work everything out as a group while still trying to move the project along. The key to a constructive collaborative relationship is to balance what gets decided at the collective table and what can be delegated to sub-groups for decision making.

Another area where collaborative decision making might be challenged is with the evaluative component of the initiative. As the primary funder, is the Ministry of Health Services ultimately accountable and thus the most interested in driving the key performance indicators? Should we anticipate consensus on performance indicators and targets? The partners are coming from discrepant experiences – family physicians might be less familiar and comfortable with being measured by performance matrixes; the health authority is experienced with performance matrixes centred around acute and community care; and the Ministry is looking for a system-level assessment. The process of developing an evaluation plan might be less straight forward in a collaborative setting[48].

Physician Fatigue

Currently there are six organizations that represent family physicians in British Columbia: the Society of General Practitioners of BC, the Divisions of Family Practice, the BC Medical

[48] To address this potential challenge, the Division of Family Practice and the Collaborative Services Committee have adopted the Triple Aim approach to quality improvement and evaluation from the Institute for Healthcare Improvement. The Triple Aim approach does a good job of capturing the different motivations of all the partners, (i.e., patient and practitioner satisfaction, quality, and sustainability).

Association, the College of Physicians and Surgeons of BC, the BC College of Family Physicians, and the College of Family Physicians of Canada (Society of General Practitioners of BC, n.d.). The Divisions of Family Practice are the latest organizational form created to support family physicians in British Columbia. Local, regional, provincial, and national efforts to support and represent family physicians must be streamlined and coordinated to ensure there are no gaps or duplications in efforts, and no misuse of limited resources. It is especially vital to effectively engage their constituents, the family physicians. Family physicians want to be heard and supported, but physician engagement needs to be properly channelled. Otherwise, their voice will be lost in a sea of bureaucracy and family physicians will revert to feeling undervalued and unheard.

The Complexity Paradox

One of the objectives of the Division of Family Practice is to reduce the complexity of the daily life of the family physician. But on the other hand, the Division of Family Practice as a new organizational form is generating increased complexity in the system. At this time, 37 communities in British Columbia have established or are in the process of establishing a Division of Family Practice (BCGPSC, 2011). Each of these Divisions requires a great deal of financial and human resources for it to run autonomously. A group of family physicians in each community has to dedicate time outside of their clinical practices to run the non-profit society. The demand of operating a Division not only requires family physicians' time, but for them to acquire leadership and management skills as well. Even though family physicians can receive management and leadership training through the GPSC, not all family

physicians are interested in or skilled at running a Division of Family Practice. If it was left to those family physicians who are skilled and interested in Divisional work, it would be important to ensure there is a succession process for each of the Divisions so that physicians who volunteer with the Division of Family Practice do not get burnt out. Another solution is for the Divisions of Family Practice to hire a director to run the society so family physicians are freed from the administrative duties of the Division.

The creation of Divisions of Family Practice is an attempt to use a collaborative framework to promote system and professional practice change in primary care. The findings from the dissertation suggest the professional boundaries of GPs involved with the Division of Family Practice in WRSS were reshaped. In order for the Division of Family Practice to be sustainable, it is important for partners to continue to engage the family physicians effectively and to ensure the Division of Family practice as an organizational entity do not become too burdensome to operate.

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Appendices

Appendix A: List of Articles in the Analysis

Authors	Main Theme	Country	Publication Yr
AB et al.	GP experience with intervention (prescribing for diabetes)	OTH	2009
Aluise et al.	Managerialism in US	US	1994
Beaulieu et al.	Definition of GP (in FR and BEL from trainees)	OTH	2006
Beaulieu et al.	Definition of GP (in FR and BEL and CDN from trainees)	CDN, OTH	2009
Beaulieu et al.	Definition of GP (in CDN from trainees, teachers, assoc specialties)	CDN	2008
Brooks	GP experience with intervention (nursing home)	US	1998
Burns & Muller	Managerialism in US (types of hospital-physician relationships)	US	2008
Burns et al.	Managerialism in US (types of hospital-physician relationships)	US	1993
Campbell et al.	GP experience with intervention (QOF)	UK	2008
Carlsen et al.	GP's attitude with intervention (clinical guide practices)	OTH	2007
Checkland et al.	GP experience with intervention (moving to biomedical type practice, rhetorical strategies to maintain 'holism')	UK	2008
de Stampa et al.	GP experience with intervention (integrated network thing); relationships (patient, other practitioners)	CDN	2009
Feron et al.	GP experience with intervention in BEL (working in a group practice vs. solo)	OTH	2003
Grant et al.	GP experience with intervention (P4P, i.e. QOF, and with it IT systems), managerialism	UK	2009
Green	Description of solo GP, conventional view (1993)	UK	1993

Authors	Main Theme	Country	Publication Yr
Hansson et al.	Description of roles & characteristic by GP profession (SWE)	OTH	2007
Hansson et al.	Description of characteristics by GP & nurse to collaboration (SWE)	OTH	2009
Hardy et al.	Description of professional territories (not just GP)	UK	2001
Hogarth-Scott & Wright	Description of GP characteristics	UK	1997
Hughes & McCann	GP experience with intervention (inter-prof collaboration with pharmacists)	UK	2003
Jang et al.	GP experience with intervention (assessment of medical fitness to drive)	CDN	2007
Keenan et al.	GP experience with intervention (home visiting)	US	1992
Lawlor et al.	GP experience with intervention (towards adopting a population approach to lifestyle advice)	UK	2000
Loxterkamp	Description of GP characteristics (readiness for change)	US	2009a
Loxterkamp	Description of GP characteristics (ownership vs. working in hospital)	US	2009b
Loxterkamp	Description of GP characteristics (generational change)	US	2009c
Manca et al.	Description of GP characteristics (perception of respect by specialists)	CDN	2008
McDonald	GP experience with intervention (introduction of market sys)	UK	2009
McDonald & Roland	GP experience with intervention (P4P) in CA and UK	UK, US	2009
Mirand et al.	GP experience with intervention (primary prevention)	US	2003
Moffat et al.	Description of GP characteristics (respiratory GP)	UK	2006
Norfolk & Siriwardena	Description of GP characteristics (clinical competence model)	UK	2009
Pomeroy & Worsley	GP experience with intervention (nutritional care for cardiac)	OTH	2008

Authors	Main Theme	Country	Publication Yr
Porche & Margolis	GP experience with intervention (Rural MH)	OTH	2006
Rahmner et al.	Description of GP characteristics (responsibility to drug list in SWE)	OTH	2010
Ringard	GP experience with intervention (abandon hospital in NOR)	OTH	2010
Samoil	Relationship w/hospital	CDN	2008
Stange	Description of GP characteristics (model)	US	2009
San Martin-Rodriguez et al.	Description of professional characteristics (inter-professional collaboration)	CDN	2005
Suggs	GP experience with intervention (prescribing through formulary)	CDN	2009
Tabenkin et al.	Description of GP characteristics (ISR)	OTH	2001
Terry et al.	GP experience with intervention (adoption of EMR)	CDN	2009
Walker & Mathers	GP experience with intervention (group prescribing initiative)	UK	2004
Watson et al.	GP experience with intervention (genetics)	UK	1999
Weiss	Description of GP characteristics	US	2004
Whitcomb & Desgroseilliers	Description of GP history in CDN	CDN	1992
Whitfield et al.	GP experience with intervention (responsibility for medical tasks in UK, NETH)	UK, OTH	1989
Williams et al.	GP experience with intervention (epileptic guidelines)	UK	2007
Wilson	Relationship w/hospital	CDN	2008
Wright et al.	GP experience with intervention (geriatrics interdisciplinary team)	CDN	2007

Appendix B - List of Organizational Documents

From the White Rock/South Surrey Division of Family Practice & Collaborative Services Committee

- Proposal for Enhanced GP services at Peace Arch Hospital, March 2008
- Department of General Practice Meeting, June 2008 (PowerPoint Presentation)
- Document of Intent for the Division of Family Practice at White Rock-South Surrey, December 2008
- Collaborative Services Committee, Terms of Reference White Rock/South Surrey Division of Family Practice
- PAH hospital program evaluation and summary, March 2009
- Institute of Health Improvement presentation, March 2009 (PowerPoint Presentation)
- Interim agreement: funding for WRSS Division of Family Practice Service Agreement, May 2009
- WRSS Division of Family Practice Infrastructure Agreement, April 2010
- WRSS Division of Family Practice-FHA Integration status reports
- Project documents on the Attachment Initiative
- Project documents on the Locum and Recruitment Initiative
- Project proposal for Service Delivery Model for Residential Care, October 2010
- Attachment and Integration Meeting with WRSS membership, meeting notes, January 2011
- WRSS 2010 Annual Review
- The White Rock-South Surrey Bulletins from Volume 1 (1), July 2010 to Volume 2 (1), February 2011
- Board Meeting Minutes from October 2008 to March 2011
- Board Meeting Agendas from October 2008 to March 2011
- Collaborative Services Committee Meeting Minutes from April 2010 to March 2011
- Collaborative Services Committee Meeting Agendas from April 2010 to March 2011

From British Columbia Medical Association, General Practice Services Committee and Divisions of Family Practice Subgroup

- Professional Quality Improvement Days feedback summary, 2004
- The future of primary care symposium report, April 2005
- Divisions of Family Practice FAQ for family physicians, January 2009
- Presentations from the Division of Family Practice workshop on June, 2009
- Physician Engagement in Community Practice Redesign - based on experience from British Columbia, Canada, March 2010 (PowerPoint Presentation)
- General Practice Services Committee Annual Report 2006/07 – 2010/11

- General Practice Services Committee website - www.gpscbc.ca
- Divisions of Family Practice website - www.divisionsbc.ca/

From the Government of British Columbia

- Physician Master Agreement 2007, Appendix A-K, and amendments
- Primary Health Care Charter 2007
- Chronic Disease Management Update Bulletins from December 2002 to September 2003

From Health Canada

- British Columbia primary health care transition fund initiative, provincial-territorial envelope, 2006