THE THIRD MISSION OF UBC’S HEALTH FACULTIES, DEPARTMENTS, AND SCHOOLS:

A ROLE IN SOCIETY BEYOND EDUCATION AND RESEARCH

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Abstract

Universities are increasingly playing roles in society beyond education and research, often referred to as a third mission. As such, there are discussions within universities about their relationship with society, their desired impact in society, society’s expectations of universities, and how universities can be more accountable to society. This dissertation explores the role that health Faculties, Departments, and Schools at the University of British Columbia (UBC) play in society, beyond the education of health professionals and conducting health-related research. UBC Faculty of Pharmaceutical Sciences, School of Nursing, and Department of Physical Therapy provided a comparative case study to explore the relationship between a university’s health units and society. This dissertation outlines the role each unit articulated beyond education and research in their strategic plans. It explores the dominant and competing neo-liberal and socially-oriented discourses embodied in how each unit articulated its relationship with society through a critical discourse. It also discusses an advocacy role played by units identified through interviews and a focus group with leaders from each unit. This dissertation explores this advocacy concept and determines how this role was operationalized similarly and differently across the three units, and presents an emerging framework to help other health units think critically about their relationship with society. This research highlights commonalities around how three health units at UBC articulated and operationalized their relationship with society and differences that stem from how they are situated within the university and the broader province landscape.
Lay Summary

Universities are powerful institutions in society that hold a place of privilege. They engage in education and research activities that have economic and social impacts in society. Increasingly, universities play a role in society that extends beyond their traditional education and research missions. This research looks at the role that health Faculties, Departments, and Schools at the University of British Columbia (UBC) play in society, beyond the education of health professionals and conducting research. The research findings discussed in this paper reveal that health units have a social contract to ensure access to services provided by the health professionals they have the mandate to train; contribute to improvements in service delivery to improve health outcomes; and enhance equity and social justice. They are increasingly contributing to these aims by playing an advocacy role in society.
Preface

This dissertation is an original intellectual product of the author, V. Wood. The comparative case study reported in Chapters 3-5 was covered by UBC Ethics Certificate number H21-00322.
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**Glossary**

**Health Discipline** – “A branch or domain of knowledge, instruction, or learning. Nursing, medicine, physical therapy, and social work are examples of health-related or professional disciplines. History, sociology, psychology, chemistry, and physics are examples of academic disciplines” (Segen's Medical Dictionary, 2011, n.p.).

**Health Profession** – “An occupation requiring intense preparation in a body of erudite knowledge—eg, law, medicine, which is applied in service to society, [and] has a system of self-governance” (Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, 2003, n.p.).

**Health Professional Program** – The educational activities within a Faculty, Department, or School that prepare students to become licensed health professionals.

**Health Unit** – A Faculty, Department, or School that has an education mandate to train a health profession and where faculty members conduct research.

**Third Mission** – “The conceptual position of universities in society as well as real-life practices in the interaction between universities and society” (Maassen et al., 2019, p. 5). Activities that extend beyond the traditional missions of education and research.
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“With great power comes great responsibility.”


According to Maassen et al. (2019), “universities are currently facing again fundamental discussions about what they are expected to accomplish for society, how they are to be made more accountable to society, and what kind of relationship they should have with core organizations and actors in society” (p. 8). They argue that “new demands from society imply that universities are expected to become more strategic, proactive and explicit in the development, operationalization, implementation and presentation of their relationships with society, in other words, their ‘third mission’” (Maassen et al., 2019, p. 8). According to Jones (2008), universities in Canada have moved away from the notion of an ivory tower, separate from society. They are now very much a part of the societies in which they are situated. Jones described universities in Canada as institutions that contribute to education, generate new knowledge, further public debate, and engage in partnerships with community and industry. This research centres generally on the role of universities in contributing to society, which has often been described as a ‘third mission’ beyond the traditional roles of education and research (Compagnucci & Spigarelli, 2020; Maassen et al., 2019; Pinheiro et al., 2015b). This research aimed to explore the role university leaders envision for health Faculties, Schools, and Departments in contributing to society beyond the education of healthcare professionals and health-related research.

I was interested in how health units at the University of British Columbia (UBC) articulated a third mission; the dominant and competing discourses connected to a third mission; and how UBC’s health units enacted a third mission. My research aimed to address two gaps: one I have experienced in my
professional practice related to a third mission and one I found in the third mission literature. My experience working at UBC for almost two decades, and the literature about higher education in North America and Europe, left no doubt in my mind that universities engage in activities that extend beyond their traditional missions of education and research. I believe universities hold a place of privilege within society, that they have an important role to play in improving society, and that they should therefore be critical of the ways they articulate and operationalize their relationship with society. My interest in the role of health units in society came from my professional practice working with health Faculties, Schools, and Departments at UBC, as well as my personal belief that health professionals hold a place of privilege in society and have an important role to play in its improvement. Through a case study of three specific health units at UBC – nursing, pharmacy, and physical therapy – my goal was to explore how leaders from these units conceptualized their relationship with society; how they articulated their role in society through their strategic plans; how they saw a third mission being operationalized; and the drivers, as well as the dominant and competing discourses, that influenced the way they did so.

The way that the third mission of the university is conceptualized and discussed in the literature reflects two dominant and competing discourses – one neo-liberal and one that is socially-oriented. Maassen et al. (2019) argued that universities aim to contribute to innovation and competitiveness and to civil society and society’s grand challenges. They highlight how third mission “outcomes are expected to contribute to improving individual life chances and well-being, enhancing national or regional economic and technological competitiveness, strengthening social cohesion, and finding solutions to the grand challenges that our societies face” (Maassen et al., 2019, p. 15). Much of the literature discussing the third mission, and the relationship between universities and society, has argued that third mission activities have become increasingly neo-liberal, involving entrepreneurial and commercial efforts, whereby universities aim to contribute to both economic development and the institutions’ financial well-
being (Compagnucci & Spigarelli, 2020). According to scholarly literature about higher education in North America and Europe, university efforts to generate revenue from novel sources have been in response to cuts to government funding and budget shortfalls stemming from a number of economic and societal forces emanating from outside the institution (Fisher et al., 2009).

Through my professional practice at UBC, I have experienced the pressures on units within the institution to generate revenue. However, my desire to work at a university, in part, stemmed from wanting to work in an environment where my and the organization’s success were not measured by the amount of money made. Regardless, over the past two decades, I have experienced growing pressures within the university to engage in activities that are, at a minimum, revenue-neutral. For example, I have been involved in developing educational programs delivered to industry partners to generate revenue to make-up budget shortfalls within the unit. Conversely, I have witnessed the university’s commitment to a more socially-oriented relationship with society, demonstrated through activities such as community-service learning and community-engaged research. I have been involved in a number of ‘social accountability’ initiatives at UBC focused on, for example, the recruitment and retention of rural and Indigenous students or designed to foster student learning about marginalized groups within society (Jarvis-Selinger et al., 2008). However, I struggled with the fact that the definition of social accountability introduced by the World Health Organization (WHO) challenged medical schools, and later other health disciplines, to “direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve” (Boelen et al., 1995, p. 3), without extrapolating what this meant beyond education and research.

I have always found this concept of ‘service’ nebulous. It is an established part of promotion and tenure processes, whereby faculty are expected to contribute to the institution through activities such as
committee work. However, I was interested in what this meant on an institutional level and within particular units across the institution. I have increasingly seen a mission beyond education and research articulated in the strategic plans of the units I collaborated with that extends beyond the concept of service. UBC Health, the unit I currently work for, has the mandate to facilitate collaborations across the university’s health Faculties, Departments, and Schools. The unit defines three core areas of activity – education, research, and systems – with some uncertainty about what the latter entails. It is from here that my research questions emerged and that I identified the concept of a university’s ‘third mission’ presented in the literature as a relevant starting point for my inquiry (Compagnucci & Spigarelli, 2020; Maassen et al., 2019; Pinheiro et al., 2015a; Zomer & Benneworth, 2011).

The most general conceptualization of the ‘third mission’ discussed in the literature combines all activities that extend beyond the traditional missions of education and research together, including the notion of “service.” Authors such as Compagnucci and Spigarelli (2020) and Maassen et al. (2019) have used the term specifically to describe the relationship between universities and society and its external relationships. I was interested in learning how health units working with UBC Health articulated and operationalized a role beyond education and research. I also wanted to understand whether the health units were more socially-oriented in their relationship with society, as reflected in their social accountability initiatives, or were subject to the neo-liberal drivers that dominated the third mission literature. The concept of a third mission, as discussed in the literature, reflects both neo-liberal and socially-oriented discourses and activities, making it a relevant concept for my exploration of the role of university health units in society beyond education and research, where roles beyond those have not been explored in the health disciplines literature.
I was interested in exploring the relationship between the university and society on an institutional level from a sociological perspective, whereby an institution is a “concept concerning sets of norms that are generalized across groups of people as a common way of acting, thinking, and feeling; they entail power relationships that help entrench them (Scott, 2007)” (Cowin, 2018, p. 60). During my time at UBC, I have become attuned to the extensive efforts made across the university to create a sense of “who we are” as an institution and to collectively commit to having an impact in society, with such aspirations being reflected in the strategic plans of the institution and its respective units. In particular, as someone involved in the development and implementation of the UBC Health strategic plan, I was interested in how the health units at UBC point to a role beyond education and research in their strategic plans and then how leaders attempted to operationalize these plans.

**Research Questions**

The specific research questions I chose to explore through a comparative case study that included a critical discourse analysis (CDA) of strategic plans, as well as interviews and a focus group with leaders from the health units, were:

1. How do specific health units at UBC – nursing, pharmacy, physical therapy – articulate and operationalize a third mission? What are the dominant and competing discourses?
   
   a. What drivers have influenced the way in which these health units at UBC articulate and operationalize a third mission?
   
   b. How does the third mission of these health units influence the education and research missions? How is it influenced by the other two missions?

2. What are the collective opportunities and possibilities across the health units at UBC related to the third mission?
My interest in the relationship between health Faculties, Schools, Departments and society came from my professional practice working across the health disciplines at UBC.

**My Professional Practice**

Since 2006, I have worked as a researcher, curriculum developer, manager, strategic lead, and eventually assistant director for units at UBC, with the mandate to facilitate collaborations across the university’s health disciplines. My professional practice involves working with 14 health disciplines at UBC that both deliver health professional training programs and conduct health-related research: audiology, dentistry, dental hygiene, dietetics, kinesiology, medicine, midwifery, nursing, occupational therapy, pharmacy, physical therapy, population and public health, social work, and speech language pathology. As a curriculum developer and project manager, between 2006 and 2018, I was responsible for leading interdisciplinary education and research initiatives across the health Faculties, Departments, and Schools at UBC. In July 2018, UBC created a new Vice-President Health portfolio to lead UBC Health, a consortium of the university’s health disciplines, within which I was appointed as the Strategic Lead for Health Systems. I was responsible for the new “Health Systems Pillar,” which was the third of three portfolios within this new Vice-President Health portfolio, with the other two focusing on the traditional university missions of education and research.

In this new role, I helped facilitate a stakeholder engagement process during which we held 21 Summits with groups of UBC faculty, students, staff, and community partners between October 2018 and February 2019. Through these Summits, my colleague and I, on behalf of UBC Health, presented the priority areas being defined within the new UBC Health portfolio and sought input from stakeholders on the structure and functioning of the portfolio. We spoke with 346 individuals from across the health units at UBC about the new UBC Health portfolio, which was described as “an institutional consortium designed to enable
more systematic collaboration across health programs at the University” (www.health.ubc.ca). During these Summits, participants expressed a lack of clarity about the “Health Systems Pillar.” The Summit Report shared the message with the Vice-President of Health that “while Strategic Summit participants feel the Health Systems Pillar is the hardest to define and the most open to interpretation, they also recognized its importance within the UBC Health portfolio” (Jarvis-Selinger & Wood, 2019).

As the UBC Health team continued to work with the health units to define the strategic priorities for this new portfolio and unit, there remained uncertainty around this “Health Systems Pillar” and the potential role of a unit such as UBC Health beyond education and research. Since 2020, I have been Assistant Director, Strategic Initiatives for UBC Health. In this role, I was involved in the development of the UBC Health Strategic Plan and currently support the UBC Health team to operationalize interdisciplinary activities that align with the strategic objectives outlined in the plan. As this plan was being developed, this third pillar was described as externally focused, involving engagement with partners outside the university; contributing to provincial priorities and initiatives; and helping to improve health systems. However, it was unclear what a unit within a university could do toward these aims. As I set out on this research journey, this remained unclear within UBC Health and its partner health units. However, as a consortium of the health disciplines at UBC - designed to contribute to, align with, and facilitate collaboration across the health Faculties, Departments, and Schools - UBC Health could potentially learn a lot from how these health units articulated and operationalized their role in society beyond education and research.

My Positionality

Between working at UBC and completing an undergraduate, masters and now doctoral degree, I have spent the majority of my adult life immersed in the university environment. I have experienced the
tensions between the need for universities to generate revenue and their desire to contribute to societal change and improvement. I remember concerns in the late 1990s from both within and outside the institution about some of the industry partnerships being pursued by both UBC and Simon Fraser University (SFU), where I was completing my undergraduate degree in sociology and anthropology.

Within the sociology and anthropology department at SFU Faculty members tended to focus on criticisms of capitalist society and feminist theory, teaching the works of Karl Marx and Mary Wollstonecraft. During this time, I developed a distaste for the unbridled pursuit of profit, which has been tempered with age yet remains in many ways. Working with the health disciplines since 2006, I have been exposed to criticisms of university partnerships with pharmaceutical companies and how they may taint the outcomes of the research they fund. I agree with concerns that industry partnerships and other neo-liberal activities may jeopardize the university’s ability to educate future generations and generate new knowledge in a way that holds true to the epistemic values of the institutions, free from outside influence and pressure. That being said, I am also opposed to universities acting as ivory towers, separate from society. I believe they need to be responsive to the society in which they operate, contributing to both societal and economic improvement, and I recognize that this may include the need for industry partnerships.

Working at UBC, I have also witnessed the challenges faced by faculty members leading initiatives that have the potential to make meaningful impact but are constrained by fiscal pressures. I have seen the power of partnerships between the university and industry in advancing these initiatives. They can enable students to provide services to underserved and marginalized communities, with industry covering things like the cost of student housing or medical supplies. I see value in these partnerships when they are grounded in common goals and desired impact, not focused on the neo-liberal driver of growth and profit for their own sake.
Like many, I believe universities are uniquely positioned to effect change within society by educating future generations to be agents of change and by generating new knowledge that has the ability to improve the health and wellbeing of communities (Jones, 2008). I have experienced the ways that those within the university have been thinking more critically and consciously about issues such as truth and reconciliation with Indigenous peoples and equity, diversity and inclusion (EDI), when compared with my friends and family who have not had the privilege to attend university. I am the first person in my family to have attended university and believe I have been truly privileged by this. I have noticed how being immersed in a university environment has impacted my discourses and issues I am critical about. However, being involved in the development and implementation of a strategic plan, I have also become critical about the extent to which the university may use the discourses of things like truth and reconciliation and EDI yet fail to truly embody them.

It is these tensions, both within the university and myself, that led to my interest in understanding the extent to which health units at UBC are neo-liberal or socially-oriented in their relationships with society, both in terms of how they articulate and operationalize their relationships with society. I see myself as part of the university and believe that I have a duty, within my professional practice, to think critically about how we articulate, and more importantly operationalize, our professed commitments to society. This critical lens has most certainly been influenced by the Department of Educational Studies at UBC where I have been completing my doctorate in educational policy and leadership, where this is the dominant epistemological lens brought by faculty members. It is through these tensions and this lens that I approached this research. I was aware of how my positionality might influence the way that I both approached and interpreted my data. Reflecting on my biases is one way to mitigate the extent to which they will have impacted my analysis.
The Third Mission Literature

My research questions also stemmed from a gap I found in the literature. As I searched the literature for research about the relationship between health units and society, beyond education and research, I discovered the concept of the ‘third mission’ of the university. A large body of literature discusses the role of the university in society, often using the term “third mission” to describe this role. Authors writing about the role of universities in society agreed that how the third mission is articulated and defined is contextual and subject to multiple internal and external drivers and policy actors (Bourner et al., 2017; Compagnucci & Spigarelli, 2020; Pinheiro et al., 2015b; Roper & Hirth, 2005; Zomer & Benneworth, 2011). Pinheiro et al. (2015a) stressed that disciplinary considerations are important within the context of the third mission, as there have been significant changes over the previous two decades in the way the third mission manifests itself internally within universities. They also argued that the way it is operationalized within specific institutions means different things to different people. They suggested that while the third mission holds a place of growing strategic importance within institutions as a whole, it is important to consider the complex and multifaceted characteristics of disciplinary perspectives, institutional fields, and individual academic profiles.

While the third mission is articulated and defined in contextual and disciplinary ways, there is a gap in the third mission literature related to the health disciplines. There is, however, literature that references the service mission of the university and the role of the health disciplines in society, often within a discourse of social accountability (Boelen, 2018; Boydell et al., 2019; Jarvis-Selinger et al., 2008; Rourke, 2006; Strasser et al., 2013). Boelen (2018) suggested that academic institutions should address the needs of communities they have a mandate to serve through their education, research, and service activities, without describing service activities explicitly. The literature about social accountability initiatives does not extricate nor explicitly differentiate a specific service role beyond education and research, particularly
on an institutional level (Boelen, 2015; Rourke, 2018; Strasser et al., 2013). In the context of the health disciplines, social accountability is often discussed in the literature as the responsibility of individual healthcare providers (Boydell et al., 2019). Ritz et al. (2014) acknowledged that “until relatively recently, accountability to patients, the public, and the profession, were generally held to be the private and moral concern of individual physicians, rather than the collective responsibility of institutions or the profession as a whole” (p. 152). However, Rourke (2018) has stressed the responsibility of universities in “engaging, partnering with, and responding to the needs of their community, region, and nation, especially their underserved and vulnerable populations” (p. 1121). I was most interested in the role and responsibilities of the institution and the ways that leaders articulated and enacted their relationship with society.

The fact that neither the service nor the third mission of the university is discussed separately from the education and research missions in the health disciplines literature may be due to the interconnected nature of the three missions, as discussed by Bourner and colleagues (Bourner et al., 2013, 2016, 2017, 2020). They have suggested that education, research, and service to society are three legs of a tripartite mission, referring to service as the “third leg.” They explored how universities “can contribute to the community and society in ways that also support the advancement of knowledge and the higher education of its students” (Bourner et al., 2017, p. 5). Maassen et al. (2019) have stressed that the third mission cannot be extricated from universities’ well-established first and second missions: education and research. Pinheiro et al. (2015a) also argued that third mission activities “should be embedded in, and/or tightly coupled with, teaching and research endeavours” (p. 235). Zomer and Benneworth (2011) suggested that the third mission has moved from the periphery to an integral part of higher education that involves both commercialization and engagement activities that are entangled with the teaching and research enterprise of the university.
Within the context of the health disciplines, Boelen (2015) suggested that universities consider the three domains of education, research, and service individually; be judged in each domain; and seek consistency among the three domains. Maassen and colleagues (2019) suggested an urgent need to clarify the third mission of universities in order to align society’s expectations of universities with the university’s operationalization processes. Within the context of the health disciplines, Boelen (2015) argued that important transformations are required for the research and service functions of universities, without specifying what this looks like for the service mission. The need for clarity about the role of the health units beyond education and research led to my research questions.

**A Case Study of Three Health Units at UBC**

While interested in the role of universities in society generally, I was particularly concerned with identifying how leaders from the health disciplines strategized third mission activities and how those were intended to impact society. In his often cited yet solely descriptive history of higher education in Canada, Harris (1976) discussed how faculties and schools of health disciplines such as medicine, dentistry, pharmacy, nursing, physical therapy, and occupational therapy featured prominently within the formation of Canadian universities since the early 20th century. At UBC, there are upwards of 14 health professional programs situated across five Faculties that train health professionals, and arguably even more units spanning all UBC Faculties conducting health-related research.

I have used the term ‘health unit’ to refer to health-related Faculties, Departments, Schools, and Programs that have an educational mission to train healthcare professionals and a research mission to conduct health-related research. Unlike some universities with a Faculty of Health Disciplines, the education, research, and possibly third mission activities of the health units at UBC take place within
Departments, Schools, and Programs situated across different Faculties. Table 1 highlights the units that collaborate through UBC Health and shows how they are situated within the different Faculties at UBC.

Table 1 - Faculties, Departments, Schools and Programs that Work with UBC Health

<table>
<thead>
<tr>
<th>Faculties</th>
<th>Health Departments/Schools/Programs*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faculty of Applied Science</td>
<td>School of Nursing</td>
</tr>
<tr>
<td>Faculty of Arts</td>
<td>School of Social Work</td>
</tr>
<tr>
<td>Faculty of Education</td>
<td>School of Kinesiology</td>
</tr>
<tr>
<td>Faculty of Dentistry</td>
<td>Dental Hygiene Program</td>
</tr>
<tr>
<td></td>
<td>Doctor of Dental Medicine Program</td>
</tr>
<tr>
<td>Faculty of Medicine</td>
<td>School of Audiology and Speech Sciences</td>
</tr>
<tr>
<td></td>
<td>Undergraduate Medical Program</td>
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<tr>
<td></td>
<td>Midwifery Program</td>
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<tr>
<td></td>
<td>Department of Occupational Science and Occupational Therapy</td>
</tr>
<tr>
<td></td>
<td>Department of Physical Therapy</td>
</tr>
<tr>
<td></td>
<td>School of Population and Public Health</td>
</tr>
<tr>
<td>Faculty of Land and Food Systems</td>
<td>Dietetics Program</td>
</tr>
<tr>
<td>Faculty of Pharmaceutical Sciences</td>
<td>Doctor of Pharmacy Program</td>
</tr>
</tbody>
</table>

*This table highlights the health professional programs at UBC Vancouver that collaborate through UBC Health. Each Faculty includes other units and programs (e.g., graduate research programs) not listed here.

There are other health Departments/Schools/Programs at UBC Okanagan.
Discussing how the health disciplines need to be accountable to society, Boydell et al. (2019) and Rourke (2018) acknowledged that the role of the health disciplines in society is highly influenced by local context. Boydell et al. (2019) argued that this is due to the political nature of the health system and power dynamics pervasive throughout society. Preston et al. (2016) identified both internal and external factors that influence the relationship between health disciplines and society, the strongest of which they suggest is workforce demand, in addition to institutional environment, organizational culture, and resource allocation. As such, I chose to conduct a comparative case study of three health units that have health professional programs responsible for training licensed healthcare providers; conducting research; and articulating a role outside the university walls, thus articulating goals related to all three missions.

Each of the three programs on which I focused this comparative case study is situated differently within the provincial post-secondary context. The Faculty of Pharmaceutical Sciences and the Department of Physical Therapy are the only programs for these health professional programs in the province of British Columbia, with the latter having a distributed program whereby some students are part of a northern rural cohort situated in Prince George. There are schools of nursing at both the UBC Vancouver and Okanagan campuses (I specifically focused on the Vancouver-based School), which are two of 17 institutions offering bachelor’s degrees in nursing in the province. These differences allowed me to explore connections and contradictions across the three cases, as well as the impact of both internal and external drivers.

The Goal of This Research

The main goal of this research was to understand the way leaders from the health units at UBC articulated and operationalized their relationship with society. In doing so, I considered disciplinary differences highlighted by Pinheiro et al. (2015a) and aimed to respond to calls made by Maassen et al. (2019) within the context the third mission, and by Boelen (2015) within the context of the health
disciplines. Maassen and colleagues (2019), as discussed, have offered that universities need to reflect on their relationship with society and be more strategic about how they present and operationalize that relationship. Boelen (2015) argued that universities, specifically the health disciplines, should revise their service functions to align better with the needs of society. These calls led me to adopt a critical lens to this inquiry.

For me, questions about how health units at UBC articulate and operationalize their role in society are important in their own right. As publicly funded institutions, I feel that universities hold a place of privilege in society and have an important role in contributing to the society in which they operate. I feel this is doubly important within the context of health units. I also feel a need to be critical of how leaders articulate and operationalize that role, as there have been periods in time when there have been serious discussions about whether universities do more harm than good (Bourner, 2013). Current criticisms about the complacency of UBC in the residential school system in Canada, which forcibly separated Indigenous children from their families, are one example of the harm that universities can perpetrate. The UBC Indigenous Strategic Plan (2020) acknowledged that:

Universities bear part of the responsibility for this history, not only for having trained many of the policy makers and administrators who operated the residential school system, and doing so little to address the exclusion from higher education that the schools so effectively created, but also for tacitly accepting the silence surrounding it. (p. 8)

Throughout history, there have also been criticisms that universities have been disconnected from society, acting in relative isolation (Zomer & Benneworth, 2011). Universities are one of the oldest institutions in society, initially charged with educating the elite and later the masses, followed by an expanded mission to conduct research introduced in the late 19\textsuperscript{th} century. Given this history, universities
have often been described as “a secluded place that affords the means of treating practical issues with an impractical often escapist attitude especially: a place of learning” (Merriam-Webster, n.d.).

Authors have highlighted that Canadian universities are, more often than not, public institutions, which may require them to be more accountable to society (Atkinson, 2019; Jones, 2014). They receive government funding and according to Jones (2014), have a broader public purpose. This, arguably, has led to a context in which:

the image of the cloistered campus has been replaced by the reality of universities that are very much a part of the societies in which they function, of institutions serving a population that ‘comes and goes’ throughout a lifetime of continuing and further education, of university faculty who contribute new knowledge and further public debate, of institutions that have created new partnerships with industry and community. (Jones, 2008, p. 431)

I was interested in ascertaining whether this is true within the context of health Faculties, Departments, and Schools.

Through this research, I was interested in exploring gaps and tensions between what was articulated in strategic plans and what leaders in the health units said they were doing to contribute to society, as well as what they thought they could be doing. With many units ready to revise their strategic plans, my hope was that this research might help health units reflect on the way in which their third mission was being articulated and operationalized in order to explore new opportunities. My goal was to move beyond ‘what is’ – how UBC’s health units were currently operationalizing their third mission – to ‘what could be’ – what leaders across the health units at UBC thought the third mission should be. I was particularly interested in identifying the types of third mission activities that were taking place across the health units at UBC and how those were intended to impact society. My research questions were also important for
understanding my professional practice and for helping to inform the emerging role and strategic missions of UBC Health. The health units that were the focus of this research project – the visions and roles they articulated and the ways in which these were operationalized – offered useful case studies from which UBC Health could inform its own mandate and strategic priorities.

Bringing together literature and case studies related to the third mission, Maassen et al. (2019) argued that it is increasingly important for universities to effectively communicate third mission priorities and their place in society and to structurally embed the third mission in their management, governance, and organizational structures. According to Compagnucci and Spigarelli (2020), the third mission has often taken a back seat when compared to the traditional education and research missions of the university, receiving insufficient funding in comparison to the other two, even though it is “potentially both the most crucial mission and the one which most needs innovation within the organization of universities” (p. 2). According to Maassen et al. (2019), third mission activities are often weakly embedded within university structures. Further, many countries do not specify their preferred relationship between universities and society through political and legal frameworks. Maassen et al. (2019) have highlighted how third mission activities that take place in autonomous institutions, within which faculty members enjoy academic freedom, are dependent on the commitment of a few individuals and are usually weakly institutionalized.

Compagnucci and Spigarelli (2020) found that there is often little recognition for engagement in third mission activities and that there is little understanding about the impact of engagement activities that extend beyond the traditional roles of the university. This may be due to a lack of visibility and understanding of these activities (Maassen et al., 2019). Health-related Faculties, Schools, and Departments are a large percentage of UBC activity (Harris, 1976). As such, the relationship between these health units and society will likely influence the overall institution’s identity. This then begs the
question: how do the health units at UBC articulate and operationalize a third mission? What drivers have influenced the way that the health units articulate and operationalize their third mission? How does the third mission of the health units influence their education and research missions? How is it influenced by the other two missions?

Chapter Summaries

The next chapter presents my review of the literature and grounds my research in the concept of a third mission of the university, beyond education and research, including what led to the emergence of this concept; how it has been articulated in different contexts; and how it has been operationalized at various universities and across different units. Through this literature review, I contextualize my research within the landscape of Canadian higher education and British Columbia specifically, exploring the societal context within which UBC and the Faculty of Pharmaceutical Sciences, School of Nursing, and Department of Physical Therapy have developed and currently operate. This literature covers discussions about how the concept of the third mission emerged and has been defined, and discusses the societal forces driving that mission. In this chapter, I identify dominant and competing third mission discourses reflected in the literature – one neo-liberal and one socially-oriented – and also discuss the relationship between the third mission and the other two university missions of education and research. I link the socially-oriented third mission discourse to the concept of a social accountability mandate. I weave in literature that explores the historical and changing role of universities in Canadian society and British Columbia and positions this comparative case study of the UBC Faculty of Pharmaceutical Sciences, School of Nursing, and Department of Physical Therapy within the broader provincial context. I close the chapter with arguments in the literature about the need for universities to make their third mission explicit, which links to the goal of my research to understand the role of the health units at UBC in society.
Chapter 3 outlines case study methodology and provides a rationale for a comparative case study of the UBC Faculty of Pharmaceutical Sciences, Department of Physical Therapy, and School of Nursing as the focus of this research project. I draw specifically on Merriam’s (1998) approach to case study and provide a rationale for this particular approach. I offer an overview of the methods used to explore my research questions: document analysis, interviews and a focus group. Finally, this chapter discusses the analytical tools that led to the findings outlined in Chapters 4 and 5, specifically Fairclough’s (2004) and Gee’s (2010) approaches to critical discourse analysis (CDA), as well as Braun and Clarke’s (2006) approach to thematic analysis.

In Chapter 4, I present findings from a CDA of organizational strategic plans that identified how the University, Faculties, Department, and School have articulated their role in society. I draw on interviews throughout this chapter to illuminate some of the findings from the document analysis. Chapter 5 delves into the findings from expert interviews with one leader from the Faculty of Medicine, two leaders from the Department of Physical Therapy, two leaders from the School of Nursing, and two leaders from the Faculty of Pharmaceutical Sciences. I weave in findings from an interdisciplinary focus group with four other leaders from each of the case study units, during which I was able to explore some of the themes that emerged during interviews and discuss collective opportunities across the units related to the third mission. These interviews and the focus group allowed me to move beyond what was articulated in the strategic plans of the health units and identify the strategic activities that operationalized the role of the three units in society, beyond education and research.

Chapter 6 reflects on the societal and institutional forces driving the relationship between the health units at UBC and society and how these both overlap with and differ from the dominant drivers of the third mission discussed in the literature. I link this to the concept of a social contract between the health
units and society. I then present an emerging framework informed by this research to make better sense of the third mission of different health units. I expand on the advocacy role played by each health unit and discuss how this is operationalized differently across the three cases. Finally, I reflect on a competing discourse embodied in how the health units describe their relationship with. In doing so, I expand on the features of the university institution generally, and the health units specifically, that enable these units to play different kinds of advocacy roles. Throughout this discussion chapter, I consider the various levels of the institution and explore omissions, gaps, and contradictions across the different strategic plans and institutional units.

In the final chapter, I reflect on the implications of the findings, the limitations of this research, opportunities for further research, and implications for my professional practice. I discuss what I have learned about how the health units situate themselves within society, beyond education and research; how this might be more meaningfully reflected in the strategic visions they articulate; what UBC Health can learn from the health units at UBC across which they facilitate collaborations; and how this might influence my professional practice as I work to help operationalize the strategic mission of UBC Health.
Chapter II – Literature Review

This literature review aims to ground my research in the concept of a third mission of the university, beyond education and research. I cover what led to the emergence of this concept; how it has been articulated in different contexts; and how it has been operationalized at various universities and across different disciplines. I also contextualize my research within the landscape of Canadian higher education and British Columbia (BC) specifically, exploring the societal context within which the University of British Columbia (UBC), and its Faculty of Pharmaceutical Sciences, School of Nursing, and Department of Physical Therapy have developed and currently operate. Through a review of the literature, I outline how the concept of the third mission emerged and has been defined, and discuss the societal forces driving that mission according to various scholarly authors. I identify dominant and competing third mission discourses reflected in the literature – one neo-liberal and one socially-oriented – and also discuss the relationship between the third mission and the other two university missions of education and research. I link the socially-oriented third mission discourse to literature unique to the health disciplines that discusses a social accountability mandate. I weave in literature that explores the historical and changing role of universities in Canadian society and in British Columbia more specifically. I then position this comparative case study of the UBC Faculty of Pharmaceutical Sciences, School of Nursing, and Department of Physical Therapy within the broader provincial context. Finally, I close the chapter with arguments in the literature about the need for universities to make their third mission explicit, which links to my goal of situating the health units at UBC in society, beyond their roles in education and research.

The Emergence of the Concept of a Third Mission of the University

In his research, Bourner (2013) has explored the features of the university that have endured over time through an analysis of the Western Medieval (emerged in the 12th century), Pre-Modern/Renaissance (emerged in the 16th century) and Humboldtian (emerged in the 19th century) university. However, in
spite of this evolution, Bourner (2020) has argued that throughout history, universities have always had three missions: “the advancement of knowledge, the higher education of students, and service to those beyond the university’s walls” (p. 42). However, which mission dominated, and how the three missions existed in relation to each other has changed throughout history and in different parts of the world. For example, service was the dominant part of the Medieval university, directly serving the Latin church. Its service mission was the salvation of the immortal soul; its educational mission was to prepare priests to serve the church; and its mission related to the advancement of knowledge was to disseminate the word of god.

Canadian universities originated during the 18th century as institutions that were established by the church and reflected the European understanding of higher education at the time (Elbrekht, 2015). Jones (2014) described Canadian universities as colonial institutions that were based on the European model, founded in the church, that trained political elites to govern the new colony. He then presents a journey that started after World War II toward a society wherein higher education became accessible to a broader segment of the population. By the 1950s, the main role of Canadian universities in society was to provide a liberal education to children of the ruling class. By the 1960s, university education was seen as a key driver for economic growth, with an increase in government resources being allocated to higher education that continued into the 1970s. This marked what has often been referred to as the “democratization” or “massification” of universities, whereby university enrollments increased substantially in Canada and other countries (Jones, 2014; Metcalfe, 2010).

The concept of ‘service’ described by Bourner (2013) is institutionalized within university structures in Canada, reflected in the tenure-track process whereby individual faculty members are evaluated on their contributions in three areas: research, teaching, and service. However, this concept of service is usually
internally focused on activities such as committee work. Regardless, the general value placed on each—research (40%), teaching (40%), service (20%)—suggests that the third does not receive the same attention and recognition as the first two. According to Bourner et al. (2017), the research mission of the university dominated the middle of the 20th century, and continues today. Maassen et al. (2019) have suggested that in recent decades the notion of a third mission has “replaced the traditional, rather vague notion of university services to society” (p. 8), with service being included among third mission activities.

The concept of a third mission is now arguably used to describe relationships between the university and society broadly (Maassen et al., 2019). It is used to categorize any activity that extends beyond the traditional university missions of education and research, including service (Compagnucci & Spigarelli, 2020). However, the term itself was first articulated in 1982 by an OECD CERI think tank (Organisation for Economic Co-operation and Development Centre for Educational Research and Innovation) (Zomer & Benneworth, 2011). The OECD used this term to describe the activities beyond education and research wherein universities aimed to contribute to economic growth.

That being said, the economic conceptualization of the third mission of universities has often been traced back to the Morrill Act of 1862 in the United States, which established land grant universities that provided education in agriculture as a way to stimulate economic growth (Pinheiro et al., 2015a). A similar shift occurred in England at that time with the establishment of a set of civic universities. In both England and the United States, these shifts were linked to rising industrialization and the associated challenges this presented for the economy (Pinheiro et al., 2015a). Early in their existence, Canadian universities made efforts to serve farmers and engineers, offering public lectures designed to be of practical benefit (Harris, 1976). By the 1940s, influenced by the need to rebuild the economy after World War II, universities in Canada were recognized as a mechanism for expanding the economy (Harris, 1976). Canadian
universities, especially those in the Western provinces, were heavily influenced by the American land-grant universities, particularly around the idea that they had a role to play in the economic and social development of the broader society (Jones, 2014).

While recognizing a wider social role, the Report of the Royal Commission on Canada’s Economic Prospects (1958) stressed the economic role of universities:

> The functions of universities touch every facet of our society. Through the preservation of our heritage they maintain our way of life, and through the interest they generate in the arts, they enrich it. They enliven the perception of social processes and contribute to the orderly development of social institutions and relations. It is incredible that we would allow their services to society in these ways to lapse or to lag. But these contributions are not our direct concern. We are concerned with the contribution made by the universities to the increase in the national productivity and wealth of the country. In relation to this aspect of the national welfare Canadian universities occupy a key position. They are the source of the most highly skilled workers whose knowledge is essential in all branches of industry. In addition they make a substantial contribution to research and in the training of research scientists. (Harris, 1976, p. 453)

While the contribution universities make to the economy has been recognized for decades, as exemplified by this passage, the emergence of a third mission as an explicit concept in North America and Europe has been attributed primarily to the need for universities to generate revenue in order to secure their own financial sustainability (Maassen et al., 2019).

In the 1980s, the third mission emerged as a response by universities to fill the financial deficits that were the result of changes to higher education funding at that time (Pinheiro et al., 2015b; Roper & Hirth, 2005; Zomer & Benneworth, 2011). Decreases to post-secondary funding that continued into the 1990s...
created a need for universities to generate revenue. Like England and the United States, Canada experienced an economic recession during the early 1980s that resulted in funding cuts to public institutions, marking the end of the wide-ranging growth for universities (Cowin, 2017; Jones, 2014). In Canada, publicly funded universities started to adopt a market approach designed to generate revenue beyond that provided by the government (Fisher et al., 2014). In Canada, universities were considered economic drivers for workforce demand and the creation of new products during the 1980s and early 1990s, contributing to the “marketization,” “commercialization,” or “commodification” of universities in Canada that has continued well into the 21st century (Metcalfe, 2010).

The emergence of the knowledge society, within which economies became increasingly dependent on their ability to create scientific and technological knowledge, influenced the third mission of universities in the last half of the 20th century and the first part of the new millennium, creating a focus on knowledge transfer from universities to society, and university contributions to innovation (Zomer & Benneworth, 2011). Maassen and colleagues (2019), who included Canada in their comparative case study of the third mission, argued that

the emergence of the knowledge-based economy, combined with the withdrawal of governments from providing certain public services, the massification of higher education, and other major trends, have resulted in a growing interest around the world in the universities’ relationships with society. (p. 13)

Similarly, Compagnucci and Spigarelli (2020) attributed the extension of university missions to changes in society, including the knowledge economy, globalization, financial crises, environmental crises, and other unprecedented challenges facing the world. According to Atkinson (2019), Canadian universities are both committed to the tradition of liberal education and the German model of research, and are expected to teach, support innovation, and drive the economy. Discussions across the literature about the role of
universities in society, and their relationship with stakeholders external to the university, demonstrate that this relationship has changed throughout history and has been influenced by both internal and external factors.

The Current Conceptualization of a Third Mission of Universities

The concept of a third mission of the university is now used across the literature more broadly to describe a strategic mission and a role for universities in society, often grouping everything the university does that is not education or research into one category (Compagnucci & Spigarelli, 2020). Authors writing about the concept of the third mission of universities argue that it is contextual and subject to multiple internal and external drivers and policy actors (Bourner et al., 2017; Compagnucci & Spigarelli, 2020; Pinheiro et al., 2015b; Roper & Hirth, 2005; Zomer & Benneworth, 2011). Maassen et al. (2019) suggested that third mission activities take shape in a context of uncertainty and are increasingly affected by “trends, demands, and expectations originating outside the university” (p. 14). According to Zomer and Benneworth (2011), the third mission of a university is influenced by national policies and institutional and regulatory environments and internal cultures and perceptions about the demands from external stakeholders.

The term “third mission” is now used in the literature to describe activities that range from involvement in industry partnerships and other entrepreneurial endeavours to knowledge transfer and social engagement activities directed at addressing society’s grand challenges. In the literature, it is used in conjunction with terms such as “third stream” (Laredo, 2007), “third leg” (Bourner, 2013), “engagement” (Roper & Hirth, 2005), “technology transfer” (Maassen et al., 2019), “service mission” (Vargiu, 2014), and the “entrepreneurial university” (Compagnucci & Spigarelli, 2020). According to Compagnucci and
Spigarelli (2020), who conducted a systematic review of the third mission literature, there is no consensus nor universal concept of the third mission nor agreement about what activities should be included.

While there are a broad array of activities often grouped under the concept of a third mission, there is a dominant focus on economically-driven activities within the literature, reflecting its origins. Compagnucci and Spigarelli (2020) included and focused on literature related to the “entrepreneurial university,” a term coined by Etzkowitz (1983) to describe the increasingly commercial activities of North American and European universities in his systematic literature review of the third mission of universities (e.g. Etzkowitz, 2001; Rothaermel et al., 2007; Shore & McLauchlan, 2012; Van Looy et al., 2011). Brophy and Tucker-Abramson (2012) attributed the creation of public-private partnerships in both the healthcare and education sectors to the breakdown of the welfare state in Canada. However, some literature does focus on the services that universities provide to society, including activities such as community engagement and efforts to contribute to innovation and social change (Benneworth, 2013; Giusepponi & Tavoletti, 2018; Roper & Hirth, 2005).

In the absence of an agreed-upon definition of the third mission and a clear understanding of what activities fit within the concept, universities interpret and operationalize their third mission in many different ways (Benneworth, 2013b; Bourner et al., 2016; Pinheiro et al., 2015b, 2015c; Zomer & Benneworth, 2011). Authors discuss diverse third mission activities such as entrepreneurialism, innovation, community development, academic capitalism, and academic activism (Maassen et al., 2019; Pinheiro et al., 2015a). Compagnucci and Spigarelli's (2020) systematic literature review reveals a wide range of activities that are grouped predominantly as entrepreneurial; engagement; or knowledge translation. Maassen et al. (2019) grouped third mission activities as either “knowledge translation (KT)” or “engagement” in their comparative case study of six countries – Canada (Ontario), Japan, Chile, South
Africa, England, and Germany. In the next two sections, I differentiate between third mission activities that are entrepreneurial in nature and those that are focused on community engagement.

**Entrepreneurial and Knowledge Translation Third Mission Activities**

Entrepreneurial activities aim to diversify university incomes and generate revenue by developing services for industry, former students, or society. This includes the creation of spin-offs, patenting, licensing, partnerships with industry, and contract research, to name a few examples (Compagnucci & Spigarelli, 2020). Knowledge translation is the commercialization of the value of knowledge and technology. It includes activities such as research collaborations with industry, internships, academic publications, licensing of research outputs produced by the university, consultancy, and setting up new businesses (i.e., commercialization of research) (Maassen et al., 2019). According to Compagnucci and Spigarelli (2020), “from the KT standpoint, this dimension includes indicators like consultancy for industry, patent registration, the commercialisation of intellectual property, advisory work and contracts, shared development of research, problem-solving agendas or even contract and collaborative research” (p. 15).

**Engagement Third Mission Activities**

According to Maassen et al. (2019), engagement activities focus on social and community development and service through activities such as student participation in community service learning and health care provision to vulnerable groups in society, although they fail to expand on the latter. They noted that these activities are generally weakly institutionalized and lack clearly articulated goals. Across their case study of six countries, Maassen et al. (2019) found that there were no clear interpretations of ‘engagement’ nor rationale for these activities, resulting in a lack of national programs and funding opportunities to support university engagement activities. Compagnucci and Spigarelli (2020) highlighted that it is not clear what community engagement includes nor what its outcomes might be. According to
Pinheiro et al. (2015a, 2015b), community engagement involves universities bridging their activities with the needs and expectations of society by maintaining ongoing dialogue with its constituents. Whether entrepreneurial, knowledge transfer or community engagement, third mission activities involve university engagement with external stakeholders, including industry, communities, government, and individuals.

A Canadian Case Study of the Third Mission

Andreadakis and Maassen (2019) focused their comparative case study of Canada on five universities in the province of Ontario – McMaster University, the University of Ontario Institute of Technology, the University of Guelph, the University of Toronto, and the University of Waterloo – recognizing that universities are the policy responsibility of the provinces in Canada. According to their findings, universities in Ontario emphasized the vision of the institution as a service enterprise, with a focus on the economy, while also contributing to local and regional communities. Irrespective of the government of the day, the authors found that a “political focus on economic competitiveness and innovation has its impacts on the universities’ possibilities to follow in practice a broad social engagement/KT strategy, encompassing not only economic but also social, political and cultural aims” (Andreadakis & Maassen, 2019, p. 32). They identified the direct transfer of research-based knowledge as a dominant third mission activity, driven by the Canadian national context in which university-based research is regarded as important due to comparatively small industry-based research and development. They argued that Canada emphasizes knowledge transfer as a key mechanism for university contributions to innovation, job creation, and economic competitiveness. They described university and industry partnerships that

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1 In Canada there is comparatively small industry-based research and development (R&D), in part due to the fact that major companies in Canada are often US branch-plants, and R&D activities occur in the US. This has resulted in a situation where university-based research plays a large role in innovation strategies at both provincial and national levels (Maassen et al., 2019).
were supported and strengthened through government programs and funding opportunities,\(^2\) while community and social engagement were less clearly addressed.

Andreadakis and Maassen (2019) argued that serving their communities was a more visible and institutionalized part of Ontario’s university missions compared to others within their international comparative case study. All five universities in the Ontario case study had one or more offices to support knowledge and technology transfer to society, and some had specific units for supporting the university’s community engagement activities. They were engaged in activities that promoted access, diversity, and social justice. However, a political focus on economic competitiveness and innovation impacted the universities’ ability to be agents of social change, with a focus on broader social and cultural aims.

While rooted in an economic role for the university in society, the literature reveals the diverse activities universities are engaged in that extend beyond education and research. Put most generally, the concept of a third mission has been used to describe the relationship between universities and society, understood as stakeholders from outside the university (Compagnucci & Spigarelli, 2020; Maassen et al., 2019). This most general conceptualization of the term third mission is relevant for this exploration of the role of the health units in society, where roles beyond research and education have not been explored in the literature. Exploration of this concept raises questions about what types of activities the health units are engaged in that extend beyond the traditional missions of education and research – entrepreneurial, knowledge translation, engagement, or something else.

\(^2\) Examples: the University of Guelph’s partnership with the Ontario Ministry of Agriculture and Food and the Ontario Ministry of Rural Affairs (OMAF-MRA) developed initiatives to engage rural communities to develop a sustainable “agri-food” sector; the University of Waterloo entrepreneurship program called Velocity, viewed as the most productive start-up incubator in Canada, and GreenHouse, “a live-in social innovation incubator” to solve pressing social, environmental or health problems at their root.
Dominant and Competing Third Mission Discourses

The current conceptualization and discussions of the third mission in the literature reflect two dominant and competing discourses. While the entrepreneurial aspects of the third mission dominate the literature (Compagnucci & Spigarelli, 2020), authors discussing the third mission of the university embody two different discourses – one neo-liberal and one that is socially-oriented. Neo-liberalism is a political project that has “created competition and new markets where none existed, placed an emphasis on labour market flexibility, and asserted the superiority of individuals and their choices over social and collective goals” (Robertson & Dale, 2013, pp. 431-432). Neo-liberalism embeds market thinking into all social activities (Cowin, 2017), and includes to the privatization and globalization of education (Robertson & Dale, 2013). Conversely, socially-oriented discourses within the context of higher education focus on non-monetary societal benefit. These discourses discuss higher education as a way to “prepare educated, engaged citizens; strengthen democratic values and civic responsibility; address critical societal issues; and contribute to the public good” (Roper & Hirth, 2005, p. 13).

There are a number of authors who discuss tensions between more neo-liberal, economically driven approaches to third mission activities and those who call for universities to focus on meeting the needs of society more broadly. According to Maassen et al. (2019), universities need to make choices about whether to make contributions to innovation and competitiveness or to civil society and society’s grand challenges. They suggest that universities need to take responsibility for engaging society and sharing the knowledge generated within the institution. They highlight how third mission “outcomes are expected to contribute to improving individual life chances and well-being, enhancing national or regional economic and technological competitiveness, strengthening social cohesion, and finding solutions to the grand challenges that our societies face” (Maassen et al., 2019, p. 15). Roper and Hirth (2005) have viewed the marketization of universities as a response to calls for developing a better workforce and fostering
healthier businesses, while also highlighting how the third mission originated with the desire for higher education to serve the needs of society. Compagnucci and Spigarelli (2020) have discussed how the third mission includes contributions to “social, cultural and economic development of communities” and on the other hand “represents the gradual shifting of universities towards economic-based, or inspired, activities in the sense of commercialising knowledge” (p. 6).

**Neo-Liberal Discourses**

Pinheiro and colleagues (Pinheiro et al., 2015a, 2015b, 2016; Pinheiro & Stensaker, 2014) have reflected a predominantly neo-liberal discourse in their discussions about the third mission of universities. They have praised the way that the third mission involves the translation of research findings into intellectual property and the universities’ contributions to economic development. They have heralded the potential for universities to contribute to economic growth and social progress in North America and Europe “in the context of a much fiercer competitive higher education landscape,” which “has come to represent a ‘strategic opportunity’ for generating additional income and securing public support (external legitimacy) towards universities’ core tasks and functions” (Pinheiro et al., 2015a, p. 235). Bourner and colleagues (2017) have suggested that the third mission is a means of “seeking national and international excellence” (p. 22) and determines whether universities ‘thrive’ or ‘languish.’

In a comparative case study of post-secondary education systems in British Columbia, Ontario, and Quebec, Fisher et al. (2014) found that provincial governments invested in post-secondary education as a mechanism for economic development and security, particularly since 1980. According to their findings, operating within a political economy of international competitiveness has transformed Canadian post-secondary education to include a range of new entrepreneurial activities; however, they found that post-secondary institutions in British Columbia were slower to adopt the massive investment in research and
development that happened in Ontario and Quebec. Their case study reveals a post-secondary context across all three provinces that exists “in a neo-liberal framework, [wherein] public choice, marketization, and the privatization of education are prevalent themes, emphasizing stronger links between industry training needs and the postsecondary sector” (Fisher et al., 2014, p. 25). Dennison (1997) argued that higher education in British Columbia plays a prominent role in both the social and economic development of the province.

**Socially-Oriented Discourses**

While neo-liberal discourses dominate the third mission literature and activities, authors such as Zomer and Benneworth (2011) are critical of the impact of neo-liberalism on the ways that universities have operationalized their third mission. They are particularly concerned with how revenue-generating activities, marketization, commodification, commercialization activities, investments in innovation, and regional development activities have impacted university governance and engagement activities. Atkinson (2019) is critical of how finding new sources of revenue (i.e., the corporatization of universities) has distracted from the university’s core mission of education and negatively impacted institutional interest in being responsive to communities. In their introduction to a special issue of the *European Journal of Higher Education* on the third mission, Pinheiro et al. (2015a) reflected a more socially-oriented discourse than in some of their other writing, wherein they referred to the third mission as part of a “social contract” and “moral responsibility” that involves “helping to tackle the great challenges facing societies and local communities...under the mantra of ‘relevance’ and ‘social impact’” (p. 227). Maassen et al. (2019) referred to the university’s “social contract” or “pact with society,” and they argued that universities’ responsibility to society should be integrated into the strategic plans and frameworks of the institutions.
The Relationship Between the Health Units and Society

Several authors embodied a socially-oriented discourse related to the health disciplines that reflects a social contract, which they have discussed as a social accountability mandate. Meštrović and Rouse (2015) have been critical of what might be perceived as a neo-liberal approach to the role of the health professions in society and the way in which “the past century saw spectacular gains in the breadth and depth of biomedical knowledge, but the potential of these gains has been limited by inadequate, inequitable, and inefficient translation of knowledge and skills to the health care workplace” (p. 1). According to Ritz et al. (2014), a moral discourse across the health disciplines linking the training of health professionals to the social contract between the professions and society has been gaining strength.

Within the context of the health disciplines, the World Health Organization (WHO) put forward the idea of a social accountability mandate for academic institutions responsible for the education of health professionals, which they described as “the obligation to direct their education, research, and service activities towards addressing the priority health concerns of the community, the region, or nation they have a mandate to serve” (Boelen & Woodward, 2009, p. 43). The concept of “social accountability” is used along with terms such as “social responsibility” and “social responsiveness” (Boelen, 2015; Ritz et al., 2014). While the majority of this literature refers to medical education specifically, Boelen (2015) suggested that the principles of social accountability apply equally to nursing schools. Meštrović and Rouse (2015) included contemporary approaches to pharmacy education in the social accountability mandate described by Boelen.

According to Ritz et al. (2014) and Meštrović and Rouse (2015), calls for greater social accountability have been in response to the failings of the Flexner Report (1910) and the Alma-Ata Declaration (World Health Organization, 1978). The Flexner Report was published under the aegis of the Carnegie Foundation after
the author, Abraham Flexner, surveyed all 155 medical schools in the United States and Canada and put forward recommendations for improving the training of physicians. At this time, many American medical schools were small private institutions only affiliated with a college or university. Many cite the Flexner Report (1910) as a pivotal moment for health professional education in the United States and Canada, leading to the closing of for-profit schools that trained physicians and nurses and universities becoming responsible for educating physicians, with other professions such as nursing making similar reforms (Baker et al., 2012; Harris, 1976; Hodges, 2005). Medical education became standardized across institutions and subject to rigorous accreditation standards. Flexner (1910) also recommended that medical schools appoint clinical professors, who continue to play an important role in the training of health professionals. The Alma-Ata Declaration of 1978, a document produced by the WHO, called for widespread changes to address gross health inequalities and identified primary care as key to achieving the goal of ‘health for all.’ The document states that the realization of this goal involves many social and economic sectors, in addition to the health system.

Boydell et al. (2019) and Lodenstein et al. (2017) write about social accountability as the responsibility of individual healthcare providers. Ritz et al. (2014) acknowledged that social accountability has generally been viewed as the responsibility of individual healthcare professionals rather than the responsibility of institutions. However, according to Rourke (2018), universities are responsible for training the health professionals of tomorrow and conducting research that meets the needs of society. He stressed the responsibility of universities for “engaging, partnering with, and responding to the needs of their community, region, and nation, especially their underserved and vulnerable populations” (Rourke, 2018, p. 1121). Socially accountable universities, across their education, research, and service activities, are seen as a way to contribute to the improved health of societies, which is defined by the WHO as “a
complete state of physical, mental and social wellbeing” that can only be achieved by “acting on the spectrum of political, economic, cultural, environmental determinants of health” (Boelen, 2015, p. 615).

Social accountability activities described in much of the literature focus on the education mission of the university and do not extricate what this means when referring to service. Writing about the Northern Ontario School of Medicine (NOSM), Strasser et al. (2013) highlighted the potential of a school with an explicit social accountability mandate to graduate health professionals who have the skills and desire to provide healthcare to marginalized and underserved communities in the region, thereby meeting the needs of society. Ritz et al. (2014) argued that social accountability initiatives such as this, that focus on training students in underserved communities, are founded on the rationale that students are more likely to practice in the type of community in which they are trained. Further, this type of education gives learners exposure to and experience with marginalized groups, which will facilitate future providers’ understanding of their needs and result in being able to better address health inequities. Rourke (2006) discussed initiatives focused on recruitment of students from rural backgrounds, including increased recruitment of Indigenous students, as a mechanism to address this concern. Jarvis-Selinger et al. (2008) presented a social accountability initiative at UBC related to the expansion of its medical school to distributed centres across the province, with the goal of meeting the needs of rural communities. They also identified initiatives aimed at addressing the needs of underserved inner-city, geriatric, and Indigenous populations. Many social accountability initiatives across the health disciplines in Canada focus on improving the health of people in rural communities (Strasser et al., 2013).

Boydell et al. (2019) and Rourke (2018) have acknowledged that by its very nature, the social accountability of health disciplines is highly influenced by local context, as institutions strive to meet the needs of the communities they serve. Preston et al. (2016) accounted for both internal and external
factors that influence the social accountability of health disciplines, the strongest of which they suggested is workforce demand, in addition to institutional environment, culture, and resource allocation. In British Columbia, research has suggested that the cost of healthcare is rising due to the changing demographics and needs of the population; these needs are becoming increasingly complex, particularly around the prevalence of chronic disease, cancer, and mental health and substance use issues (Aggarwal & Hutchison, 2012). There are a growing number of patients requiring surgery due to moderate to complex medical conditions, as well as those with mental health and substance use issues, those suffering from cancer, and those experiencing frailty (BC Ministry of Health, 2015). These patients need continuity and coordination of care across providers, time, and locations, which is complicated by the distribution of the population of BC across sparsely populated rural areas over a large geographic expanse. In rural and remote communities, these challenges are exacerbated by difficulties with attracting and retaining healthcare professionals.

The concept of a social accountability mandate for health disciplines has been driven by these types of health inequities. Efforts on the part of universities to address these societal challenges through activities labelled as “social accountability initiatives” often focus on preparing students to work in underserved communities by recruiting students from rural communities and training students outside urban centres (Strasser et al., 2013). Those discussing social accountability in the literature did not differentiate activities as either education, research, or service. However, authors writing about the third mission of the university stressed that it cannot be extricated from the first and second missions traditionally performed by universities: education and research (Maassen et al., 2019; Pinheiro et al., 2015b).
The Relationship Between the Three Missions of the University

While the concept of the third mission has come to encapsulate all university activities that extend beyond the traditional roles of education and research, the boundaries between the three missions of the university remain unclear (Pinheiro et al., 2015b). The ways that the third mission has been operationalized in different contexts show an interconnectedness between the three missions of the university. Bourner and colleagues (Bourner et al., 2013, 2016, 2017) introduced the concept of the “fully functioning university” as a way to find complementarities and synergies between the tripartite mission of universities. They explored how universities “contribute to the community and society in ways that also support the advancement of knowledge and the higher education of its students” (Bourner et al., 2017, p. 5). They also argued that the way each mission has been expressed and has existed in relation to the other two missions has changed throughout history and has influenced the way that resources are allocated to support each mission. Bourner et al. (2020) developed the concept of the fully functioning university as a way to aid universities in giving equal attention to articulating and enacting all three missions. After introducing the concept of the fully functioning university in 2008, Bourner and colleagues built on this concept, writing about each of the three missions in turn – education (Bourner et al., 2013), research (Bourner et al., 2016), and the third mission (Bourner et al., 2017).

With a focus on North American and European ‘Western’ universities, Bourner et al. (2020) have suggested that there are three types of education that correspond with each of the three missions: student-centred education, subject-centred education, and society-centred education. The main purpose of society-centred education is to “equip the students with the capacity and disposition to contribute to society in general and the community in particular” (Bourner et al., 2020, p. 12). Throughout history, university education has focused on knowledge, skills, and attitudes that reflect the needs and demands of the society of the time. For example, according to Bourner et al. (2020), the focus of education in the
21st century on “transferable skills, preparation for lifelong learning, work-based learning, reflective learning, community-based learning, etc.” (p. 18) has been driven by societal and workplace demands. They suggested that an increased focus on the third mission has resulted in “the recent growth in accreditation of learning from volunteering, service-learning, student-community engagement, community-based education and civic education” (Bourner et al., 2020, p. 9). Compagnucci and Spigarelli’s (2020) systematic literature review highlighted the way in which university curricula are increasingly designed to align with society’s needs and aim to ensure students graduate with the ability to contribute to the economy. Pinheiro et al. (2016) understood the education mission of universities as a key contributor to prosperity by providing individuals with the skills to contribute to local economies. Fisher et al. (2014) discussed the desire of universities to connect the education activities of universities more closely with socio-economic realities, resulting in increased collaborations and partnerships with businesses. Bourner et al. (2020) argued that a society-centred education will continue to rise into the 22nd century.

Bourner et al. (2016) put forward that “the same reasoning can now be extended to the research, which in the fully-functioning university would contain a subject-centred part, a student-centred part and a service-centred part” (p. 5). The goal of service-centred research is “to contribute directly to those outside the walls of the university, including the local community” (Bourner et al., 2016, p. 6). This can be categorized as “problem-focused research” that is practical; “applied research” that employs theories, knowledge, methods, and techniques for a specific purpose; or “engaged research” that supports university engagement with society. However, they described the “research mission” as “the advancement of knowledge,” articulating research as the intentional creation of knowledge, while suggesting that the advancement of knowledge includes inventions and unintentional ways knowledge might be gained by society as a whole. They contended that the role of universities in advancing
knowledge beyond formal research, includes: demystifying and popularizing knowledge; developing research as a transferable skill amongst all university students; elevating the esteem in which knowledge is held; integrating and synthesizing knowledge; knowledge transfer between producers and potential users of knowledge; identifying domains of applicability of knowledge; interpreting new knowledge; liaising with other groups with interest in the advancement of knowledge; organizing knowledge; critiquing and evaluation knowledge; and advancing local knowledge (Bourner et al., 2016).

While discussions about the third mission often focus on activities designed to contribute to both the economic development of society and the financial sustainability of the institution, these activities often involve both research and education. Bourner et al. (2017) recommended that universities pursue their third service mission in a way that contributes to their education and research missions. As a way to connect the third mission to the education mission, they recommend that universities ask “what kinds of knowledge, skills and attitudes would equip a student to make a difference to the lives of others in society in general and the local community in particular?” (Bourner et al., 2017, p. 12). The question to ask with respect to the connection of the third mission and the research mission is “how can a university contribute to the advancement of knowledge and the advancement of learning through social engagement?” (Bourner et al., 2017, p. 13). Pinheiro et al. (2015a) echoed this recommendation and argued that third mission activities “should be embedded in, and/or tightly coupled with, teaching and research endeavours” (p.235). Zomer and Benneworth (2011) suggested that the third mission has moved from the periphery to being an integral part of higher education that involves both commercialization and engagement activities that are entangled with the teaching and research enterprise of the university. Interestingly, Pinheiro et al. (2015b) pointed out that “most (but not all) universities – particularly in Continental Europe but also elsewhere – have traditionally addressed external calls for increased societal engagement or third mission by decoupling their core teaching and
research activities from non-core tasks” (p. 228). Therefore, it is important to ask how the third mission influences the education and research missions, as well as how it is influenced by the other two missions in return.

Conversely, some authors have described an academic environment that needs to balance the traditional notion of academic freedom with the need for the institution to be responsive to society and contribute to social and economic development. In a case study of higher education in Western Canada, Atkinson (2019) concluded that universities need to adapt in order to meet the needs of society in a way that balances institutional autonomy with public accountability. Historically, faculty researchers have enjoyed the academic freedom to pursue their own research agenda. As in many other countries, Canadian universities are considered autonomous institutions with a commitment to academic freedom (Fisher et al., 2009) that they often prioritize above societal concerns.

While universities are expected to be more responsive to society through their education, research, and third mission activities, Dennison (1997) articulated the challenge of higher education in British Columbia to do so in a way that does not sacrifice important aspects of institutional autonomy, while also contributing to economic growth, productivity, and competitiveness. While the third mission has often been perceived as eroding this notion of the ivory tower, some argue that the third mission is dismantling the academic freedom and institutional autonomy of the university (Chantler, 2016). There are those that argue that the contribution universities make to society is achieved through the pursuit of knowledge for its own sake, protected through the concept of academic freedom and institutional autonomy, rather than being responsive to societal pressures (Kwiek, 2006).
Peels et al. (2019) discussed the epistemic responsibilities of universities stemming from their unique ability to generate knowledge. While acknowledging that universities have social responsibilities, such as producing useful technologies and effective medical intervention, they argued that these are the responsibility of all institutions and companies in society and that universities must remain committed to their epistemic goals. In making this argument, Peels et al. (2019) recognized that certain disciplines, giving the example of nutritional sciences, should have a greater responsibility in ensuring their research serves society in a practical manner. However, more practical application of research toward informing policy, producing medical interventions, and developing technologies enable the institution to be more responsive to society. The impact of the third mission on the image of the university as separate from society, and how it can be more responsive through both neo-liberal and socially-oriented university activities – underlie discussions about the third mission. The literature reviewed here suggests that the third mission, how it is articulated and operationalized, the types of discourses it embodies, and its relationship to the other two missions is influenced by a complex intersection of social, political, and economic forces from both within and outside the university.

The Socio-political Landscape of Higher Education in British Columbia

Universities reflect, influence, are influenced by and are responsive to the societies in which they operate (Jones, 1998). While finding their roots in the European university, Jones (1998) wrote about how Canadian universities are unique, suggesting that they are influenced by socio-political dimensions and, as such, reflect the world in which they operate. Jones (1998) argued that Canada has its own ideas about what a university is and should be. While there are a small number of private universities in Canada, according to his study, Canadian universities are public, secular, degree-granting institutions with the autonomy to create their own missions and mandates. According to Jones (1998), “teaching, research and service are now regarded as the three central functions of the Canadian university” (p. 71). He found
that these three missions are now institutionalized through collective faculty agreements, university policies, and institutional mission statements.

While higher education in Canada is the responsibility of the provinces, the research function of universities has been highly influenced by the federal government. In 1916, the federal government established the National Research Council, offering grants and scholarships, turning to universities as the principal source of research (Cameron, 1997). Seeing how German universities contributed to advances in manufacturing during World War I, the Council believed investments in scientific research would help develop a national infrastructure for industrial research (Jones, 2014). After World War II, the federal government created the Canada Council and three distinct research granting councils (the Medical Research Council, which would later become the Canadian Institutes of Health Research; the Natural Sciences and Engineering Research Council; and the Social Sciences and Humanities Research Council). In the 1980s, the federal government developed National Centres of Excellence that facilitated collaborations between university researchers and industry (Jones, 2014).

The education mission of universities in British Columbia has been highly influenced by pressures to increase accessibility (Skolnik, 1997). The province spans 950,000 square kilometres, with the population primarily condensed in a few urban centres but with small communities distributed across rural areas. According to Dennison (1997), British Columbia’s geographic and population disparities have influenced the development of higher education in the province. Accessibility was established as a key policy priority in 1988, creating a focus on ensuring access to degree programs outside of the province’s urban centres (Fisher et al., 2014). Ensuring access to post-secondary education across the small and distributed population has been a dominant theme in the history of higher education in BC.
In 1962, the *Higher Education in British Columbia and a Plan for the Future*, known as the MacDonald Report, led to the creation of two additional universities in BC and to the development of a community college system as a means to increase accessibility to higher education across the province. According to Dennison (1997), the MacDonald Report was the most influential document in the history of higher education in BC. Authors writing about higher education in BC have often focused on the creation of the community college system initiated by the MacDonald Report and the creation of teaching universities in the 1990s (Cowin, 2017; Dennison, 1997; Fisher, Rubenson, Trottier, et al., 2014). Community colleges offered technical and vocational programming and were distributed broadly across the province (Atkinson, 2019).

According to Fisher et al. (2014), the creation of teaching universities in British Columbia substantially changed the structure of the university sector, with the functions of each legislated by the University Act (1996). The Act makes it clear that research is within the sole purview of traditional universities, of which UBC is one of four in the province, and that research is not to be a core function of teaching universities. There are now 25 publicly funded institutions of higher education in the province – 11 universities (four of which are research-intensive universities, UBC; Simon Fraser University; University of Victoria; and University of Northern British Columbia), 11 colleges, and three institutes. There are also a small number of private universities and colleges and theological colleges. While the University Act outlines the education and research functions of both traditional research universities and teaching universities, it does not specifically refer to their role in society (Fisher et al., 2014). According to Pinheiro et al. (2016), regional discussions that have largely focused on geographic access have been separated from discussions about the role of universities in contributing to economic development. They stressed that, in Canada, provincial approaches focused on regional access have been centred on the educational role of post-secondary institutions in contributing to economic development.
According to Dennison (1997), the evolution of higher education in British Columbia has been influenced by both the geographic and population disparities discussed above, as well as changes to the economy of the province. Focused on forestry, fishing, and mining in the first half of the 20th century, there was little emphasis on sophisticated training programs that would have served to diversify the economy. However, in the 1960s and 1970s there was public pressure to diversify the economy in order to survive in increasingly competitive global markets. In addition to expanding the number of institutions, the government targeted funded enrolment to priority areas such as information technology, nursing, critical health care professions, medicine, social work, online learning, and Aboriginal education (Fisher et al., 2014).

While policy makers in British Columbia have been focused on regional access and expansion, leading to the creation of teaching universities that have been the subject of much of the literature on post-secondary education in the province, there have been similar efforts to ensure access to and distribution of health professional programs. Brophy and Tucker-Abramson (2012) noted that there was an explosion in the number of satellite and branch campuses across the country and discussed calls made by the provincial government in 2008 for Simon Fraser University to redirect its focus to health programs. Fisher et al. (2014) discussed provincial efforts in 2001 to ensure better distribution of health professionals by providing a 10% remission of student loans for each year that a medical school graduate practiced in a rural area. This program was eventually extended to nine other health professions.

Discussing the ways that health professional programs need to be accountable to the societies they have a mandate to serve, Boydell et al. (2019) and Rourke (2018) acknowledged that universities in society have been highly influenced by local context. Boydell et al. (2019) argued that this is due to the political
nature of the health system and the power dynamics pervasive throughout society. Preston et al. (2016) identified both internal and external factors that influence the relationship between health professional programs and society, the strongest of which they suggest is workforce demand, in addition to institutional environment, culture, and resource allocation. As such, it is important to consider the provincial health context, as well as the context of higher education, within which UBC and its Faculty of Pharmaceutical Sciences, School of Nursing, and Department of Physical Therapy are situated.

The University of British Columbia within the Broader Socio-political Landscape

UBC was established in 1908 as the first university in the province when the provincial legislature passed the University Act. The UBC-Vancouver Point Grey campus was built on the traditional, ancestral, unceded territory of the xʷməθkwəy̓əm (Musqueam). The UBC-Okanagan campus, originally the Okanagan University College, was formed in 2005 on the traditional, ancestral, unceded territory of the Syilx people.

Table 2 - Overview of the University of British Columbia Vancouver and Okanagan – 2019/2020

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<tbody>
<tr>
<td>Budget</td>
<td>$3.1 billion</td>
</tr>
<tr>
<td>Research Funding</td>
<td>$759.1 million</td>
</tr>
<tr>
<td>Undergraduate Students</td>
<td>56,781</td>
</tr>
<tr>
<td>Graduate Students</td>
<td>11,717</td>
</tr>
<tr>
<td>Staff</td>
<td>11,482</td>
</tr>
<tr>
<td>Faculty</td>
<td>6,296</td>
</tr>
</tbody>
</table>

The comparative case study discussed in the next chapter focuses on three health units at UBC – nursing, physical therapy, and pharmacy. I chose to focus on these three units, as they represented the different
administrative structures within which the health disciplines at UBC are situated; nursing is a School within a non-health-related Faculty (Applied Science), physical therapy is a Department with a health-related Faculty (Medicine), and pharmacy is its own Faculty. They are also situated differently within the education and health contexts of British Columbia and offer a cross-section that reflects different contributions to society.

*Faculty of Pharmaceutical Sciences* - The Faculty of Pharmacy was established at UBC Vancouver in 1946 and remains the only educator of pharmacists in the province. Prior to being trained through the university, pharmacists in British Columbia were trained by apprenticeship. The original Faculty of Pharmacy was established after the Association of Faculties of Pharmacy of Canada decided that a pharmacist license required a minimum of three years of university education. However, apprenticeship continues to feature as an important part of their training, making it a four-year program that still has a large percentage of learning happening in a clinical setting outside the university. In the late 1960s, the Faculty was renamed the Faculty of Pharmaceutical Sciences to reflect its expanded role in research. They accepted their first Ph.D. candidate in 1968 and added a research wing to their faculty building. Currently, the Faculty is engaged in activities related to pharmacy practice, foundational science, health systems and policy, and pharmaceutical sciences research (Faculty of Pharmaceutical Sciences, n.d.-a). The Faculty divides its activities into four portfolios, each led by an Associate Dean – Academic; Graduate and Post-Doctoral Studies; Research; and Practice Innovation. The UBC Pharmacists Clinic, established in 2013, is a core function of the Practice Innovation portfolio. The Clinic has a mandate to create best-practice patient care; deliver learning to students; and act as a living lab to develop new systems and processes for patient care (Faculty of Pharmaceutical Sciences, n.d.-b).
Table 3 - Overview of UBC Faculty of Pharmaceutical Sciences - 2021

| Students                                      | 881 Entry-to-Practice Doctor of Pharmacy (PharmD) |
|                                               | 21 Flexible Doctor of Pharmacy (Flex PharmD)     |
|                                               | 39 Bachelor of Pharmaceutical Sciences (BPSc)    |
|                                               | 28 Master of Science in Pharmaceutical Sciences (MSc) |
|                                               | 51 Doctor of Philosophy in Pharmaceutical Sciences (PhD) |

| Research Funding | $10.5 million |
| Staff            | 104           |
| Faculty          | 76            |

**School of Nursing** - The UBC School of Nursing on the Vancouver campus was the first degree nursing program in the British Empire, formed in 1919 and established as a Department within the Faculty of Applied Science (B.C. History of Nursing Society, n.d.). By 1930 it became a School. A separate School of Nursing in Kelowna, BC was formed as part of UBC when Okanagan College became UBC-Okanagan in 2005. Initially a five-year program, students in the UBC-Vancouver Bachelor of Nursing program completed 28 months in a clinical program at Vancouver General Hospital, the location where previously nurses in BC had completed the entirety of their training. The Bachelor of Nursing at UBC now runs as a 20-month program that continues to have a significant amount of learning in clinical settings outside the university. This shift to a 20-month program occurred in the 1990s as a response to nursing shortages, with the Director of the School during that time believing that the two-year intensive program would attract more students. The School is still led by a Director, alongside Associate Directors in charge of five portfolios – Research, Graduate Programs, Undergraduate Programs, Faculty Development, and Infrastructure and Technology. The School now offers a number of graduate degrees – Master of Health Leadership and Policy; Master of Science in Nursing; Master of Nursing; and Ph.D. (B.C. History of Nursing
The School of Nursing at UBC is one of 17 nursing schools in the province; however, one of only two at a research-intensive university, with the other at the University of Victoria.

Table 4 - Overview of UBC Vancouver School of Nursing – 2019/2020

| Students       | 120 Bachelor of Nursing (BSN) |
|               | 203 Masters                   |
|               | 41 PhD                        |
| Research Funding | $3.8 million               |
| Staff          | 72                            |
| Faculty        | 44                            |

Department of Physical Therapy - The UBC School of Rehabilitation Medicine, which once included Physical Therapy and Occupational Therapy, opened in 1961 as part of the Faculty of Medicine. Prior to this, British Columbia’s 150 physical therapists were predominantly trained outside Canada. At the outset, students completed a three-year certificate program, one year of which involved rotating internships that continue to be a key feature of physical therapy education. By 1962, the School offered a full four-year degree and awarded a Bachelor of Science in Rehabilitation Medicine, a joint degree in Physical Therapy and Occupational Therapy. These became two separate programs in 1983, offering a Bachelor of Science in Occupational Therapy or Physical Therapy, and then separate Departments within the Faculty of Medicine in 2007, continuing to offer the Masters of Physical Therapy program introduced in 1993. The Department of Physical Therapy at UBC remains the sole educator of physical therapists in the province (Physiotherapy Association of British Columbia, n.d.).
To meet the demand for physical therapists across the province, particularly in rural and other underserved communities, the Department of Physical Therapy and a group of community advocates lobbied for a distributed program that mirrored that of Medicine. The distributed model of education introduced for medical students at UBC in 2004 saw cohorts of students complete their training outside Vancouver in collaboration with other universities in the province - Prince George (University of Northern British Columbia), Victoria (University of Victoria), and Kelowna (UBC Okanagan). In 2012, 20 physical therapy students completed at least four of their six clinical placements in Northern and rural locations across BC as part of a ‘Northern and Rural Cohort,’ which eventually was located at the University of Northern British Columbia in 2020 (Department of Physical Therapy, 2020). The Department is led by a Department Head and three Associate Heads leading three portfolios – Research; the MPT Program; and Clinical Education.

Table 5 - Overview of UBC Department of Physical Therapy – 2019/2020

<table>
<thead>
<tr>
<th>Students</th>
<th>93 Master of Physical Therapy (MPT)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>39 PhD</td>
</tr>
<tr>
<td></td>
<td>27 Research-Focused Masters</td>
</tr>
<tr>
<td></td>
<td>20 Post-Doctoral Fellows</td>
</tr>
<tr>
<td>Research Funding</td>
<td>$4.5 million</td>
</tr>
<tr>
<td>Staff</td>
<td>21</td>
</tr>
<tr>
<td>Faculty</td>
<td>26</td>
</tr>
</tbody>
</table>

The Faculty of Pharmaceutical Sciences, School of Nursing, and Department of Physical Therapy were formed initially as educational units designed to respond to requirements for educational standardization set by professional associations and regulatory bodies. At UBC, they later, and increasingly, engaged in
research. Their education mission is inextricably connected to their responsibility to train their respective health professionals to meet the needs of the province, which can arguably be linked to the concept of a social accountability mandate. However, the question remains, what are the activities that these three health units are engaged in that extend beyond their education and research missions and that reflect the concept of a third mission?

**Summary**

This literature review reveals that the concept of the third mission of the university can be used to describe a wide array of activities, broadly reflecting the relationship between the university and society and encompassing anything a university does that extends beyond the traditional missions of education and research. This broad conceptualization of the third mission includes the notion of “service,” which is more commonly referred to as a mission of the university and the health units as seen through promotion and tenure structures and the definition of social accountability within the context of the health disciplines. However, this broad conceptualization extends beyond the traditional notion of service and encapsulates both neo-liberal and socially-oriented activities. This ambiguity and inclusion of a wide range of activities within the concept of the third mission make it useful for an analysis of the role the health units play in society, beyond the education of health professionals and health-related research. Across the literature, most generally, the term “third mission” is used to describe a strategic mission, and a role for universities in society, as well as the relationship between universities and society. This general conceptualization makes it relevant for analyzing whatever might emerge as activities beyond education and research performed by the health units.

The literature discussed throughout this chapter reveals a view of a third mission that is contextual and subject to multiple internal and external drivers and policy actors. Studies describe ways that the third
mission is influenced by both national policies and institutional and regulatory environments, as well as internal institutional cultures and perceptions about the demands from external stakeholders. Authors highlight the way that third mission activities take shape and are affected by drivers originating outside the university. However, identification of, and discussions about, the concept of the third mission explicitly are notably absent from any literature that discusses the health disciplines. The drivers, policy actors, and regulatory environments that influence the role of health units in society, beyond education and research, are not reflected in the literature about the third mission, higher education in Canada, nor the health disciplines.

This review of the literature sheds light on the two dominant and competing third mission discourses: one that is neo-liberal and one that is socially-oriented. Which, if either, is reflected in the third mission of the health units at UBC under study remains to be answered. Some authors discuss the tensions between the dominant neo-liberal, economically driven approaches to third mission activities and those that focus on meeting the needs of society more broadly. Many authors are concerned with the dominance of entrepreneurial activities that have fulfilled the third mission and impacted university governance and engagement activities.

In conjunction with an exploration of the literature specific to the third mission, I considered the unique context of higher education in Canada and British Columbia specifically, revealing the neo-liberal pressures that have influenced the role of universities in Canadian society. Whether the health units within the University of British Columbia have experienced and responded similarly to such pressures is unclear. Conversely, the more socially-oriented discourses reflected in the third mission literature, and related university activities, introduce the notion of universities having a “social contract” and “moral responsibility.” I have equated this with discussions in the health disciplines literature about a social
accountability mandate. The WHO definition of social accountability presented in this chapter refers to education, research, and service; however, activities described in much of the literature focus on the education mission of the health disciplines and do not extricate the service mission.

Like the university as a whole, the Faculty of Pharmaceutical Sciences, School of Nursing, and Department of Physical Therapy were formed around an educational mandate wherein they were responsive to requirements for standardization set by external professional associations and regulatory bodies. Again, like the university writ large, they later and increasingly engaged in research. While their education mission is inextricably connected to their responsibility to train their respective health professionals to meet the needs of the province, which can be arguably be linked to the concept of a social accountability mandate, the question remains: what activities are these three health units engaged in that extend beyond their education and research missions and that reflect the concept of a third mission?

Authors writing about higher education in British Columbia highlight the way that universities in the province have reflected, influenced, been influenced by, and been responsive to society. This literature sheds light on the trends in higher education that may influence the third mission of the Faculty of Pharmaceutical Sciences, School of Nursing, and Department of Physical Therapy at UBC. They exist within, and are ostensibly accountable to, a provincial context focused on ensuring access to post-secondary education across the small and distributed population. While policy makers in British Columbia have been focused on regional access and expansion, the health units at UBC describe similar efforts to ensure access to, and distribution of, health professional programs, often described within a social accountability discourse. This literature discusses both internal and external factors that influence the relationship between health professional programs and society, arguing the strongest of which is
workforce demand. The provincial health context, as well as the context of higher education, presented in this chapter highlight the landscape within which the third mission of the health units will have emerged.
Chapter III - Methodology and Methods

As discussed, on an overarching level, the purpose of my research was to explore the concept of the third mission within the context of the University of British Columbia’s (UBC’s) health units, identify intersections and contradictions, and find opportunities for alternative futures. Through my chosen methodology, I explored: 1) the third mission of the health units at UBC, as it occurred in both discourse and practice; and 2) an imagined future of what this third mission could be, according to leaders acting on behalf of UBC’s health units. The specific research questions I answered through the methodology described in this chapter were:

1. How do specific health units at UBC – nursing, pharmacy, physical therapy – articulate and operationalize a third mission? What are the dominant and competing discourses?
   a. What drivers have influenced the way in which these health units at UBC articulate and operationalize a third mission?
   b. How does the third mission of these health units influence the education and research missions? How is it influenced by the other two missions?

2. What are the collective opportunities and possibilities across the health units at UBC related to the third mission?

The focus of my research was on three health units as part of a comparative case study. In this chapter, I outline my research design and rationale, research methods, and the ethical considerations I needed to be conscious of throughout. I discuss the strengths and limitations of the case study approach and then identify three specific data collection methods – document analysis, interviews, and a focus group – and outline how I analyzed the data using critical discourse analysis (CDA) and thematic analysis.
Research Design and Rationale

Case study was a valuable approach for my inquiry because of the contextual nature of the third mission, exemplified by the fact that case study was the dominant methodology used across the third mission literature (Bourner et al., 2017; Maassen et al., 2019; Zomer & Benneworth, 2011). My research fell within the notion of an *intrinsic* case study, as defined by Stake (2008), who distinguished between *intrinsic* and *instrumental* case studies. The former is undertaken by researchers, like me, who want to understand a particular case, first and foremost, and usually begins with the case already identified. For me, this intrinsic case was the health units at UBC that I worked with as part of my professional practice.

Drawing from the third mission literature, which differentiated between the third mission of research-intensive universities and the third mission of teaching universities, I became interested in the case of UBC as a research-intensive university (Maassen et al., 2019). UBC is one of four research-intensive universities in the province of British Columbia and provided a useful case study from which other research-intensive universities that have health units might learn.

I decided to use a comparative case study approach focusing on three health units at UBC: nursing, physical therapy, and pharmacy. I chose to focus on these three units firstly because they represent the different administrative structures within which the health units at UBC are situated.
Table 6 - Overview of Each Case

<table>
<thead>
<tr>
<th>Case</th>
<th>Faculty of Pharmaceutical Sciences (2020)</th>
<th>Department of Physical Therapy (2020)</th>
<th>School of Nursing (2020)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structure within the University</td>
<td>Own Faculty</td>
<td>Department in a health-related Faculty (Medicine)</td>
<td>School in a non-health-related Faculty (Applied Science)</td>
</tr>
<tr>
<td>Provincal Education Mandate</td>
<td>Sole educator of pharmacists in BC</td>
<td>Sole educator of physical therapists in BC</td>
<td>One of 17 educators of nurses in the province</td>
</tr>
<tr>
<td></td>
<td>Situated on Vancouver campus</td>
<td>Distributed program with Northern and Vancouver cohorts</td>
<td>One of two schools in BC in a research-intensive university</td>
</tr>
<tr>
<td></td>
<td>1,020 students</td>
<td>179 students</td>
<td>346 students</td>
</tr>
<tr>
<td>Research</td>
<td>$10.5 million</td>
<td>$4.5 million</td>
<td>$3.8 million</td>
</tr>
<tr>
<td></td>
<td>76 tenure-stream faculty members</td>
<td>26 tenure-stream faculty members</td>
<td>44 tenure-stream faculty members</td>
</tr>
</tbody>
</table>

As discussed in Chapter II, nursing is a School within a non-health-related Faculty (Applied Science), physical therapy is a Department within a health-related Faculty (Medicine), and Pharmacy is its own Faculty. Secondly, these units are situated differently within the educational and health contexts of British Columbia: the Faculty of Pharmaceutical Sciences is the only educator of pharmacists in the province; the Department of Physical Therapy, with its distributed program that trains students in both the north of the province and the urban centre of Vancouver, is the only educator of physical therapists in the province; and the School of Nursing is one of 17 academic institutions responsible for the training of nurses in the
province. Thirdly, these units also offer a cross-section that reflects different contributions to society - biological sciences (nursing), rehabilitation sciences (physical therapy), and pharmaceutical sciences (pharmacy). Finally, the profession each unit is responsible for training works predominantly within a different model of practice within the province’s publicly funded health system – mostly private industry (pharmacy); both public and private (physical therapy); and mostly public, including community (nursing).

The Case Study Approach

I drew on Merriam’s (1998) approach to case study, which provided a constructivist lens but also offered a step-by-step, detailed process for designing a case study. According to Yazan (2015), Merriam’s approach is useful for novice investigators. Merriam’s approach to case study also aligned with the goals of my research, as it allows the researcher to focus on a particular situation, event, program, or phenomenon; describe something about the phenomenon being researched; and illuminate the reader's understanding of the phenomenon under study. However, within the social sciences there is a fair amount of debate about what case study is; what constitutes a case; when to use this methodological approach; and how it can be differentiated from other types of qualitative research (Merriam, 1998; Stake, 2008; Yazan, 2015; Yin, 1994). This debate stems from the fact that case study is described as a unit of study (the case); a methodological approach; and the product of the investigation.

The Unit of Study - An important characteristic in case study research is the unit of study, the case – a delimited object of study, a thing, a single entity, a unit around which there are boundaries (Merriam, 1998). This could be anything from a person to a non-governmental organization. To determine the boundedness of a topic, one should ask how finite the data collection would be. My interest was in the strategic priorities articulated by specific health units and how these priorities were being operationalized at an institutional level, not the activities of individuals (e.g. specific faculty members). A comparative
case study of three health units at UBC – nursing, pharmacy and physical therapy - set boundaries that facilitated deep analysis both within and across the three cases. Each case had a finite number of documents to be analyzed and number of leaders who could be engaged through interviews and a focus group.

**Methodological Approach** - As a methodological approach, according to Merriam (1998), case study design allows researchers to gain an in-depth understanding of the situation and meaning for those involved. It involves an exploration of process rather than outcomes; discovery rather than confirmation; and description rather than explanation. Like other qualitative methodologies, case study design is emergent, with the researcher not knowing in advance who should be interviewed, all the questions that should be asked, or what data needs to be collected. According to Merriam (1998), researchers conducting a case study need to be flexible and adapt throughout the research process. Later in this section, I discuss three methods that provided data specific to answering my research questions. Within this case study, each method built on the previous, which indeed required me to be flexible and adaptive. The document analysis informed my interview questions. Interviewees identified other potential interview participants. Data collected from the interviews determined the focus group format and questions. Findings from the analysis of my interview data were presented during this focus group in order to develop a greater understanding of emerging themes. This iterative approach, whereby the collection of data informed the collection and analysis of subsequent data, facilitated a deeper understanding of what the third mission meant to those involved, exploration of that meaning, and description of how the third mission of three health units was operationalized. Focus on process rather than outcomes allowed for an exploration of the collective opportunities and possibilities across the health units at UBC related to the third mission.
**Product of the Investigation** - As a product, case study is “an intensive, holistic description and analysis” (Merriam, 1998, Overview of the Contents, para. 3). This plays an important role in how the findings of a case study are understood. Readers play a role in the interpretation process. They bring their own experience to the case study that may lead to generalizations as their data are added to the data presented by the researcher (Merriam, 1998). As such, it is important for the researcher to provide the reader with enough detail to show the conclusions make sense and give the reader the vicarious experience of having been there, so the reader can come up with their own generalizations. It results in a rich, holistic description of a phenomenon that can reveal knowledge and illuminate meaning that would not have been accessible to the reader otherwise (Merriam, 1998). It allows readers, through rich description, to compare findings with their own case and draw comparisons. My goal in presenting this comparative case study was for readers to be able to make general theoretical statements about social structures and processes related to the third mission and the dominant and competing discourses as they are articulated across the health units more broadly. My aim was to provide a holistic description that will enable readers from other health units and institutions to apply their own experiences to the case study and build on the concepts presented. This was accomplished by using interview and focus group data to provide insights into the document analysis findings and by using quotes from participants that exemplify the findings.

Frequent criticisms of case study methodology refer to limitations around reliability, validity, and generalizability by those who have suggested that case study has a “lack of rigor in the collection, construction, and analysis of the empirical materials that give rise to this study, validity and reliability” (Hamel et al., 1993, p. 23). According to Stake (2008), the goal of case study should be optimizing understanding of a particular case, not generalizability. However, Borman et al. (2006) argued that multiple cases facilitate greater generalization, while maintaining that qualitative researchers should
emphasize trustworthiness rather than reliability and validity. Trustworthiness can be “achieved through careful work in constructing the research design and approach, conducting the research ethically and honestly, analyzing findings carefully, and providing a presentation of results informed by rich descriptions in turn leading to appropriate extrapolations from the data” (p. 130). Plummer (2017) summarized a number of strategies that can ensure the trustworthiness of qualitative data, including peer review, researcher disclosure to identify biases, and construction of an audit trail, all three of which were incorporated into my research design.

**Methods**

My dissertation research employed three methods within the broader comparative case study approach: document analysis, interviews, and a focus group. I received ethics approval from the UBC Behavioural Research Ethics Board (BREB) to conduct semi-structured interviews (n=7: 2 pharmacy; 3 physical therapy; 2 nursing) and a focus group with different participants (n=4: 2 pharmacy; 1 physical therapy; 1 nursing). I knew participants already and specifically targeted them for their role in contributing to the strategic priorities of their unit and their ability to speak to the role of their unit in society, beyond education and research. While participants were known to me, I was not in a position of power over them in the professional setting of UBC, which allowed me to conduct the interviews and focus group myself. Each method built on the previous and involved an iterative analysis whereby I returned to and compared previously collected data with subsequent data.

**Document Analysis** - Merriam (1998) argued that documents provide a valuable source of data because they can offer information about things that cannot be observed, as well as things that happened in the past. Documentary data are particularly good for case studies because they can ground the study in the context being investigated. However, documents also have their limitations. Because documents are
usually produced for reasons other than use in case study research, they may be fragmented; not fit the conceptual framework of the research; not align with the research agenda; or have questionable authenticity. It is for this reason that I chose to combine the analysis of documents with data from the interviews.

Document analysis has been a common method used by those researching the third mission of the university. Within the context of each case study, Maassen et al. (2019) relied heavily on document analyses in conjunction with surveys and interviews. They have posited that strategic plans play an important role in how universities present their role in society. They used these to map and interpret the visions of each institution. Surveys and interviews then enabled them to gather information from university leaders about how they operationalized their relationship with society. Like Maassen et al. (2019), I started with an analysis of strategic plans. The objective of this analysis was to identify ways in which each unit articulated a mission beyond education and research.

Since the units that were the focus of this case study were situated across a particular institution and within different Faculties, it was important to analyze the institution’s strategic plan, as well as the strategic plans of each unit and the Faculty in which it was situated. These documents included:

- The UBC Strategic Plan (*Shaping UBC’s Next Century*, 2018)
- Faculty of Medicine Strategic Plan (*Building the Future*, 2016)
  - Department of Physical Therapy Strategic Plan (*UBC Department of Physical Therapy Strategic Plan*, 2018)
- Faculty of Pharmaceutical Sciences Strategic Plan (*Catalyst for Change*, 2017)
- Faculty of Applied Science Strategic Plan (*Transforming Tomorrow*, 2020)
  - School of Nursing Strategic Plan (*En)Vision 2020*, 2016)
I analyzed each document independently and extracted content united by the concept of the third mission, taken as “the conceptual position of universities in society as well as real-life practices in the interaction between universities and society” (Maassen et al., 2019, p. 5). I discuss the way in which I analyzed these extracted pieces of text later in this chapter.

**Interviews** - I chose to interview Deans, Associate Deans, Department Heads, Directors, and Associate Directors as a way to gain additional insights into my analysis of these strategic documents, as these individuals were involved in the development of their respective strategic plans and were responsible for their operationalization. Similarly, Maassen et al. (2019) used interviews to gather information from university leaders about how they enacted their relationship with society. According to Merriam (1998), interviews allow the researcher to explore what is presented in documents in more detail, which can provide context and additional analyses.

In writing about interview methods, Brenner (2006) discussed the many decisions that researchers need to make when conducting interviews, including structure, types of questions, and probing techniques. While structure can facilitate comparability across interviews and be more comfortable for novice researchers, a semi-structured approach allows researchers to follow up and build on responses. These decisions are, in part, influenced by the relationship between the interviewee and the researcher and whether the researcher is using an inductive or deductive approach. Brenner (2006) pointed out that decisions about interview protocols and when to probe are the start of the analytic process. Through a combination of verbatim quotes and summaries of the data in a narrative format, interviews contribute to the rich description required of case study. Most importantly, the researcher must describe who they are in relation to the interviewees and reflect on how they may have influenced the discussion. Brenner (2006) recommended confirming interpretations of meaning with participants.
After receiving ethics approval from the UBC BREB, I contacted identified leaders in each unit by email (see Appendix A) to share the goals of my research (see Appendix B) and formally invite them to participate in an interview, providing a consent form to return in the event that they agreed to participate (see Appendix C). Interviews were scheduled for 60 minutes via Zoom at a mutually agreed upon time. As part of this comparative case study, I set out to interview leaders from each of the health units of focus – nursing, pharmacy, and physical therapy – who were identified in collaboration with my committee as able to speak to the strategic priorities and external role of their unit. Two to three key individuals were identified within each unit, all of whom agreed to participate in an interview. I used semi-structured interviews that did not adhere rigidly to a pre-determined set of questions. Guiding questions and prompts (see Appendix D) were informed by the document analysis and literature review.

Brenner (2006) stressed the interactional nature of interviews, whereby both the interviewee and researcher are involved in the process of creating meaning. This was particularly the case within the context of my research, where I knew the participants and was very much an insider. Like others in education, my interviews applied a cultural anthropology disciplinary frame, where the goal is “to understand the shared experiences, practices, and beliefs that arise from shared cultural perspectives” (Brenner, 2006, p. 358). I applied a deductive approach, grounded in the concept of the third mission and how it had been operationalized, in contrast to an inductive approach whereby themes emerge during the analytical process. My questions were built around this concept, and my probing questions were often informed by my experience working across the health units and knowledge about where they converged and where there were inequities.
Throughout the interviews, I had to remain attuned to the fact that I worked closely with participants within the context of my professional practice and that what I was hearing was influenced by our prior and ongoing working relationships. I also had to be conscientious about how my own knowledge of the health units and my subjectivities influenced the interview process. I asked naïve questions that might be asked by an outsider in order to gain insights into the perspectives of interviewees about the context in which their third mission existed. In doing so, I used a deductive approach, which is often employed by critical theorists who explicitly explore the interviewees’ position in society and the inequities that exist (Brenner, 2006). I was attuned to the fact that the health units existed within a hierarchical social context that translated into inequities and differing positions of power in society (Green et al., 2017). Probing questions allowed me to apply a critical lens that considered and explored these disciplinary issues of power and privilege that were of particular interest to me. Interviews were recorded and transcribed using the automated features in Zoom. I then edited the transcriptions manually to ensure accuracy and coded for key themes. I shared individual transcripts and my preliminary analysis with interviewees for feedback. I then created a summary of the data, which was used as a foundation for a focus group discussion.

**Focus Group** - There was an element of my research that moved beyond the comparative case study toward an imagined future. According to Brinkmann (2013), focus groups are well suited for exploratory studies that examine newly emerging phenomena, which is arguably the case with the third mission of the health units at UBC. According to Liamputtong (2011), focus groups can answer diverse research questions and go beyond preliminary or exploratory research. They can help gain a deeper perspective. Focus groups, or group interviews, use group dynamics to bring out different perspectives (Brinkmann, 2013). When used with other methods, such as in-depth interviews, focus groups can enhance the researcher’s understanding of topics that require both depth and breadth of understanding.
Focus groups allow the researcher to hear about different facets of people’s experiences. They allow for deeper insights, bring together multiple perspectives that might not be achieved through interviews, and create an environment within which new and creative ideas can be explored (Halliday et al., 2021).

My final research question – What are the collective opportunities and possibilities across the health units at UBC related to the third mission? – moved beyond a description of ‘what is,’ which is a feature of case study, to an exploration of ‘what could be.’ To do so, I brought together different leaders than those I interviewed from the three units in order to collectively discuss opportunities and possibilities as part of a focus group. Interviewees and two of my committee members, who are themselves leaders from these health units, identified 2-3 faculty members in each unit who would be able to speak to the external role for their unit, beyond those who participated in an interview. I contacted identified leaders in each unit by email (see Appendix E) to share the goals of my research (see Appendix B) and formally invite them to participate in a focus group, providing a consent form to return in the event that they agreed to participate (see Appendix C). The 90-minute focus group conducted on Zoom was scheduled using a Doodle poll to identify a time that ensured the participation of at least one individual from each unit (n=4; 2 pharmacy, 1 nursing, 1 physical therapy). I started by presenting the findings from my document analysis and interviews. I then facilitated a focus group discussion using a series of guiding questions (see Appendix F) that was recorded, transcribed, and analyzed using the approach described in the next section. The goal of the focus group was to explore more deeply the concept of the third mission of the health units, identified through my document analysis and interviews, and an imagined future of what the third mission of the health units could be. I emailed participants a summary of the focus group analysis and provided them with an opportunity to provide individual written feedback.
Due to COVID-19 restrictions, both interviews and the focus group were conducted online using Zoom, which brought some advantages. On a basic level, online focus groups are easier to organize. I used the embedded recording and transcription functions in Zoom and saved recordings automatically to my UBC password-protected computer. According to Liamputtong (2011), within the context of virtual focus groups, participants’ inhibitions are often reduced, personal disclosure increases, interactions amongst participants increase, and the pressure to conform decreases. This was the case with the focus group, where participants waited until the person speaking stopped before unmuting their audio and contributing to the conversation. Writing within the context of a virtual focus group conducted during COVID-19, Halliday et al. (2021) shared how online focus groups reduce dropout rates and allow for the recruitment of geographically dispersed participants. According to their study, the transcripts and data from the virtual focus groups did not vary in quality from the face-to-face focus groups conducted as a part of the same project. They actually noticed that there was less over-talking in the online focus groups, which was very much the case within my own focus group. They did note, however, that the effectiveness of the online focus groups was likely enhanced by the fact that participants were familiar and comfortable with the technology, which was also the case with my participant population.

**Critical Discourse Analysis**

Based on the idea that universities have often been perceived as ivory towers – disconnected from society, perpetuating inequality by virtue of who has access, conducting research for the sake of research – suggesting a power imbalance between the institution and society, I sought to apply a critical lens to this inquiry. I was also interested in how the relationship between the health units and society was articulated at an institutional level through publicly facing documents such as strategic plans. As such, critical discourse analysis (CDA) offered a useful approach for unpacking the ways in which the third mission of the health units at UBC were articulated and operationalized. CDA is often applied to
institutional discourse, draws on critical social theory, and has the ability to examine the ways in which macro-structures play out (Rogers et al., 2016).

CDA brings together discourse analysis and social theory as a way to “describe, interpret, and explain the ways in which discourse constructs, becomes constructed by, represents, and becomes represented by the social world” (Rogers et al., 2016, p. 366). According to Lawless and Chen (2019), “critical discourse analysts understand power as embedded in texts as a way to reproduce understandings of social positioning and reinforce hegemonic understandings of culture” (p. 94). CDA “explores how texts construct representations of the world, social relationships, and social identities” (Taylor, 2004, p. 434). As such, CDA offered a useful approach for analyzing how the third mission was not just articulated but also operationalized.

According to Rogers et al. (2016), researchers should change, modify, and adjust CDA frameworks to suit their research questions. Fairclough’s (2004) approach to CDA offers a way to explore the meaning behind the words that are used and explores dominant and competing discourses, which are:

- a particular way of representing some part of the (physical, social, psychological) world – there are alternative and often competing discourses, associated with different groups of people in different social positions. Discourses differ in how social events are represented, what is excluded or included, how abstractly or concretely events are represented, and how more specifically the processes and relations, social actors, time and place of events are represented. (Fairclough, 2004, p. 17)
My analysis drew on both Fairclough's (2004) and Gee's (2010) approaches to CDA, the latter providing a number of tools to support my analysis. I analyzed text from strategic plans and linked in data from interviews and a focus group using:

1. **Word choice and order used** (Fairclough, 2004)

2. **The Big C Conversation Tool** for considering dominant and competing discourses by asking
   
   “What issues, sides, debates, and claims the communication assumes hearers or readers know or what issues, sides, debates, and claims they need to know to understand the communication in terms of wider historical and social issues and debates? Can the communication be seen as carrying out a historical or widely known debate or discussion between or among Discourses? Which Discourses?” (Gee, 2010, p. 191).

3. **The Activities Building Tool** as a way to link how the third mission was articulated with how it was operationalized by asking “What activity (practice) or activities (practices) this communication is building or enacting. What activity or activities is this communication seeking to get others to recognize as being accomplished?” (Gee, 2010, p. 104).

4. **The Politics Building Tool** to identify what counted as a social good and for analyzing the way in which different discourses contributed to this good or withheld it (Gee, 2010). This was useful for considering the drivers that influenced the way in which the third mission was articulated and operationalized.

5. **The Making Strange Tool** as a way to consciously think about the knowledge, assumptions, and inferences that influenced the way I interpreted communications. In using this tool, the researcher asks, “What would someone (perhaps, even a Martian) find strange here (unclear, confusing, worth questioning) if that person did not share the knowledge and assumptions and make the inferences that render the communication so natural and taken-for-granted by insiders?” (Gee, 2010, p. 19).
Through the document analysis, I identified specific sections of each strategic plan that related to the role of the health unit and university in society. The University, and unit strategic plans, explicitly articulated a number of different missions, which they also described as “core areas,” “pillars,” “activities,” and “commitments.” The plans were structured around each of these. I extracted text from these sections and analyzed each line of text independently using each of these five CDA tools. These CDA tools led to questions about what was presented in each strategic plan, and the interview and focus group data provided insights into these plans. Interview and focus group data added meaning to the words in the plans through the use of the CDA tools described above.

**Thematic Analysis**

With the hope of comparing the three cases and identifying connections and contradictions, I turned to thematic analysis as a way to unpack interview and focus group data. According to Braun and Clarke (2006), thematic analysis overlaps with discourse analysis, focuses on latent themes, and allows the researcher to “theorize the sociocultural contexts, and structural conditions, that enable the individual accounts that are provided” (p. 85). According to Lawless and Chen (2019), Braun and Clarke's (2006) approach to thematic analysis is flexible enough for researchers to apply a critical framework to their analysis. Lawless and Chen (2019) used thematic analysis to examine the relationship between interview discourses, social practices, power relations, and ideologies. They argued that critical thematic analysis is more useful for qualitative interview data, whereas critical discourse analysis can be used for document analysis. A thematic analysis of interview and focus group data allowed me to move beyond what was articulated in strategic plans and identify themes around how the third mission of the health units was operationalized. By integrating this analysis with the document analysis, I was able to identify intersections and contradictions in the ways that the third mission was articulated and operationalized.
Braun and Clarke (2006) provided clear guidelines that enabled me to use thematic analysis in a way that was deliberate and rigorous. Following their approach to thematic analysis, I identified, analyzed, and reported patterns within the data and described them in rich detail. The process of coding was iterative and required constantly questioning my own assumptions and interpretations, recognizing that my analysis occurred at the intersection of data, the analytic process, and my own subjectivities (Braun & Clarke, 2019). Each theme captured an important aspect of the data and meaning in relation to the research questions, which did not need to be quantifiable.

As discussed, I adopted a deductive approach rather than an inductive approach, wherein I linked themes to the data themselves. Within a deductive approach, the analysis is driven by the researcher’s theoretical interest in the topic. It focuses on a rich description of some aspect of the data, often coding for specific research questions and themes reflected in the literature. The thematic analysis was conducted on what Braun and Clarke (2006) refer to as a data set, in that I did not analyze all the data but rather a subset of the data that was directly connected to my interest in the institutional third mission. As I worked with participants to unpack this concept, there were inevitably conversations that were not directly related to my research questions, with participants focusing on their role as faculty members or on education and research rather than the role of the institution in society. I focused on data explicitly related to the external role of the institution, beyond education and research. Coming from a critical perspective, I identified themes at what Braun and Clarke (2006) refer to as a latent level, which goes beyond the semantic content of the data. This approach “starts to identify or examine the underlying ideas, assumptions, and conceptualizations - and ideologies - that are theorized as shaping or informing the semantic content of the data” (Braun & Clarke, 2006, p. 84). This involved interpretive work that went beyond description and contributed to the discourse analysis.
Ethical Considerations

There were a number of ethical considerations that I needed to be conscious of throughout this research project. First, I did not have the ability to protect the anonymity of participants. As leaders from the UBC health units, individuals were easily identifiable. However, the goal of this research was to identify and discuss the public face of the health units at UBC in relation to society, which limited the sensitive nature of the discussions. Merriam (1998) recommended that researchers be sensitive to the context, including the physical setting, the people within it, and any overt or covert agendas. According to Stake (2008), this requires paying close attention to the influence of both social and political contexts. With respect to this issue, it was important to be transparent with participants about the aims of the research, potential benefits and risks (although minimal), gain informed consent, and ensure accurate representation of participants’ responses by providing them with an opportunity to review their transcripts and my analyses.

Second, I considered my positionality as an insider. At the time, I was an Assistant Director for UBC Health and was involved with strategic discussions that were taking place across the health units at UBC. This allowed me to gain access to senior leaders at the university but might have also impacted their willingness to participate and disclose certain information, both positively and negatively. Everyone I contacted to participate in this research study accepted my invitation, likely because I was known to them and a colleague. However, what they chose to share will have been influenced by my professional role and their desire to communicate in a way that reflected the relationship of their respective units with UBC Health. I thought carefully about how I recruited participants, what questions I asked, and how I asked them. The data collected was certainly influenced by what participants gave access to and volunteered to share. It was important to recognize that they were operating "in a cultural and discursive context, under particular cultural and discursive conditions that may conform to general or even universal
theories, rules or principles, but they are operationalized and applied under immediate local cultural and discursive conditions” (Kemmis, 2009, p. 152). I recognized that data was influenced by both me as an insider acting as a tool of research and the participants acting as interpreters of information.

Summary

The comparative case study described in this chapter was both intrinsic and instrumental in nature, allowing me to gain an in-depth understanding of the third mission of three specific health units at UBC, while also allowing me to consider the role of the health units in society more broadly. Through a critical discourse analysis of documents, supported by data from the interviews and focus group, I was able to explore the concept of the third mission within the context of UBC’s health units, identify intersections and contradictions, and find opportunities for alternative futures. The document analysis facilitated an understanding of the ways in which the University of British Columbia, Faculty of Medicine, Department of Physical Therapy, Faculty of Applied Science, School of Nursing, and Faculty of Pharmaceutical Sciences articulated a third mission. Interviews provided insights into how leaders from these Faculty, Department, and School thought their third mission was being operationalized. Through a focus group, I was able to delve into the themes that emerged during interviews and explore collective opportunities related to the third mission of the health units. Both interviews and the focus group enabled me to make connections between the third mission and the education and research missions of the health units. Collectively, these methods enabled me to identify intersections and contradictions between how the third mission was articulated and how it was operationalized in practice. Chapter 4 presents findings related to the way that the third mission was articulated across the Faculty of Pharmaceutical Sciences, Department of Physical Therapy, and School of Nursing. Chapter 5 presents findings related to how the third mission was operationalized across the three units, according to interview and focus group participants.
Chapter IV – Findings: Articulation of the Third Mission

This chapter presents the findings from a critical discourse analysis (CDA). In this chapter, I focus on findings related to the way in which the Department of Physical Therapy, School of Nursing, and Faculty of Pharmaceutical Sciences at the University of British Columbia (UBC) articulated a third mission, beyond education and research.

Analyses

To understand how the health units at UBC – specifically nursing, pharmacy, and physical therapy – play a role in society beyond education and research, I started with an analysis of organizational strategic plans. This allowed me to identify how the University, Faculties, Department and School explicitly articulated that role. I draw on insights provided by interview and focus group participants throughout this chapter to illuminate the findings from the document analysis. In the next chapter, I delve more deeply into findings from interviews and the focus group. I link them to the document analysis and move beyond the way in which the third mission was articulated and explore how the units operationalized a role in society beyond education and research.

Document Analysis - Strategic plans are public-facing documents that set missions, visions, goals, outcomes, and metrics by which the organization will hold itself to account and articulate the direction the organization will take over the coming years. They are used to guide activities and resource allocation within the university and individual units. Faculties, Departments, and Schools across the university have their own strategic plans and contribute collectively to the strategic vision of the university. The Department of Physical Therapy and School of Nursing also contribute to the strategic priorities of the Faculties in which they are situated (Medicine and Applied Science, respectively). Therefore, I analyzed the following University and unit strategic plans:

- The UBC Strategic Plan (*Shaping UBC’s Next Century, 2018*)
Faculty of Medicine Strategic Plan (*Building the Future*, 2016)
  - Department of Physical Therapy Strategic Plan (*UBC Department of Physical Therapy Strategic Plan*, 2018)

Faculty of Pharmaceutical Sciences Strategic Plan (*Catalyst for Change*, 2017)

Faculty of Applied Science Strategic Plan (*Transforming Tomorrow*, 2020)
  - School of Nursing Strategic Plan (*En)Vision 2020*, 2016)

These documents capture lofty goals and aspirations for the institution at a single moment in time, setting out the strategic vision for the university and its constituent units for the coming years.

Launched between 2016 and 2020, these plans were developed over the year, give or take, preceding their respective launches. The strategic planning processes were led by the Deans, Directors, and Department Heads who participated in the interviews and focus group. The University, Faculty of Medicine, and Faculty of Pharmaceutical Sciences strategic plans were facilitated by the same consultant who contributed to the UBC Health strategic plan that was launched in 2021. The Department of Physical Therapy and School of Nursing strategic plans were written by their unit heads in collaboration with key faculty members. All these plans were developed with input from both internal and external stakeholders who were identified by the leadership within the respective Faculty, School, and Department.

After getting input over the preceding year or so, each strategic plan sets out a timeframe over which it would work towards the strategic objectives set out in the plan:

- University of British Columbia Plan – 2018 to 2028
- Faculty of Medicine – 2012 to 2021
- Department of Physical Therapy – 2018 to 2023
- Faculty of Applied Science – 2020 (did not specify timeline)
School of Nursing – 2016 to 2020

Faculty of Pharmaceutical Sciences – 2017 to 2022

Interviews and Focus Group - Interviews and a focus group with leaders from the Faculty of Medicine, Department of Physical Therapy, School of Nursing, and Faculty of Pharmaceutical Sciences provided insights into the meaning behind the words used in these strategic plans, the drivers that influenced the plans, and the types of impact sought through their strategic priorities. During each interview, I focused on the first set of my research questions:

1. How do specific health units at UBC – nursing, pharmacy, physical therapy – articulate and operationalize a third mission? What are the dominant and competing discourses?
   
   a. What drivers have influenced the way in which these health units at UBC articulate and operationalize a third mission?
   b. How does the third mission of these health units influence the education and research missions? How is it influenced by the other two missions?

During the focus group, I presented findings from the interviews in order to delve more deeply into the themes that emerged, and focused on my second research question:

2. What are the collective opportunities and possibilities across the health units at UBC related to the third mission?

While focus groups use group dynamics to bring out different perspectives, I found that the perspectives presented by focus group participants echoed those discussed during interviews with participants from the same unit. Themes were consistent across all interview and focus group participants within the same unit, which was not surprising given their similar roles within their respective units as Deans, Associate Deans, Directors, Department Heads, and Associate Heads, all involved in the development and
implementation of their respective strategic plans. Given the extent to which participants within each unit revealed similar themes, I have combined the findings from interview and focus group participants.

Table 7 identifies the participants within each unit in the order that I spoke with them and assigns a code that reflects this, as well as whether they participated in an interview or focus group. I have used these codes to reference quotes throughout this and the next chapter. I have chosen quotes from particular participants that reflect the themes expressed across participants within the same unit.

**Table 7 - Interview and Focus Group Participants**

<table>
<thead>
<tr>
<th>Faculty/Department/School</th>
<th>Participant</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faculty of Medicine</td>
<td>Interviewee</td>
<td>Med1-I</td>
</tr>
<tr>
<td>Department of Physical Therapy</td>
<td>Interviewee</td>
<td>PT1-I</td>
</tr>
<tr>
<td></td>
<td>Interviewee</td>
<td>PT2-I</td>
</tr>
<tr>
<td></td>
<td>Focus Group Participant</td>
<td>PT3-F</td>
</tr>
<tr>
<td>School of Nursing</td>
<td>Interviewee</td>
<td>Nurs1-I</td>
</tr>
<tr>
<td></td>
<td>Interviewee</td>
<td>Nurs2-I</td>
</tr>
<tr>
<td></td>
<td>Focus Group Participant</td>
<td>Nurs3-F</td>
</tr>
<tr>
<td>Faculty of Pharmaceutical Sciences</td>
<td>Interviewee</td>
<td>Pharm1-I</td>
</tr>
<tr>
<td></td>
<td>Interviewee</td>
<td>Pharm2-I</td>
</tr>
<tr>
<td></td>
<td>Focus Group Participant</td>
<td>Pharm3-F</td>
</tr>
<tr>
<td></td>
<td>Focus Group Participant</td>
<td>Pharm4-F</td>
</tr>
</tbody>
</table>
Critical Discourse Analysis - As discussed in Chapter III, my analysis used both Fairclough's (2004) and Gee's (2010) approaches to CDA. I have structured the rest of this chapter around the findings to which each tool contributed.

A. Explicit Articulation of a Third Mission – Drawing on Fairclough, I looked critically at the choice of words used in each strategic plan to describe a third mission.

B. External Relationships – Each strategic plan also articulated specific external relationships involved in their respective third mission activities – either as partners or beneficiaries – which were expanded on during interviews.

C. Third Mission Actions – Gee’s Activities Building Tool helped draw insights by connecting the words in the strategic plans with data from interview and focus group participants into what activities or practices the words used were attempting to build or enact and what activities these communications were seeking to get others to recognize as being accomplished.

D. Drivers of the Third Mission – Gee’s Big C Conversation Tool allowed me to identify the issues, sides, debates, and claims that the reader needed to know to understand the communication and the wider historical and social issues and debates. Both my knowledge as an insider and the insights provided by interview and focus group participants provided an understanding of why certain relationships were highlighted over others and helped me to identify some of the drivers that influenced the way in which the third mission was articulated.

E. Desired Impact of the Third Mission – Gee’s Politics Building Tool, which allowed me to identify what counts as a social good that exploring the findings from the document analysis with interview participants, enabled me to unpack the desired impact of the third mission that was articulated in each strategic plan.
Throughout the CDA process, I applied Gee’s *Making Strange Tool* as a way to consciously think about the knowledge, assumptions, and inferences that influenced the way I was interpreting these communications. This was important for me to do as an insider. By putting myself in the mind frame of an outsider, I asked myself naïve questions about every communication and was able to distance myself from my relationships with participants and their context of practice. I then brought in my contextual knowledge and comments from interview and focus group participants to help shed light on the “ naïve” questions I asked about the data.

**Explicit Articulation of a Third Mission**

The University and unit strategic plans explicitly articulated a number of different missions, which they also described as “core areas,” “pillars,” “activities,” and “commitments.” Education and research were clearly and consistently the primary missions of the institution, with others summarized in Table 8. Each part of the institution articulated a third mission in one way or another that was more externally facing. This was communicated as “Local and Global Engagement” in the UBC strategic plan and described as “engaging ethically through the exchange of knowledge and resources for everyone’s benefit” (*Shaping UBC’s Next Century*, 2018, p. 62). The Faculty of Medicine strategic plan articulated “Partnerships” as the third of its four pillars, describing it as “collective system leadership to help shape practices and policies for improved care of the population across the province” (*Building the Future*, 2016, p. 7). The Faculty of Applied Science “defines and embodies the University for the Future throughout its core mission of research, education and community engagement” (*Transforming Tomorrow*, 2020, p. 13), while the School of Nursing used the term “Community” to describe one of its three commitments (along with “Research” and “Learning”), which they expanded to “community engagement and collaboration with peers and partners to foster and sustain health and a healthy work environment in order to responsively advance people’s wellbeing” (*En*Vision 2020, 2016, p. 20). The Faculty of Pharmaceutical Sciences
strategic plan set ‘Practice’ as one of four priorities, describing this as “optimization of the pharmacist role,” “integrated models of care,” and “strategic practice partnerships” (Catalyst for Change, 2017, p. 28). This reflected their governance structure, wherein they had four portfolios, each led by an Associate Dean – Academic, Research, Practice Innovation, and Graduate Studies. “Practice” is a common term used across the health units to refer to the roles their respective professions play in the provision of healthcare. The Department of Physical Therapy strategic plan did not have a specific section that articulated a third mission; however, they included “Partnerships” several times when they referred to their education and research missions, for example, “through teaching, research and partnerships, the Department of Physical Therapy strives to meet its social contract of reducing health inequities, addressing population health needs and contributing expertise to specialized areas of practice” (UBC Department of Physical Therapy Strategic Plan, 2018, p. 10).

Some parts of the institution also articulated a fourth mission – “People and Places” or “Organization.” The UBC strategic plan described this fourth core area as “the mutually reinforcing groups of people and locations (physical and virtual) that endow UBC with its special qualities and define how our work is accomplished” (Shaping UBC’s Next Century, 2018, p. 38). The Faculty of Pharmaceutical Sciences referred to “strengthened culture, governance and operational infrastructure” under ‘People and Place’ (Catalyst for Change, 2017, p. 28). The Faculty of Medicine’s fourth pillar was “Organization: creation of a working environment that inspires innovation, strengthens academic and operational affiliation, and fosters agility” (Building the Future, 2016 p. 7).
Table 8 - University Missions

<table>
<thead>
<tr>
<th>UBC (core areas)</th>
<th>Faculty of Medicine (pillars)</th>
<th>Department of Physical Therapy (activities)</th>
<th>Faculty of Applied Science (missions)</th>
<th>School of Nursing (commitments)</th>
<th>Faculty of Pharmaceutical Sciences (priorities)</th>
</tr>
</thead>
</table>

External Relationships

As they articulated an external role in society, beyond education and research, each strategic plan described “our” partners and communities with whom the unit would work to operationalize their third mission activities. The use of the possessive “our” might arguably have been an attempt to counter the perception of the university institution as separate from society. However, this possessive might also be read as somewhat paternalistic, understood as both an infringement on autonomy with a beneficent or protective intent (Thompson, 2013). In the UBC strategic plan, this paternalistic discourse was perpetuated by terms such as “affiliated communities,” “beyond the university,” and “the world around us” when referring to external partnerships. At the institutional level, partnerships were described in grandiose and all-encompassing terms, referring to “every level” and “local and global” partnerships.
The Faculty of Medicine strategic plan identified partners at three levels – “government,” “sector partners,” and “communities” – while the Department of Physical Therapy plan was specific in describing “Indigenous and First Nations communities” as well as “rural and underserved communities” as key stakeholders that they aimed to serve. The Faculty of Applied Science referred to “communities” and “people,” suggesting both a commitment to work with and impact society at the collective as well as at the individual level. The School of Nursing strategic plan said its stakeholders were “beyond geographic and social communities” and existed “across the health spectrum.” This plan also used the term “friends of the school,” perhaps attempting to reflect what a participant from the School of Nursing said in her interview about not being an ivory tower:

I think we already are, we're very much not ivory tower. And we're very community engaged and part of that is our community engaged research, and our community practice. (Nurs1-I)

The Faculty of Pharmaceutical Sciences strategic plan offered a list of specific partners, “BC Ministry of Health, health authorities, hospital and community pharmacy, other healthcare providers, patients, communities and industry” (Catalyst for Change, 2017, p. 28). When I asked a participant from the Faculty of Pharmaceutical Sciences how he would conceptualize society and the relationship of the Faculty with it, he said:

It's not a term I'll admit, it's not a term that I use. It's not a term that is kind of in the jargon of pharmacy – that word society as an entity. (Pharm2-I)

Throughout the interview, this participant used the term “system” when describing their partnerships. Combined with “Practice” defined as one of four priorities, this suggested a particular focus on the healthcare system within society. The goals of the “Practice” mission were described as optimization of the pharmacist role, integrated models of care, and strategic practice partnerships through innovation,
translation, and leadership. When describing the “Practice” priority, the Faculty of Pharmaceutical Sciences strategic plan reflected this focus in their goal to “leverage our relationships and experience in practice innovation to accelerate change in areas that are fundamental to optimal patient care and health system sustainability” (Catalyst for Change, 2017, p. 28). Meanwhile, the other units discussed partnerships and a third mission across society generally.

While strategic plans offered vague descriptions of how the University, Faculties, Department, and School conceptualized society and who they perceived their stakeholders and partners to be, I asked interviewees to identify specific partners with whom they worked in relation to their third mission. According to a participant from the School of Nursing, they had important partnerships with organizations that governed the nursing profession:

> We would have partnerships with the professional association, with our regulatory body, you know, all of those things that have to do with the profession. (Nurs1-I)

Another participant from the School of Nursing talked less about external partnerships and more about their faculty members playing leadership roles in society:

> So, when we think of society, we often think of nurses embedded within the variety of locations, including things like government. And in fact, in leadership roles across the various health authorities and governance, you know, are nurses. (Nurs2-I)

Reflecting the spectrum of local to global, this participant also highlighted the international organizations that faculty members in the School partnered with and the way faculty members contributed to organizations such as the World Health Organization (WHO) and the Organization of Economic Co-operation and Development (OECD). She also stressed that industry partnerships, often a key feature of the third mission in non-health units intended to generate revenue for the institution, were not only absent from their third mission activities but frowned upon:
At the moment I can say pretty clearly, I can’t think of any example where it is for like consulting with industry that is a for-profit. Like, we don't have people who are doing that kind of work with Big Pharma or with, like, tech device organizations where there's like money to be made...profit is actually really looked at quite suspiciously within our discipline, in our School, well at least within our School values. (Nurs2-I)

Participants from the Faculty of Medicine and Department of Physical Therapy described relationships at the professional, local, provincial, and national levels. Two participants from the Department spoke about the important relationships they had with their national association, regulatory body, and accrediting body. As one discussed:

We are quite fortunate in BC. Not all physio, entry level physio programs, have the same kind of partnerships with their regulatory body and professional association. So, I think that opportunity to meet regularly with a group from our college, and professional association and the university and discuss a lot of those shared goals and visions and discuss kind of a strategic plan or response. (PT2-I)

These two participants also talked about the importance of relationships with the health authorities and clinicians who worked within the health authorities, as well as in private practice, highlighting an important connection to the education mission of the Department. One participant shared:

We also have strong relationships with our clinical partners in the health authorities. And in some of the private practices too. Not only because we send students there and have them as clinical preceptors, but where they also sit on committees they help with interviews, admission interviews, those kinds of things. And through committees such as curriculum development and those kinds of things, they provide input into and keep us current as to what we need to know and what we need to be thinking about for the future. (PT1-I)
One participant from the Faculty of Pharmaceutical Sciences described a continuum of partnerships in this way:

You have to foster relationships with all the components of society from the individual patient, all the way through to governments that fund programs and everything in between. (Pharm2-I)

This comment and the list of partners articulated explicitly in their strategic plan reflected the focus of their third mission on the healthcare sector and the influence of the pharmacy profession on that mission. Like others, participants from the Faculty specified health authorities and the Ministry of Health as key partners. Unlike the Department of Physical Therapy and the School of Nursing, leaders from the Faculty of Pharmaceutical Sciences also mentioned partnerships with the private sector that provided important funding opportunities related to their research mission:

So, the interactions the society there would touch other areas like funding agencies and certainly would touch partners, philanthropic from a development perspective, foundational work, and then national bodies that would support research. (Pharm2-I)

Many of the partners articulated in the strategic plans and by participants from all three units – the Ministry of Health, health authorities, and regulators – demonstrate their relationship with society as being with the healthcare sector specifically. Participants talked about these partners as important to their education mission to train physical therapists, nurses, and pharmacists. The education mission of the Department of Physical Therapy, the School of Nursing, and the Faculty of Pharmaceutical Sciences is to train health professionals to meet the health service delivery needs of the province. The Ministry of Health determines the health human resource needs of each profession and the Ministry of Advanced Education, Skills and Training provides funding for the associated number of seats in each program. With approximately 40% of these professional education programs occurring in the practice setting, their
relationships with clinical partners, including health authorities and private practice, are important for sustaining the delivery of their programs. These professional education programs are accredited and have to ensure they prepare graduates for the professional licensing exams run by their respective regulatory bodies, leading to the important relationships between a Faculty, Department, or School with their accrediting bodies, professional associations, and regulatory organizations.

**Third Mission Actions**

In order to draw insights into what activities or practices the strategic plans aim to build or enact and what activities these communications seek to get others to recognize as being accomplished (Gee, 2010), I considered the impact of word choice, specifically the verbs used in the strategic plans when describing the units’ relationship with society. On a University level, the verbs used in the strategic plan articulated a relationship with society that embodied multiple discourses and power dynamics. For example, the plan used the verbs “engage,” “co-create,” and “work with” communities when discussing the “Local and Community Engagement” mission, reflecting an egalitarian discourse where contributions are not valued according to the status or position of power of those who make them (Flecha, 2000). This sometimes embodied a responsive element whereby the university committed to adapting to the evolving needs of society. The verbs “assist,” “mobilize,” and “empower” might be viewed as embodying a more paternalistic discourse, with the university suggesting it has the power to give others what they need in order to act. Statements such as “solving problems of local and global importance” also reflected this discourse, with the university presented as being in a unique position to provide knowledge and answers.

When discussing their partnerships, the Department of Physical Therapy strategic plan embodied an ethos of service, as reflected in their values statement, within their commitments to develop partnerships to “meet its social contract – reducing health inequities, addressing population health needs and
contributing expertise to specialized areas of practice” (UBC Department of Physical Therapy Strategic Plan, 2018, p. 10).

While they identified “Community Engagement” as their third mission, the Faculty of Applied Science strategic plan also reflected a paternalistic discourse whereby they saw themselves as being in a unique position in society to provide solutions. This plan used statements such as “drive innovative organizational change, social innovation and new venture,” “radically transform,” “address local and global complex challenges across society, health and the environment,” “create highly impactful solutions,” and “support communities and solve problems.” The School of Nursing strategic plan, while using verbs such as “be responsive,” “be of service,” and “participate,” frequently referred to their ability to “lead.” Their strategic plan “imagines a way forward to create opportunities in research and education for the development of leaders who will cultivate systemic change in nursing and health, locally, nationally, and globally” ((En)Vision 2020, 2016, p. 1). The plan articulates a role for the School to “engage,” “lead,” and “improve.”

The Faculty of Pharmaceutical Sciences strategic plan, when discussing their “Practice” priority area, used both egalitarian language such as “work with,” as well as paternalistic terms such as “accelerate change,” positioning themselves as the ones with the ability to affect change, rather than the agency lying with their practice partners. Verbs such as “lead,” “sustain,” and “strengthen” conveyed a relationship with society wherein the Faculty was uniquely positioned with the expertise to support changes to the pharmacist role, models of care, and improved patient outcomes.

The words used across the strategic plans reflected an institution that was both part of and separate from society. They perpetuated the image of the university as separate from society, while seemingly wanting
to break down perceived hierarchies. They suggested power dynamics and imbalances between the institution and society, while also ostensibly seeking to foster partnerships with society. They embodied both paternalistic and egalitarian discourses that, together, positioned their units within the institution as uniquely able to contribute to societal improvement, whether through leadership or partnership. They contributed to the image of a powerful institution with the sole ability to shape, change, and transform society. Yet, at the same time, they reflected a commitment to be responsive to the society that they had a mandate to serve.

**Drivers of the Third Mission**

Thinking about the issues, sides, debates, and claims related to the wider historical and social issues that the reader needed to know to understand the communications in each strategic plan (Gee, 2010) helped me to identify some of the drivers that influenced the ways that the third mission was articulated. The Faculty of Medicine “Partnerships” pillar was described as a mechanism for achieving excellence, addressing health inequities, meeting provincial needs, generating revenue, being socially accountable, contributing to the economy, and meeting government and health sector priorities. Their strategic plan included a commitment to addressing health challenges across the province:

Geography, ancestry and economics create a complex tapestry of health challenges in British Columbia and in Canada, and it is imperative that we work with our system partners to influence practices and outcomes in specific populations, as well as across the province as a whole. *(Building the Future, 2016)*

Referring to a social contract, the Department of Physical Therapy strategic plan identified the goal of reducing health inequities as a driver for their third mission:
Through teaching, research and partnerships, the Department of Physical Therapy strives to meet its social contract of reducing health inequities, addressing population health needs and contributing expertise to specialized areas of practice. (UBC Department of Physical Therapy Strategic Plan, 2018, p. 10)

As the only educators of physical therapists in the province, the Department of Physical Therapy described a social contract with British Columbia specifically, as articulated by a participant from the Department of Physical Therapy:

I would see that we have a contract with society directly to meet the physical therapy needs of British Columbians or to train people to do that. (PT1-I)

Their strategic plan specifically identified a commitment “to improve physical therapy capacity in underserved areas, including Indigenous communities, and in specialty areas of practice” (UBC Department of Physical Therapy Strategic Plan, 2018, p. 6).

Conversely, the School of Nursing strategic plan positioned the School within a more global context:

Because of the School’s world-leading service innovations in collaboration with many diverse communities external to UBC, ranging from children and youth to seniors’ care, the School of Nursing is uniquely qualified to act as a global leader and valued partner to improve health and health care sustainability and to be of service to others. (En)Vision 2020, 2016, p. 19)

A participant from the School of Nursing discussed their position as one of 17 schools of nursing in the province by differentiating them from the others in the province as a leader. This perception likely stems from the fact that they are located within a research-intensive university:

I think we are, we very much see ourselves as a leader among the schools, but we are also a collaborator with the schools. And we recognize that some other schools have other expertise that
we don’t have, and they play to their strengths and we play to ours, and together we get it done.

(Nurs1-I)

In her opening message to the strategic plan, the Director of the School of Nursing at the time articulated a broad commitment to society and the influential role she felt they were well situated to play:

We are perfectly placed to address these challenges and continually influence the health of our local, national, and global community...This is the UBC School of Nursing. This is nursing to engage, lead, and improve. What they share is the intention to be of service, and a commitment to just and equitable health outcomes for all people. ([En]Vision 2020, 2016, p. 1)

The Faculty of Applied Science strategic plan described the need to respond to society’s most complex challenges, specifying climate change and Truth and Reconciliation as drivers for their “Community Engagement” mission. The School of Nursing strategic plan identified the need to address health problems and health inequities as the drivers of their “Community Engagement and Partnerships” commitment. One participant from the School of Nursing spoke about efforts within the School to counter inequities for Indigenous communities:

One of our faculty was involved as one of the investigators for the In Plain Sight report on anti-Indigenous racism and healthcare settings, and has then contributed with us in sort of identifying within our school, so what are the actions we as a school take to address racism and anti-Indigenous racism in healthcare? (Nurs1-I)

The Faculty of Pharmaceutical Sciences strategic plan specified that its priorities were “driven by a combination of evolving demographics, societal expectations, technological advances and funding pressures” (Catalyst for Change, 2017, p. 12). Like others, the Faculty of Pharmaceutical strategic plan specified a commitment to Indigenous communities specifically, through an integrated approach to underserved communities:
Work with sector and University partners to identify and implement ways to strengthen healthcare delivery for underserved populations, building from our early experience such as those with Indigenous Communities. (*Catalyst for Change*, 2017, p. 32)

A participant from the Faculty of Pharmaceutical Sciences, spoke about their relationship with society and their education mission:

> You go right back to you know, what is, where did the faculty come from? And you know, it serves the population of British Columbia by training people to be pharmacists, first and foremost. And obviously that is an important societal role. And, you know, a lot of our funding obviously comes from that role of training people to be pharmacists. And you know, that has been one of the, you know, central missions of the faculty obviously since its inception 75 years ago. (Pharm1-I)

At the core of the third mission of these three health units, based on how it was articulated in their strategic plans, was the perception that they had a contract with society to meet the health needs of the population of BC, respond to problems of societal importance, and address systemic inequities. Each plan articulated a commitment to respond to the *Truth and Reconciliation Commission of Canada: Calls to Action* (2015), aimed at redressing the legacy of residential schools and advancing the process of reconciliation between settlers and Indigenous communities in Canada.

Against the backdrop of this broader societal context, each strategic plan highlighted the impact the Faculties, Department, and School hoped to have in relation to their externally focused activities. Simply put, while articulating objectives not simple to achieve, the Department of Physical Therapy strategic plan stated that they were working towards “meeting the needs of all communities.” The School of Nursing strategic plan set out equally lofty goals around its desired impact on society, including “systemic change” and “transformation.” The Faculty of Pharmaceutical Sciences was no less ambitious, striving to have an impact on “the financial sustainability of the health system,” “improved patient experience and patient
outcomes,” and “technological advancement,” as well as the broad notion of “systemic change.” These broad, lofty aspirations might leave one asking: what kinds of change? What constitutes transformation? Who decides? How is this accomplished?

As discussed, the strategic plans analyzed as part of this CDA capture the missions, visions, and goals of the institution at a single moment in time. Strategic plans are regularly reviewed to ensure they continue to align with and reflect the evolving context of both the institution and the society in which it is situated and ostensibly serves. During the course of this research, interviewees informed me that the Faculty of Medicine and Department of Physical Therapy were undergoing a “refresh” of their strategic plans. The School of Nursing was preparing to launch a new strategic plan. These new and refreshed plans were being developed within the social context of the COVID-19 pandemic, heightened calls for Indigenization and decolonization of the institution, and the increasing prominence of Black Lives Matter, a political and social movement that emphasizes basic human rights and racial equality. In 2020 and 2021, discourses related to justice, equity, diversity, and inclusion were increasing within the university and Canadian society more broadly.

A participant in the Department of Physical Therapy highlighted the changes that were expected within the refresh of their strategic plan, reflecting this social context:

It won't change dramatically, I don't think because I wanted to do a refresh just to make sure that we were still on track with our strategic plan. And actually, so we sent out a short survey to people and really most of it's pretty much going to stay as is. But there's just going to be an increased focus on social justice and equity, you know, the usual things that are being embedded in all the strategic plans. (PT1-I)
One participant from the School of Nursing spoke about the contextual factors that were going to be reflected in their 2021-2026 strategic plan:

So, it’s like, all of these different things are going to have a distinct, you know, imprint on our strategic commitments, along with the other priorities around continuing to respond to Truth and Reconciliation, murdered and missing Indigenous women, girls and two-spirit people, the In Plain Sight report, and anti-racist action. (Nurs2-I)

Summary

The third mission discussed in this chapter is reflective of a provincial context within which there are inequities that the units feel it is their mission to address. Their strategic plans explicitly articulated a third mission, which they also described as “core areas,” “pillars,” “activities,” and “commitments” – Local and Global Engagement (UBC); Partnerships (FOM and PT); Community Engagement (APSI & Nursing); Practice (Pharmacy). These missions were described broadly and were connected to a goal of extensive societal impact. When discussing their third mission, the health units identified specific external relationships that were connected to their education mission and the health professions they have a mandate to train. Their articulation of a third mission embodied competing discourses that reflect the idea of the university as an institution separate from society, and also as an integral part of society. While somewhat paternalistic, they also reflect a responsive relationship with society. They embody a common discourse whereby universities are portrayed as being in a unique position to have the power, knowledge, expertise, and position to change society. However, they also embody a health professional discourse reflective of social accountability, whereby they aim to be of service to society and responsive to society’s needs. The lofty, high-level goals articulated in strategic plans are one of the limitations of strategic plans. Questions about the desired impact and role of the health units at UBC in contributing to societal change drove the interviews and focus group with participants from the Faculty of Medicine, Department of
Physical Therapy, School of Nursing, and Faculty of Pharmaceutical Sciences. The findings based on the qualitative data are presented in the next chapter.
Chapter V – Findings: Operationalization of the Third Mission

This chapter moves beyond findings related to the way that the Department of Physical Therapy, School of Nursing, and Faculty of Pharmaceutical Sciences at the University of British Columbia articulated a third mission within their strategic plans. It takes the next step and shares findings related to the ways in which the third mission was being operationalized across the units, according to interview and focus group participants. By delving into the interview and focus group data through a thematic analysis, I gained insight into the notion of a social contract which emerged as a key theme, and which was identified as a driver of the third mission of these three health units according to the document analysis presented in Chapter IV. This thematic analysis also revealed a dominant theme of advocacy as a third mission activity across all three units and identified some of the enablers associated with the university that leaders felt allowed them to play an advocacy role.

This chapter focuses on findings from interviews with one leader from the Faculty of Medicine, two leaders from the Department of Physical Therapy, two leaders from the School of Nursing, and two leaders from the Faculty of Pharmaceutical Sciences. The goal of the interviews was to unpack the relationship between these three units and society. I asked interviewees about:

- How they would conceptualize society and the relationship of their unit with society
- The impact or contribution their unit was striving to make in society
- The partnerships involved in the external role of their unit
- What they considered to be the most important part of the relationship between their unit and society and what was driving that
- The barriers to aligning their connection to society in their unit
- How to enable closer links to society in their unit
- What they thought the role of their unit should be in society
I weave in findings from the interdisciplinary focus group with four different leaders from each of the units that formed this comparative case study (1=nursing; 1=physical therapy; 2= pharmacy), during which I explored some of the themes that emerged during interviews. During the focus group, I asked about collective opportunities across the units related to the third mission. After conducting a thematic analysis of the interview data, through which the primary themes of a social contract and advocacy emerged, I presented focus group participants with these findings and asked them to discuss:

- How they would describe the social contract of the health units
- The ways their unit played an advocacy role in advancing their unit
- The ways their unit played an advocacy role in changing or advancing new models of care
- The need for advocacy to remain within the focus of individual units versus collective opportunities across the health units
- Barriers and enablers to collective opportunities

Interviews and a focus group allowed me to both make sense of, and move beyond, what was articulated in their strategic plans and identify the strategic activities that leaders thought operationalized the role of the unit in society, beyond education and research. In this chapter, I have grouped the findings by theme, discussing each unit in turn, while also making comparisons across the three cases. As I did in Chapter IV, I have combined interview and focus group findings and have selected quotes from specific participants to reflect the themes that were common across participants within the same unit. I have used the same codes when quoting participants as used in Chapter IV.

**Thematic Analysis**

I conducted a thematic analysis on a subset of the data that was directly connected to my interest in the institutional third mission. The thematic analysis considered data explicitly related to the external role of
the institution, beyond education and research. I adopted a deductive approach, coding first based on the key concepts reflected in my research questions – the third mission; drivers; the influence of the other two missions; and collective opportunities and possibilities. I then examined each theme for differences and intersections across units and considered the underlying ideas, assumptions, and conceptualizations that were reflected in each theme. This involved interpretive work that went beyond description and resulted in a reconnecting and consolidation of themes. The remainder of this chapter is structured around the following key themes and sub-themes that emerged through this thematic analysis:

I. A Social Contract

II. The Advocacy Role of the Health Units

III. Institutional Enablers of the Advocacy Role

- Leadership
- Professional Expertise
- Institutional Support

IV. Collective Opportunities

A Social Contract

Interview participants from each unit discussed the relationship of their respective unit with society as being driven by what some referred to explicitly as “a social contract,” originating from the university as a publicly funded institution and the responsibilities of the health professions they have a mandate to train.

School of Nursing - Participants from the School of Nursing discussed their social responsibility as a commitment to “health for all,” which was also referred to explicitly in their strategic plan. For example, one participant said:
I presume it probably is for other disciplines or health professions that also have, you know, a mandate for improving health for all. But for us, that's very much a key component that is reflective of our perspective on health equity and social justice. (Nurs1-I)

Several participants from the School of Nursing talked about how their relationship with society originated with the nursing profession and its commitment to access, justice, and equity. One participant discussed the role of nursing in meeting society’s needs throughout history:

That's sort of a universal, internationally, that nursing’s history and tradition has been about sort of seeing what the need is and flexing and adapting toward meeting that need. (Nurs1-I)

Another participant from the School similarly grounded this contract in the history of the nursing profession:

I think that's a fairly solid tradition, you know. Look back to Florence Nightingale and the fierce work she did to create the poor lot. To recognize that people were not well served. And that you know that comes from the kind of thing that we would now articulate as pretty core to nursing. (Nurs2-I)

Participants from the School of Nursing spoke extensively about how nursing, as a trusted profession with a mandate to ensure health for all, influenced their relationship with society. Talking specifically about the relationship of the School with society, one participant linked the social contract of the School to the mandate of nursing in society and the way they were ostensibly perceived by society as trustworthy and as having integrity:

I would say that the most important part of that relationship is that we have a mandate as nurses to promote the health of all. And we are considered one of the most trusted professions. And that brings with it an obligation to be trustworthy, but also to use that reputation and that integrity to
provide both an opportunity to help improve health and well-being by improving the variety of access and resources and sort of speaking that evidence-based truth to power. But also, helping the broader community understand the consequences of the decisions they make as it relates to health and well-being and health equity. (Nurs2-I)

This participant also provided some insight into how being in service to society was achieved through consultation and advice by offering their disciplinary expertise; in doing so, they were committed to improving health equity and social justice, which were clearly the paramount objectives of the School of Nursing and its role in society:

It's really about that service to society that involves creating things open access or actually attending to and providing consultation, advice, and practice to improve health equity and social justice...I would say for our school, probably one of the key fundamental values is health for all and with a very specific and explicit attention to health equity and social justice. (Nurs2-I)

Participants from the School of Nursing presented a broad conceptualization of the society that they have a mandate to serve, reflecting the global focus that was embedded within their strategic plan. All participants connected the relationship between the School and society with the role of nurses in society. They described the nursing profession as one with a long-standing, historical commitment and mandate to ensure “health for all.” They also described the commitment of both the nursing profession and the School to improving access, equity, and justice. They suggested that their social contract was to the most vulnerable members of society, giving examples of work they did to support children and youth, women who had suffered abuse, transgender people, Indigenous peoples, and homeless populations. A social justice discourse was dominant across nursing. They also embodied a discourse of excellence and one
that suggested that the School was in the unique position to contribute to equity and justice, articulating lofty goals such as “health for all”.

**Department of Physical Therapy** - Participants from the Department of Physical Therapy talked about their contract with society, stemming from the way they were funded. For example, one interviewee said:

> And I guess, you know, big picture, I would see that the university has a contract with society because we are funded by society basically through taxes obviously and so on. So, I think that gives us a mandate to serve society’s needs. So that’s the sort of big picture thing. (PT1-I)

A participant from the Department of Physical Therapy, speaking during the focus group, further linked this social contact to the education mission of the Department:

> I might add from the educator perspective, I feel like we’re also accountable socially to select learners or future health professionals and I think that’s a big part of our role to be socially accountable in how we select and who we select and who ultimately graduates and become health practitioners in the communities in which we serve. So, I see that as being a really big social accountability role as well. (PT3-F)

When discussing the relationship between their social contract and their education mission, all participants from the Department of Physical Therapy stressed the importance of access and distribution of services across the province, meeting the needs of rural and remote communities. For example, one participant from the Department talked about their distributed program where students are trained in rural communities, with the goal that they are more likely to work in those communities when they graduate:

> We are also the only physio program in BC, and are expanding and distributing too, with the primary goal to physiotherapists, you know, there’s huge vacancies, as I’m sure there are many
health professionals. So, one of our goals is to educate future physios in communities that they will actually serve. So that I think is a huge kind of societal piece. (PT1-I)

Participants from the Department of Physical Therapy also raised issues of access, equity and justice and their contract with society, specifying a commitment to serve marginalized populations. For example, one participant spoke about the importance of Indigenous health in relation to their contract with society:

So, you know a big priority right now is around Indigenous health, racism, and healthcare, identifying and serving marginalized populations. (PT2-I)

While participants from the School of Nursing spoke about society and their contract with it in broad global terms, participants in the Department of Physical Therapy spoke about a provincial mandate. They discussed a commitment to meeting physical therapy needs across the province, which was intimately connected to their education mission. They also reflected the values of access, equity, and social justice discussed by participants from the School of Nursing, however, with a specific focus on improving access to physical therapy services for rural and Indigenous populations. As the sole educator of physical therapists in the province of BC, meeting societal needs for physical therapy services was at the core of how participants from the Department discussed their social contract. This type of social accountability discourse was dominant across the discussions with participants from physical therapy. Within this discourse was the message that ensuring access to the expertise of physical therapists and their services had the ability to improve the health and wellbeing of society, another lofty goal.

Faculty of Pharmaceutical Sciences - One Leader from the Faculty of Pharmaceutical Sciences discussed the idea that they have an obligation to impact society in some way by virtue of the fact that they are part of a publicly-funded institution:
I mean, what's the impact that we strive to have? You know, I think we would like to think that, you know, across all aspects of what we do, that we do have some impact on the broader, you know, beyond the walls of the university. So, and you know, I think that's really important because, as a publicly funded university we are duty bound to, you know, to contribute to society in whatever ways we can. (Pharm1-I)

All participants from the Faculty of Pharmaceutical Sciences focused on healthcare systems as the part of society that they have a commitment to impact, as reflected in this comment by one participant:

From a professional perspective, I view this, I guess, I would interpret society as being, you know, we're all consumers of the healthcare system and the society, as I think you're using it, would be the areas in which our patients would interact with professionals such as pharmacists to get healthcare. And that society could span everything from primary care through acute tertiary care services, and everything in between. (Pharm2-I)

This participant alluded to the relationship of the Faculty with society being connected to the pharmacy profession. Another participant linked this to being in service to patients:

I see healthcare as a serving, healthcare is a service industry, if you will. And we are in service to patients and society. Again, society in particular in Canada, socialized healthcare system. (Pharm3-F)

Participants from the Faculty of Pharmaceutical Sciences also highlighted the importance of access and distribution across the province around their social contract, addressed primarily through their educational mission:

You know, underserved communities that you mentioned, that's another big part of our strategic plan implementation. And you know we have a task force, which is, you know, tries to have a sort of more coordinated approach there. (Pharm1-I)
Like participants from the Department of Physical Therapy, participants from the Faculty of Pharmaceutical Sciences discussed a relationship with society that stemmed from the fact that they are part of a publicly-funded institution. However, they identified a mandate to specifically impact healthcare and patient outcomes, which they linked to the relationship between the pharmacy profession and society. As the only educator of pharmacists in the province, they described a provincial mandate that echoed that of the Department of Physical Therapy. Through their education mission, they committed to meeting the needs of underserved communities. Pharmacy reflected a service discourse and one of transformation, specific to the context of the healthcare sector. They too embodied a discourse that suggested pharmacists and the Faculty had the power to transform the health system and improve health outcomes.

**The Advocacy Role of the Health Units**

Each interviewee explicitly referred to an “advocacy” role for their unit, which was both a surprising and dominant theme throughout the discussions and how they viewed their role beyond education and research being operationalized, as advocacy is not a university role articulated in the literature. The literature that discusses the third mission explicitly, nor the literature focusing on higher education in Canada, nor literature related to the health units within a university discuss advocacy activities explicitly.

Participants from the School of Nursing discussed a policy advocacy role, with the following two interviewees using this term explicitly:

> And nursing also has that sense that it has a special role as something that looks out for where the system's not doing what it means to be doing, speaks up as the advocate, and kind of recognizes problems and gaps. (Nurs1-I)
And nursing’s role in, not just providing care and practice, but also advocacy and policy as part of our scope. But also, in our conversations around setting policy and adopting policy. So, I think, you know, there's a, there's a key advocacy and education, like, I think, societal education. Not individuals who pay tuition but the education of society, about both the health issues and the research that can guide the evidence base. Actually, guide policies well beyond the health sector.

(Nurs2-I)

Participants from the Department of Physical Therapy discussed an advocacy role related to the profession, with both interviewees articulating this explicitly:

So, one of our strongest advocacy works really is advocating with government for an increase in the number of seats. I mean, basically we could double the number of seats and still have everybody walk out into a job. (PT1-I)

And so, I really do think there’s this whole kind of discussion and kind of wrestling with - we need to be advocates for our profession. And we need to be, as a university, we need to be pushing that forward. We need to be a strong voice and advocates for the scope and value of our profession, and our knowledge and what we have to offer, and really carving out those opportunities. (P2-I)

Participants from the Faculty of Pharmaceutical Sciences talked about an advocacy role related to both the profession itself and models of care, with one interviewee using the term advocacy explicitly and the other alluding to an advocacy role:

You know, I think there are some things you know, advocating for the profession, I think is really important. It’s another thing is part of our, you know, strategic plan and how do we influence, how

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3 Number of applicants a program can accept based on government funding.
do we influence the decision-makers to move the needle on the scope of practice for example.

(Pharm1-I)

So, the whole catalyst for me was to push an agenda to try and change that for pharmacists. This was pre-patient medical home, pre-primary care network, pre-everything. We presented the concept to the Ministry. The Ministry loved the concept and asked us to develop business case, we did. (Pharm2-I)

An advocacy role for the units was not revealed during the document analysis of their respective strategic plans. Therefore, during the focus group, I introduced the theme of advocacy in order to unpack it further. The following sections present the way that both interviewees and focus group participants discussed this advocacy role.

**School of Nursing** - One interview participant from the School of Nursing discussed the amount of advocacy work going on across the School “around setting policy and adopting policy”:

> It could literally, our consulting and advising organizations and governments and non-profits and extra-governmental, you know like the UN agency type folks, we, each of us, could actually fill up our entire lives with that and never have time to teach or do research. (Nurs2-I)

She discussed the idea that this policy work extended beyond the health sector:

> I think really trying to articulate the places where nursing in particular can make a difference. But also, in our conversations around setting policy and adopting policy, actually guide policies well beyond the health sector. (Nurs2-I)

She also spoke about the fact that faculty members were supported by the School to take on these types of roles and that faculty members represented the School and the nursing profession as they did so:
As a school, there is a lot of support and value for individual faculty and groups of faculty to be taking up that work in various settings around the province, around the world. And that is, and in a way sort of, representing nursing and representing our School in that process. (Nurs2-I)

Another participant from the School gave examples of faculty members involved in influencing policies, providing testimony in court cases, sitting on human rights tribunals, and influencing legislation related to medical assistance in dying. She linked the ability of faculty members to make these contributions to a combination of their professional experiences and research knowledge, for example:

Registered Nurses are very actively involved with most, if not all, people who are in the process of making decisions about end of life. They are not providers of assisted dying, they're not the assessors and providers, by legislation that's NPs [Nurse Practitioners] and medical doctors. But Registered Nurses are usually spending far more time in creating the conditions under which that happens. So, we've been studying from their perspective. And that information that we created went into the submission by the Canadian Nurses Association, our national professional association. It was almost completely based on our research with regard to the most recent changes in the Criminal Code. (Nurs1-I)

The focus group participant from the School of Nursing, who was asked specifically to speak the advocacy role of the School, discussed the role of the School in advocating for the integration of nurses existing and emerging models of care:

When I looked at the advocacy for the role, advocating for scope, full scope of practice. So, I'm just sort of repeating what you all have said already. Putting NPs [Nurse Practitioners] in primary care centers. (Nurs3-I)
During interviews and the focus group, all participants from the School of Nursing spoke extensively about the role of faculty members in advocating for the nursing role across the continuum of care, including primary care and emergency. For example, one participant talked about:

Different approaches to reducing racism and improving intercultural safety in emergency rooms originally and then in primary healthcare settings. And interestingly, you know, this work has then been disseminated and it’s been studied and all of that. So, it’s sort of your typical research piece of it, but it’s also been turned into or has been taken up by government during the pandemic. (Nurs2-I)

Another participant discussed the fact that while a School Director would not necessarily advocate directly with the government, deferring normally to the Dean of their Faculty, the School of Nursing was unique as the only health unit in a non-health faculty. As such, the Director “acted more like a dean” (Nurs1-I). This points to the different administrative structures of the university within which each unit is positioned and how this impacts their external relationships.

Participants from the School of Nursing explicitly identified an advocacy role that extended from the health sector to policy. They talked about the dominance of this advocacy work within the School and provided a large number of examples, with just a few provided here, that highlight the ways that their faculty members advocate for the nursing profession. They also referred to the desired contribution in both influencing decision-makers and enhancing health care delivery. The advocacy work they described was very much about integrating nursing perspectives into policy decisions. They attributed the ability of their faculty members to effectively play this role, on behalf of the School, to the combination of their professional expertise and the research they conducted through the university.
Department of Physical Therapy - One participant from the Department of Physical Therapy initially talked about their perceived limitations of the Department to advocate at a policy level. She talked about the fact that this happened at the Faculty level, with the Dean of Medicine interfacing with the government on behalf of the Department of Physical Therapy. The one exception discussed was around funding for extra student seats, related to the ability of the Department to meet the demand for physical therapists in the province; they perceived this to be part of their social contract. Here, the Physical Therapy Department Head advocated with government alongside the Dean. One participant described this as a provincial mandate:

There's a huge shortage of physical therapists within the province. So really, we're starting from ground zero in a lot of ways. Like, we need to provide health care, health care providers, you know, we don't have enough physical therapists in the province and we haven't for decades. So, one of our strongest advocacy works really is advocating with government for an increase in the number of seats. (PT1-I)

Both interview participants from the Department of Physical Therapy spoke about an advocacy role related to meeting the demand for physical therapists in the province, extending their scope of practice, and the potential to contribute to new areas of practice. Another participant talked about the importance of partnerships with professional bodies and their shared vision for advancing the profession:

I think there's a common shared vision of advancing care, advancing our profession, and supporting student education and research that contributes to our profession. That's my perspective, there is this shared common goals and vision, and the partnerships are mutually beneficial and really reciprocal in that we rely on our clinical community to run our program. (PT2-I)

She went on to speak about the success of the Department and these advocacy efforts, which resulted in an increase in the number of seats and the distribution of their program to other parts of the province.
Interviewees from the Department of Physical Therapy suggested that their efforts to meet the demand for physical therapists in the province impacted their ability to consider and advocate for the integration of physical therapists into new and evolving models of care. This was talked about as a barrier to the potential role of the Department in society:

So, we're not fulfilling the needs that are advertised out there. But, and because of that, we're also not really looking at what other things physical therapy could offer to clients that aren't being served right now because, you know, a hospital may have 10 but you know 10, 20, 30 vacancies for PTs [Physical Therapists]. And that's only the positions that they already have. We're not really looking to innovation of other roles that PTs could have, different populations that we could serve, all those cutting-edge things that we'd like to do. (PT1-I)

Another participant felt that if the Department was meeting this demand, they could do more around the ways they advocated for the profession:

You know, it's when I think of systems, that's to me where it's like, there's so much more we could be doing. And physio has a really critical role in all of that. And so, it's been identified in the Department that yeah, we have a role we need to advocate for this within our profession and broadly. And it seems to happen at individual levels but it doesn't seem to happen at a higher, broader, coordinated level. (PT2-I)

One participant identified ways that the Department could advocate for the role of physical therapists in contributing to areas of widespread social impact like chronic pain, mental health, and addictions, where physical therapists currently do not often work; taking on these areas can carve out a greater role for physical therapists in the province:
Could we do this, should we or should we have more of a role in, for example, mental health and addictions? You know there's hardly any PTs [Physical Therapists] if any working in those areas. What should we be doing with those who are maybe learning disabled or intellectually challenged, is there something that physical therapy can do there? So I would like to see a lot of these areas being explored both in, by our researchers, which is already happening to some degree, but also by the practice side of our, the education side of our program so that you know, so that when students go out there, they can say, ‘Hey I'm, you know, we can provide enhanced service for these communities, we can actually contribute to the overall health and well-being of British Columbia.’

(PT1-I)

Interview participants in the Department expressed a desire to have greater bandwidth for an advocacy role. One participant talked about the way in which the student-led Physical Therapy and Research Clinic (PTRC) on campus contributed to the education mission of the Department, as well as one that extended beyond education and research. The clinic met the needs of underserved populations, while also offering insights into innovations in care that might link to the way that they would like to advocate for the profession within existing and emerging models of care:

We had a meeting yesterday about our student-led clinic where it's proven to really blossom into this clinic where we are serving the underserved. Like, people are finding us with these really complex health care needs and identifying from that this need to really emphasize skills and competencies around trauma-informed practice, and what other partnerships can we establish on campus, you know, to ensure that our students have the supports they need to offer safe, effective care for the community that they're serving through the PTRC, while also facilitating their learning and ensuring they're developing the competencies to be really that next generation of clinicians that will effectively serve the community and those patient populations. (PT2-I)
Unlike participants from the School of Nursing, participants from the Department of Physical Therapy did not feel like they were able to play an ideal advocacy role with respect to influencing government and other decision-makers. They presented a context within which their advocacy role had to focus on increasing the number of physical therapy seats funded within their program in order to meet the service needs of the province. They discussed the ways that their advocacy efforts had been successful in meeting this goal, while also expressing frustrations about the capacity that still needed to be gained. Despite the need to continue to focus on advocating for the capacity within the program to meet the physical therapy needs of British Columbia, participants did express a desire to advocate for new roles for physical therapists within new and emerging areas of practice. They identified their Physical Therapy and Research Clinic as one initiative that was providing the evidence for them to do so.

**Faculty of Pharmaceutical Sciences** - Participants from the Faculty of Pharmaceutical Sciences outlined a unique situation with respect to their advocacy role, which they directly connected to their campus-based UBC Pharmacists Clinic, an initiative within their “Practice Innovation” portfolio. The clinic is “Canada’s first university-affiliated, licensed, pharmacist-led patient care clinic” (Gobis et al., 2016, p. 9). The care model in the clinic extends beyond what is regulated for the pharmacist profession in the province and aims to demonstrate what pharmacy practice could be. Patients are referred to the clinic by a physician and then receive comprehensive medication management from pharmacists practicing to the full extent of their scope.

Both interview and focus group participants described the clinic as an initiative that was not just about providing education to their students, although it did; for them, the clinic was about designing and testing innovative models of care for pharmacists and new roles for the profession within primary care. They
talked about how the Ministry of Health was exploring and funding models of team-based primary care; however, they were focused on the roles of family physicians and nurse practitioners in supporting these approaches to service delivery and were not, according to participants from the Faculty of Pharmaceutical Sciences, thinking about pharmacists within these emerging models of care.

According to participants, the evidence generated by the UBC Pharmacists Clinic enabled the Faculty to advocate with the government for the role of pharmacists in primary care:

If we hadn’t been doing this innovative work at our Clinic and had some relationships with certain people in government, team-based primary care would have rolled out with no pharmacists. And we didn’t know that was going to happen. So, we had to be courageous and be out there modelling. (Pharm3-F)

Another participant believed they were ahead of the system and were able to contribute to what it would look like to have pharmacists working in primary care – i.e., working directly in a family physician’s office.

The interest was there, but we were ahead of the system. And so, the system was then starting to evolve with this now, with what we see now, which is a team-based primary care environment, whereas this pharmacy proposal was already cooked as to how it could work. (Pharm2-I)

One participant articulated the mandate of the Clinic and how it extended beyond the education mandate of the Faculty to include providing patient care, exploring advances in pharmacy practice, and contributing to changes in practice:

So, the practice innovation portfolio is all about stimulating practice change. So, our mandate at the Clinic is fourfold. Number one is to provide best-practice care to patients to demonstrate what a pharmacist working at full scope can contribute. And with that message out there, then it facilitates conversations around practice change. Number two, we contribute to the academic
program to help students and learners become more practice-ready when they graduate with practical skills, cases, and things like that. Number three, we're a living lab, we build systems and processes to support pharmacists in practicing in more advanced ways. And the fourth mandate is quite frankly to be disruptive, to make people sufficiently uncomfortable that they'll start to let go of some of the old ways that aren't serving them very well and move towards new ways that can serve them and society better. (Pharm3-F)

Another participant highlighted that the work of the Clinic was extending care to rural and Indigenous communities, reflecting the efforts of the other units and their advocacy role related to access, equity, and justice:

You know, another example is the work that our Clinic does with First Nations. We've had several contracts with the First Nations Health Authority to support pharmacists who are working in Indigenous communities. And, you know, to understand the unique nature of that relationship, those relationships. Because there are almost no Indigenous pharmacists in the province. (Pharm1-I)

Interestingly, this unique role played by the Faculty of Pharmaceutical Sciences, which was not directly related to their education nor their research missions, brought some controversy and questions about whether this foray into healthcare service delivery extended beyond the role a university should play:

I can tell you when we opened our Clinic, there was a lot of, we've had a lot of political pressure from various places about our Clinic and being disruptive. And our Clinic was investigated by the Ministry of Advanced Education because there was an accusation that the Faculty was out of line by creating a clinic. And the Ministry of Advanced Education investigated us, and the bottom line of their briefing note was that the innovation that we do at our Clinic is exactly what a university
should be doing and it’s exactly what the Ministry of Advanced Ed wants universities to be moving into. (Pharm3-I)

This participant went on to argue that UBC was uniquely positioned to play this kind of role developing, testing, and disseminating models of care:

And, as I think about what we've been doing at our Clinic, I am convinced that there is no other entity or organization, other than UBC, who could have done what we've done. The regulatory bodies, the advocacy bodies, private enterprises, health authorities, none of them could have done what we've been able to do because we are UBC. (Pharm3-I)

The UBC Pharmacists Clinic was at the heart of all the discussions with participants from the Faculty of Pharmaceutical Sciences. They presented this as the core of their third mission activities and argued that it enabled them to advocate for the role of the pharmacy profession within existing and emerging models of care. Participants described a situation where they were able to engage in a unique initiative that extended far beyond education and research into practice. Despite initial reactions that this was not within the purview of a university, they shared their journey in being able to successfully influence government and policy makers, sharing evidence generated by their campus-based clinic, and in advocating for the role of pharmacists in primary care.

Institutional Enablers of the Advocacy Role

Participants also discussed features of the university generally, and the health units specifically, that they thought enabled each unit to play an advocacy role. They discussed enablers such as leadership, professional expertise, and institutional support. In this section, I discuss each of these sub-themes in turn, connecting all three units.
Leadership - Participants from all three units attributed their ability to play an advocacy role to their belief that there was a perception on the part of external partners that their respective School, Department, and Faculty were leaders in society. One participant from the School of Nursing spoke about this stemming from their reputation as leaders in nursing education and research, ostensibly contributing to their authority to contribute to society more broadly:

UBC, as the oldest baccalaureate education nursing program in all of Canada, and in fact in the, what used to be the British Empire, the British Commonwealth countries everywhere outside the United States in fact, has both a long-standing history and a sort of commitment to leadership. And so, we regularly are identified, especially as the only research-intensive School of Nursing. (Nurs2-I)

A participant from the Department of Physical Therapy participant saw it as the Department’s responsibility, as part of a university, to be a leader and contribute to practice:

I think as a university program we have a responsibility to be a leader in that, you know, we have a responsibility for excellence in clinical practice and so on. (PT1-I)

A participant from the Faculty of Pharmaceutical Sciences spoke about the reputation they felt that they were building as leaders through the dissemination of their innovations in clinical practice. He discussed their international reputation, despite efforts being focused provincially:

I think the other elements of that – the research and the innovations in clinical practice – have implications, you know nationally and internationally. You know, so, although, you know, the likes of the practice Pharmacy Practice things in primary care, those are things that are happening in the province. But, you know the concepts, you know, those are published and read about. And you know, we get, you know, people from the UK or Australia or whatever you know really interested in what the Faculty is doing in that regard. (Pharm1-I)
The notion of the university as a leader in society, with the ability to impact and improve society, was articulated by participants from all three units and was a dominant discourse across all the strategic plans. The way that this leadership role was described by participants embodied notions of institutional excellence, which was also a common discourse within the strategic plans. They placed this within the context of the university’s institutional structure, as well as their belief that society had trust in the institution and the health units based on their reputations. The way that participants described leadership and an advocacy role was connected to their research and practice activities.

**Professional Expertise** - Participants from all three units also connected the ability of their School, Department, or Faculty to play an advocacy role in the combination of professional and research expertise brought by their respective faculty members. A participant from the School of Nursing talked extensively about the way that practitioners who saw problems or issues that they wanted to address or situations they wanted to improve viewed the university as a place where they could do that:

> They see problems and instead of getting discouraged and leaving the profession, they figure I'm going to come back to UBC and see if they can give me anything... And we've got the privilege of bringing in those who are really, really interested in making a difference in the world. (Nurs1-I)

She also talked about how this was about more than becoming an academic and conducting research to answer some of society’s pressing challenges, but was about contributing to policy and being able to contribute as leaders in society:

> And it's always that they'd hit a point of frustration. They could see what needed to be done. Their angle of vision as a nurse could cause them to see what needed to be done, but they didn't yet have the tools and skills to be able to move that forward. I think at the Ph.D. level, they're not simply saying you know I want to get out of nursing and be an academic. But they're saying, I can see now that it's not just the policy and the leadership in the school, those kinds of skills, but it's
also the knowledge generation skills, how can I generate the knowledge that's going to be able to move forward. (Nurs1-I)

During the focus group, a participant from the Department of Physical Therapy spoke about how it was important to have “the right people” in the Department. By this, they were referring to a commitment to making an impact in society through the advocacy role of their Department and the expertise their faculty members from the physical therapy profession brought to those efforts:

I found that it sometimes comes down to the right person in the right role, who just has that interest and passion and energy to make something happen that you've been trying to push forward for a long time. Sometimes it's just the changing of the guard and a new way of looking at things or an experience that somebody brings to a different setting to say, ‘Hey, this can happen here.’ (PT3-F)

Another participant from the Department talked about the way that physical therapists working in practice, as part of a clinical community connected to the university, had a desire to contribute to research:

I think there's a strong connection with our clinical community. Our clinical community would love to all do research and have a research connection with UBC but we simply don’t have enough faculty members to fulfill that need. You know, we have people approaching us with Oh I'd like to work on this research project, you know, all the time but there's nobody to sort of buddy up with them on that. (PT1-I)

Again, thee were perceived limitations in the Department.
A focus group participant from the Faculty of Pharmaceutical Sciences spoke explicitly about how their Practice portfolio diverged from traditional academic activities and required contributions from individuals working in clinical practice:

It takes a different mindset than, I think, what we think of in traditional academic or perhaps research portfolios. So, it does require a slightly different skillset. And so, there are things to learn and to draw into the innovation agenda for a university that you can't learn in academia that have to come from practice. (Pharm3-F)

She also talked about other types of expertise and experience that contributed to the Faculty’s ability to play an advocacy role, stressing the benefits of being a practitioner who had experience working with government:

And most of them can't do what I do because I have the street smarts, I suppose, maybe, of having been in boardrooms and in various places in the private sector that we don't always get a chance to go into. But that, and I worked in government for a couple of years. So that really helped us get our foot in the door. I mean, who would have thought that that time I spent working in government would come back to help our profession now, but it did. So, I really think that we need to broaden our definition of the skill set that we need the university to tap into. (Phar3-F)

Participants from all three units described a unique feature of the health units and their research activities that enabled them to play an advocacy role, that being the involvement of health professionals as faculty members or within their research activities. They described a passion and commitment from nurses, physical therapists, and pharmacists who wanted to contribute to society in a different way and who came to work at the university as a way to do that. They alluded to different skillsets that the health professions brought to research that extended beyond traditional notions of academic research, seeking to contribute to society in meaningful ways. They also described the university as the only place they
could generate knowledge and contribute in this way, perpetuating the image of the university as a powerful institution.

**Institutional Support** - While the goal of the interviews and focus group was to discuss the role of the institution in society, the reality was that this role was operationalized by individual faculty members. Participants across all three units talked about the importance of institutional support for faculty members involved in advocacy work and other externally focused activities as being key to their unit having an impact in society.

A participant from the School of Nursing talked about the fact that many of these activities involved formal agreements between the School and external partners:

> There are a few clear partnerships that we have with, you know, memorandum of understanding...

> It also involves, I would say, approval for secondments or external involvement with, like, government, where they’re requesting someone to spend time and so, releasing them from some of their regular work requirements. (Nurs2-I)

She went on to specify that in order to be approved, the partnership had to contribute to society:

> Those approvals are, those discussions are pretty consistently following along the lines of, ‘And does this contribute to societal policy or program or evidence to change things?’ (Nurs2-I)

She also talked about how contributions to society were actually viewed as more important within the School’s tenure-track process than contributions to research, which was particularly noteworthy as promotion and tenure often play a determining role in how faculty members dedicate their time:

> I would say that our school has regularly identified within the promotion and tenure process, and within the appointment and reappointment process for teaching intensive faculty who aren’t on the tenure track, the engagement with society and the impact of work with society – whether
that's serving on the regulatory committees for licensure, whether that's providing consultation to
WHO or OECD or the province, or, you know, health systems, or regularly engaging with First
Nations Health Authority... And in fact, we value that even more than h index\textsuperscript{4} or, you know,
citation numbers. Because there are ways to gain that, but at the end of the day, the work that
actually engages with communities and changes policies or changes practices or increases access,
actually changes health and changes lives. (Nurs2-I)

A participant from the Department of Physical Therapy also talked about the integration of service into
their tenure processes and the way that influenced the commitment of faculty members to engage in
activities that impacted the profession and models of care in society:

So, I think we have a really strong commitment across our faculty and from our leadership in really
engaging in those through that service piece. When you talk about the tenure stream service piece
like that, I think, I don't think it's a requirement, I think there's a really authentic commitment to
that service piece, and the value of that. (PT2-I)

A participant from the Faculty of Pharmaceutical Sciences identified the creation of the Practice portfolio
as a signal of the Faculty’s support for an externally facing role and described how stakeholder
engagement with external partners was necessary for its creation:

[The Dean] at the time created this portfolio as new. So, very much lived the stakeholder
development in our Faculty. And the stakeholder development around the whole spectrum from
government associations, regulatory bodies, health authorities, community pharmacy, and patient

\textsuperscript{4} A metric that is used to evaluate the impact of a faculty member’s scholarly output and performance – e.g.,
publications.
groups as well. I think they’re all, they were all more loosely held in our Faculty and oftentimes driven by the Dean, prior to having this portfolio. (Pharm2-I)

As leaders from the three units, it is not surprising that participants spoke about the institutional support that they felt enabled them to operationalize their third mission activities. They highlighted the formal recognition of faculty members involved in advocacy work as being important. As leaders, it would be hard to argue that advocacy-related work and other third mission activities were core missions of the institution without the allocation of resources and institutional support.

Collective Opportunities

In order to answer my research question about the collective opportunities and possibilities across the health units at UBC related to their third mission, I asked interviewees what they thought the role of their unit should be in society. I asked focus group participants about the need for advocacy to remain within the focus of individual units versus collective opportunities across the health units. Participants struggled to answer these questions and identify collective opportunities. Most participants responded with stories about existing collaborations with other units that were unrelated to their third mission or advocacy activities. For example, one participant from the School of Nursing spoke about another university she had worked at where there was a lot of interdisciplinary collaboration related to the delivery of their education. A participant from the Department of Physical Therapy responded with a story about the number of leaders within their program who were committed to interdisciplinary education. Another participant from the Faculty of Pharmaceutical Sciences shared a story about hiring a student from another unit in their Pharmacists Clinic when asked about collective opportunities. However, a few participants spoke about the challenges associated with their respective advocacy roles, providing some insights into why participants might have had difficulty identifying collective opportunities.
Participants from the School of Nursing alluded to disciplinary inequities, turf issues, and competition that drove a need to individually advocate for their unit and their ability to be effective in doing so:

We tend to act out of scarcity, rather than abundance. And, you know, it’s something I felt within the health professions at UBC and that I’ve always felt. You know there’s competition between the professions. (Nurs2-I)

Another participant from the School of Nursing spoke about the need to advocate for nurses to lead efforts related to specific issues where their expertise could be of value because decision-makers often turned to physicians for their expertise rather than nurses:

We do have a societal assumption that physicians are always the top point of expertise. Watch it happening right now in long-term care [related to the COVID-19 pandemic]. And let me tell you, there are so few physicians in this whole country that have ever functionally been involved in long-term care. But the government would not go first to say, ‘Let’s find who in nursing would be there’. They would set up the panel, say ‘doctor so-and-so’s the boss of it.’ (Nurs1-I)

This was just one of many examples provided by participants from the School of Nursing about the expertise of physicians being sought out over the expertise of nurses, resulting in the feeling that the School has an important advocacy role to play in ensuring that nursing perspectives are heard by decision-makers.

Despite having said that there were places where nursing should have been relied on for their expertise rather than physicians, one participant from the School went on to say that there were few places that the School was not already having an impact, given their size:

But as a School, a number of us are, like, doing the reaching-out or speaking-out or making suggestions or creating the networks to actually insert ourselves into those roles. So, I’m not sure
that there would be places that we aren't already, that at least that I can think of in terms of the size of our School and the things that we do across so many different professions. No, I think we're at, we're at a surprising number of tables. (Nurs2-I)

Another participant from the School stressed the need to maintain a disciplinary voice and advocate for their profession specifically, limiting the opportunities for a collective approach:

I think that the part that we would, the place where we might have a difference of opinion is that we feel very strongly that we do need to also work very, very hard to preserve that disciplinary integrity of what it is we do. (Nurs1-I)

When asked explicitly about collective opportunities related to the advocacy role of the health units, the focus group participant from the School of Nursing talked about the importance of playing a role in preventative care:

I love this discussion about disruptive innovation. I think that's where we need to keep hammering that health promotion is really key, and health professionals have a responsibility to society to all have some knowledge about. (Nurs3-F)

One participant from the Department of Physical Therapy also talked about the issue of disciplinary competition affecting their ability to advocate with decision-makers, specifically referring to their ability to advocate for an increase in the number of seats within their educational program. She pointed out that each unit was advocating for their profession with government in the same regard, and with finite resources, the government had to make choices about which units’ advocacy efforts were successful:

Of course, when you get into all the politics of this and government says, ‘Well, okay, you've had your bit now we're moving on to another group who's also screaming at us that we need more.’ (PT1-I)
She felt that the capacity of the Department to advocate for their profession and models of care within which the profession could contribute was impacted by the sheer number and complexity of their external relationships:

We're a servant of so many different masters. We have our – for example, let's just set aside the research part for a minute – but if we just look at our entry-level MPT [Master of Physical Therapy] curriculum, you know, there are things that we would love to do some of which I just mentioned. *Well, let's develop a program for this or develop a program for that*, so there's all of that sort of creative side that we would like to do. Then we have our accreditation bodies saying this is the curriculum. These are the curricula guidelines that, you know, you must follow. And then we've got our licensing body saying okay this is a licensing exam, so you need to make sure your graduates can pass the licensing exam, which I mean they are all related, you know, everything is in there is related but it's different perspective from all of these things so we do feel like we're a servant of many masters sometimes. (PT1-I)

This participant was the only one from the Department of Physical Therapy who identified a concrete opportunity for collaboration with other units:

We need to look broader than just being a siloed *Okay we're going to provide the physical therapy services and that's it*. Obviously, we need to be part of the bigger picture. So, we are you know, we need to be working with other professions providing our perspective to other professions, because if we're really going to push healthcare forward we need to look at new models of care, we need to look at new models of how do we do things, how have we been doing things. And that may mean that the role of physical therapy changes and changes dramatically. But we can't do that in isolation in our silo, you know, we need to be with other health care professionals to really, and other professionals too, but primarily healthcare professionals to say, okay, how do we collaboratively as
A participant from the Faculty of Pharmaceutical Sciences talked about being satisfied with the impact they were able to have in society and did not feel like they should be doing more:

I think I would rather see us, you know, really try and make the big differences that we can in the areas where we already are. You know, from our little corner of the world, you know, I think, we probably, you know, do quite a bit and have quite a bit of impact on society. And, you know, I think we do pretty well for what's certainly on a UBC scale, it's a pretty, is a small part of the enterprise. (Pharm1-I)

He talked about their need to advocate with government for the role of pharmacists and highlighted additional collaboration within their own unit as an opportunity, not collaboration with other units:

You know, I think there are some things you know, advocating for the profession, I think is really important. It’s another thing is part of our, you know, strategic plan and how do we influence, how do we influence the decision-makers to move the needle on the scope of practice for example. And that’s complex. So, you know, how do we get to a point where a pharmacist can prescribe in BC, for example. And you know, that’s a complex issue with many roadblocks and so on. But I think we have a role to play. And that’s why I think, you know, as I said, our students, our graduates, have a role to play there. And it’s a role that they do play in really advocating for that. (Pharm1-I)

While not identified as a collective opportunity explicitly, another participant from the Faculty suggested that patient engagement was one area where their external relationships might be improved:

I think we could probably do a better job with impacting the way we interact with patients. It’s a weird thing to say. Because we interact with patients all the time as healthcare providers, whether it be on student rotations or some of the specific work where we want patient impact or
involvement in work that we do. But I still think that there's other ways in which we can do a better job at including patients in ways that can help inform all the things that we do in our faculty.

(Pharm2-I)

Despite my desire to identify collective opportunities across the health units at UBC related to the third mission, participants across all three units struggled to identify such opportunities. Based on comments made by participants from the School of Nursing, this appeared to stem from a perceived need to ensure nursing perspectives were valued by decision-makers over those of other units, specifically physicians. Comments from a participant from the Department of Physical Therapy suggested that the inability of participants from that unit to identify collective opportunities may have been influenced by the focus of the Department on gaining funding for additional seats and the perception that there was competition for resources to support additional seats across the different units. Her comments also provided some insight into why participants from the Department of Physical Therapy responded with examples about their interprofessional education initiatives, based on pressures within the Department to meet competing pressures from external partners that influenced the way that they had to deliver their educational program. Comments from participants from the Faculty of Pharmaceutical Sciences reflected their view that they were doing all they could do with respect to their third mission activities.

Summary

The idea of a social contract was reflected across data from the document analysis as well as the interviews. I then explored this theme further with focus group participants. Interview and focus group data both supported and provided additional insights into this notion of a social contract. For participants from the Department of Physical Therapy and Faculty of Pharmaceutical Sciences, this contract was grounded in their role in a publicly funded institution and the perception that their primary mandate was
to meet the demand in British Columbia for physical therapists and pharmacists respectively. This likely stemmed from the fact that they are the only educators of these professions in the province. Conversely, participants from the School of Nursing, as one of 17 schools in the province, spoke about society in more global terms and discussed a commitment to ensuring health for all. Despite these differences, participants from all three units discussed a commitment to improving access, equity, and social justice, focusing on meeting the needs of Indigenous and underserved communities.

The other dominant theme that emerged was more surprising, as it was not reflected in the document analysis of their strategic plans. While all interview participants introduced the notion of advocacy as a key activity of the health units explicitly, beyond their education and research missions, there were only two references to “advocacy” in the Physical Therapy and Nursing strategic plans:

- “Use of data collected in the Diversity Survey to influence policy more broadly and advocate for broader representation (geographically and demographically)” (UBC Department of Physical Therapy Strategic Plan, 2018, p. 9).
- “As community connectors, advocates, and engagers we strive towards collaboration and cultural safety; pairing active recognition of leadership excellence and a culturally safe environment with ongoing support for personal and professional development” ((En)Vision 2020, 2016, p. 6).

Participants described the role of their respective units in advocating for the professions they have a mandate to train, closely reflecting the way they defined their social contract. In the case of the School of Nursing, this was predominantly about ensuring that the expertise of nurses was contributing to society broadly. Participants shared examples about the large amount of work that was happening within the School to advocate for the nursing profession and the contribution it could make in both influencing decision-makers and enhancing health care delivery. Participants from the Department of Physical
Therapy did not feel like they were able to play this type of advocacy role, despite a desire to do so; they felt they had to focus on advocating for an increase in the number of physical therapy seats funded within their program in order to meet the service needs of the province. The Faculty of Pharmaceutical Sciences was playing the kind of advocacy role that participants from the Department of Physical Therapy wished they could play. This involved advocating for innovative roles for the pharmacy profession within existing and emerging models of care, facilitated through a unique UBC Pharmacists Clinic initiative.

While not articulated in their strategic plans, the themes that emerged through the interviews and focus group reflected some of the unique characteristics of UBC, a research-intensive university, and of the health units specifically, which leaders thought positioned these units to play different kinds of advocacy roles. Firstly, the perception of external partners that the School of Nursing, Department of Physical Therapy, and Faculty of Pharmaceutical Sciences were leaders with a unique ability to inform policy and practice enabled them to play an advocacy role. This arguably stemmed, in part, from the combination of professional and research expertise brought by their respective faculty members, a unique feature of the health units. Finally, participants from the units all described a context within which their third mission advocacy activities were formalized and supported within institutional structures. As such, participants felt that they were at capacity with respect to their third mission advocacy activities and were not able to identify any collective opportunities. However, hierarchy, competition, and a focus on advocacy for their own discipline seemed to create barriers to collective action and collaboration.
Chapter VI – Discussion

This research leaves no doubt that the health units at UBC play a role in society beyond the education of health professionals and conducting research. The UBC Faculty of Pharmaceutical Sciences, School of Nursing, and Department of Physical Therapy proved to be a useful comparative case study to explore the relationship between a university’s health units and society. Each unit articulated a role beyond education and research in its strategic plan that both reflects and diverges from the concept of the third mission of the university discussed in the literature. I was able to explore the dominant and competing neo-liberal and socially-oriented discourses embodied in the way that each unit articulated its relationship with society through a critical discourse analysis involving their strategic plans. However, interview and focus group participants discussed an ‘advocacy’ role played by their units that was not reflected in the third mission literature nor in these plans. Discussions with participants from each unit helped me explore this advocacy concept and determine how this role was being operationalized similarly and differently across the three units.

This research highlights commonalities around how the three units articulated and operationalized their relationship with society, as well as differences that stem from how they are situated within the university and the province. The findings helped me to answer the following research questions:

1. How do specific health units at UBC – nursing, pharmacy, physical therapy – articulate and operationalize a third mission? What are the dominant and competing discourses?
   a. What drivers have influenced the way in which these health units at UBC articulate and operationalize a third mission?
   b. How does the third mission of these health units influence the education and research missions? How is it influenced by the other two missions?
2. What are the collective opportunities and possibilities across the health units at UBC related to the third mission?

Throughout this chapter, I connect the findings from this comparative case study with dominant themes from the third mission literature. As was the case with the third mission activities discussed in the literature (see Chapter 2), this comparative case study reveals an institutional mission, beyond education and research, that is contextual and subject to multiple internal and external drivers and policy actors (Bourner et al., 2017; Compagnucci & Spigarelli, 2020; Pinheiro et al., 2015a; Roper & Hirth, 2005; Zomer & Benneworth, 2011). In this chapter, I discuss how the concept of an advocacy role played by the health units at UBC has been influenced by both provincial policies and institutional and regulatory environments, as well as internal cultures and perceptions about demands from external stakeholders (Zomer & Benneworth, 2011).

I start by reflecting on the societal and institutional forces driving the relationship between the health units at UBC and society and compare this to the dominant drivers of the third mission discussed in the literature. I link this to the concept of a social contract between the health units and society and how this is influenced by their responsibility for training health professionals to meet the needs of society, in addition to their position within a publicly funded university. I then present an emerging framework based on the findings from this research that expands on the third mission of different health units. I expand on the advocacy role played by each health unit and discuss how this is enacted differently across the three cases in this study. Finally, I reflect on competing discourses embodied in how the health units describe their relationship with society. In doing so, I expand on the features of the university institution generally, and the health units specifically, that participants argued enabled these units to play different
kinds of advocacy roles. Throughout this discussion chapter, I consider the various levels of the institution and explore omissions, gaps, and contradictions across the different strategic plans and institutional units.

**Third Mission Drivers within the Health Units at UBC**

This research project started with a critical analysis of several strategic plans from various health units at UBC. These documents are influenced by the broader social context within which the institution and the various health units exist. Launched between 2016 and 2020, each unit’s strategic plan was developed over the year, give or take, preceding their respective launches. The Dean of Medicine highlighted that their plan was launched during a time when they had demonstrated a commitment to social accountability through a decade of distributed medical education in the province (*Building the Future*, 2016). The Department of Physical Therapy also situated its strategic plan within the context of a “Northern and Rural Cohort enabling Masters of Physical Therapy (MPT) students to provide physiotherapy services in underserved communities” (*UBC Department of Physical Therapy Strategic Plan*, 2018, p. 3). The Department of Physical Therapy’s strategic plan stated that “through teaching, research and partnerships, the Department of Physical Therapy strives to meet its social contract of reducing health inequities, addressing population health needs and contributing expertise to specialized areas of practice” (*UBC Department of Physical Therapy Strategic Plan*, 2018, p. 10). They were specific in describing “Indigenous and First Nations communities” as well as “rural and underserved communities” as key stakeholders that they aimed to serve.

The Dean of Pharmaceutical Sciences described an environment of rapid change within which they were setting out their strategic priorities for the coming years (*Catalyst for Change*, 2017). Their strategic plan set “Practice” as one of four priorities, describing this as “optimization of the pharmacist role,” “integrated models of care,” and “strategic practice partnerships,” and the plan presented a list of
specific partners to work with to achieve their strategic objectives, including the “BC Ministry of Health, health authorities, hospital and community pharmacy, other healthcare providers, patients, communities and industry” (Catalyst for Change, 2017, p. 28). The plan suggested that there was a “mutual benefit in creating close connections with all communities across the province, and we are deeply committed to enhancing our interface with Indigenous populations” (Catalyst for Change, 2017, p. 26).

In the opening of the School of Nursing strategic plan, the Director at that time described a context within which:

the health care system is facing crisis – climbing costs, decreasing access to care, lack of equitable resourcing – simultaneously our knowledge continues to explode: the microbiome and cellular level, genetic effects on health as well as the social determinants of health and impact of trauma and stress. Our need for an understanding of chronic disease management in addition to communicable disease control and the impact of diet, exercise, and mindfulness on health and well-being challenges the models of health care we have come to depend upon. ((En)Vision 2020, 2016, p. 1)

In the plan, the School committed to “community engagement and collaboration with peers and partners to foster and sustain health and a healthy work environment in order to responsively advance people’s wellbeing” ((En)Vision 2020, 2016, p. 20). The School of Nursing strategic plan said their stakeholders were “beyond geographic and social communities” and existed “across the health spectrum.”

The strategic planning processes were led by the Deans, Associate Deans, Directors, and Department Heads who participated in the interviews and focus group that allowed me to explore what was driving the priorities presented in these plans. While universities in Canada have faced pressure to generate revenue, resulting in the commercialization of university activities through industry partnerships (Cowin,
2017; Dennison & Schuetze, 2004; Fisher, Rubenson, Lee, et al., 2014), the health units in this case study did not seem to have responded similarly to such pressures.

The way that the health units are funded, based on their responsibility for training health professionals to meet the needs of the province, has resulted in a situation where they respond to fiscal pressures differently from other facets of the university. These three health units receive government funding to train a specified number of students in accordance with what the government deems to be the provincial demand for that particular profession. Tuition rates for these professional programs, which are usually higher than those for non-professional programs (e.g., Bachelor’s in English, Master’s in Political Science), then cover the remainder of the costs associated with training students to be regulated health professionals. They focus less on the development and delivery of revenue-generating programs and often direct their energy to advocate for increases in the number of seats funded by the Ministry of Advance Education, Skills and Training or raising tuition fees in order to balance their budgets.

The three health units in this case study are situated within three of only five Faculties at UBC that are not in financial deficit – Faculty of Medicine, Faculty of Applied Science, Faculty of Pharmaceutical Sciences, Sauder School of Business, and Faculty of Science. While Faculties like Business and Science develop innovative programing that responds to market demands, and attract and enroll international students who pay higher tuition rates in order to generate revenue, the relationship between the health units and society is impacted primarily by the fact that they are responsible for training regulated health professionals.

The impact of this was explicitly described by one participant from the Department of Physical Therapy:

There are things that we would love to do, some of which I just mentioned – well, let’s develop a program for this or develop a program for that so there’s all of that sort of creative side that we
would like to do. Then we have our accreditation bodies saying ‘this is the curriculum.’ These are the curricula guidelines that, you know, you must follow. And then we’ve got our licensing body saying, ‘Okay this is a licensing exam, so you need to make sure your graduates can pass the licensing exam,’ which, I mean, they are all related, you know, everything is in there is related but it’s a different perspective from all of these things so we do feel like we’re a servant of many masters sometimes. (PT1-I)

All three units in this case study deliver professional education programs that have been accredited, with regulatory bodies influencing their curricula. While they may create programs that respond to market demands as a mechanism for generating revenue, accreditation is a mechanism through which health units differentiate themselves and respond to market demands, as many employers require graduates to have been trained in an accredited program. As such, units have to ensure they prepare graduates for the professional licensing exams run by their respective regulatory bodies, leading to the important relationship between the units with their accrediting body, professional association, and regulatory organization.

Participants from all three units commented that they work closely with professional and regulatory bodies, the Ministry of Health, and the health authorities, and less with industry. The Ministry of Health determines the health human resource needs of each profession and the Ministry of Advanced Education, Skills and Training provides funding for the associated number of seats in each program. Participants from the Faculty of Pharmaceutical Sciences and Department of Physical Therapy described working closely with their professional associations and regulatory bodies to advocate with the Ministry for increased seats within their professional program and expanded scopes of practice for the profession. Similarly, a participant from the School of Nursing talked about the important relationship with their professional association and how they collaboratively advocated with government to implement a role for
registered nurses in primary care. While this type of advocacy is an explicit mandate for professional associations, participants described a role for their units in doing so collaboratively.

Many units within the university develop industry partnerships as a way to make up budget shortfalls by leveraging the research activities of the university (Compagnucci & Spigarelli, 2020). How each health profession is situated within the health system seems to have influenced the extent to which each unit engages in industry partnerships. Pharmacists work primarily in private practice within an industry that is dominated by large chain stores, which explains the Faculty of Pharmaceutical Science’s commitment to “find ways of working more closely and effectively with industry” (Catalyst for Change, 2017, p. 28). Conversely, the Department of Physical Therapy strategic plan does not mention industry partnerships despite the fact that many physical therapists also work in private practice. This might be explained by the fact that private physical therapy practices operate as clinics rather than companies. During an interview, a participant from the School of Nursing specified that it was frowned upon for them to engage in industry partnerships, referring to the values of the nursing discipline:

> We don't have people who are doing that kind of work with Big Pharma or with, like, tech device organizations where there's like money to be made...profit is actually really looked at quite suspiciously within our discipline, in our School, well at least within our School values. (Nurs2-I)

Despite the fact that the health units within a publicly funded, research-intensive university engage in a broad array of activities, including research, their relationship with society is driven primarily by their responsibility to educate health professionals to meet the needs of the province.

They are less driven by the need to create industry partnerships and generate revenue. A large piece of their funding model is based on this education mandate, and they are beholden to accrediting bodies and regulators that dictate what certain programs can entail. However, this means that they have not been
subject as much to the neo-liberal pressures felt within other parts of the university to generate revenue – often through their research activities and industry partnerships – impacting their relationship with society and driving their third mission activities differently. This research reveals a unique relationship between the health units and society in contrast to other parts of the university that is influenced by the way they are funded, the professional programs they deliver, and the concept of a social contract.

The Social Contract of the Health Units at UBC

The emergence of the third mission of universities has been attributed to both neo-liberal drivers and the notion of universities as having a “social contract” and “moral responsibility” (Maassen et al., 2019; Pinheiro et al., 2015d). Participants across all three units in this comparative case study described their relationship with society stemming from a social contract that was driven by the fact that they are part of a publicly funded university. For example, one participant from the Faculty of Pharmaceutical Sciences said:

So, and you know, I think that's really important because, as a publicly funded university we are duty bound to, you know, to contribute to society in whatever ways we can. (Pharm1-I)

According to participants from all three units, they have a social contract that stems from both the relationship of the university with society as a publicly funded institution (Jones, 1998) and the relationship between the health units and society as educators of health service providers.

A social contract, which was equated by some participants with the concept of a “social accountability mandate” and a commitment to “social justice,” was at the heart of the relationship with society discussed by participants from all three units (Boelen, 2016; Meštrović & Rouse, 2015; Ritz et al., 2014; Ventres et al., 2018). Participants described their relationship with society in a way that reflects this moral, social accountability discourse that Ritz et al. (2014) have argued has been gaining strength across
the health disciplines. A commitment to ensuring access to physical therapists across all regions of the province was a foundational part of the social contract of the Department of Physical Therapy, as explained by one participant from the Department:

We are also the only physio program in BC, and are expanding and distributing too, with the primary goal to physiotherapists, you know, there's huge vacancies, as I'm sure there are many health professionals. So, one of our goals is to educate future physios in communities that they will actually serve. So that I think is a huge kind of societal piece. (PT1-I)

As the only educator of physical therapists in BC, with ongoing shortages in certain regions, leaders in the Department saw their primary responsibility to society as meeting the need for physical therapists, with a particular focus on ensuring access for rural and Indigenous communities. This was achieved, in large part, through their distributed education program. Initiatives that focus on training students in underserved communities, like those delivered through UBC’s distributed physical therapy program situated in the North of the province, have been found to help ensure graduates are more likely to practice in the type of community in which they are trained, and give learners exposure and experience with marginalized groups facilitating greater understanding of their needs, arguably resulting in providers better able to address inequities (Ritz et al., 2014).

Participants from the Faculty of Pharmaceutical Sciences focused their social contract on their role in improving the healthcare system:

I see healthcare as a serving, healthcare is a service industry, if you will. And we are in service to patients and society. Again, society in particular in Canada, socialized healthcare system. (Pharm3-F)

A number of the activities described by participants from the Faculty of Pharmaceutical Sciences demonstrated a commitment to generate new knowledge and ensure it influenced models of care
delivery and improved health outcomes. They also linked the activities in their Practice Innovation portfolio, that focused on integrating pharmacists into primary care, with their ability to meet the needs of Indigenous communities:

You know, another example is the work that our clinic does with First Nations. We've had several contracts with the First Nations Health Authority to support pharmacists who are working in Indigenous communities. And, you know, to understand the unique nature of that relationship, those relationships. Because there are almost no Indigenous pharmacists in the province. (Pharm1-I)

Participants from the School of Nursing discussed their social contract as a commitment to health for all and social justice:

I presume it probably is for other disciplines, or health professions that also have, you know, a mandate for improving health for all. But for us, that's very much a key component that is reflective of our perspective on health equity and social justice. (Nurs1-I)

The School of Nursing articulated their social responsibility as a commitment to ensure ‘health for all’, which participants described as a commitment to access, justice and equity. Since 1978, the World Health Organization has called for widespread changes to address gross health inequalities and identified primary care as key to achieving the goal of “health for all” (World Health Organization, 1978).

The Provincial Landscape - Collectively, these three units articulated a commitment to meet the health needs of the population of British Columbia, improve the health and well-being of society, and address systemic inequities. However, their focus was on ensuring access to their particular profession’s services and expertise. How and whether this contributed to these professed aims was not as clear. That being said, these commitments reflect a response to the health challenges within the province.
The strategic plans of these three health units were developed within a provincial context plagued by gross health disparities. Like many other provinces in Canada, BC has been increasingly working to address the high cost of healthcare that impacts the sustainability of the publicly funded healthcare system, which has been rising due to changing demographics and needs of the population (BC Ministry of Health, 2015). The Faculty of Pharmaceutical Sciences strategic plan referred explicitly to contributing to the financial sustainability of the healthcare system by leveraging their “relationships and experience in practice innovation to accelerate change in areas that are fundamental to optimal patient care and health system sustainability” (Catalyst for Change, 2017, p. 28). Further, the health needs of the population have become increasingly complex, particularly around the prevalence of chronic disease, cancer, mental health, and substance use issues (Aggarwal & Hutchison, 2012). All three units expressed commitments to contribute to improved health outcomes through the way they train health professionals and conduct health-related research.

Continuity and coordination of care across health disciplines, time, and locations, is further complicated by the large geography and distribution of the population across sparsely populated rural areas, disproportionately impacting Indigenous peoples. As discussed in previous chapters, rural and remote communities across BC have faced reduced access to health services and health disparities (Public Health Agency of Canada, 2018). The Department of Physical Therapy was particularly focused on meeting the needs of rural communities. Indigenous communities, in both urban and rural BC, have faced disproportionate health disparities stemming from the historical, political, social, and economic conditions of colonialism. All three units explicitly articulated a commitment to meet the health needs and address the inequities affecting Indigenous peoples.
This focus on and commitment to meeting the needs of Indigenous communities was reflective of a broader societal trend. Institutions across Canada, including universities and healthcare organizations, were being called upon at the time the strategic plans in this case study were launched to implement the recommendations in the *Truth and Reconciliation Commission of Canada: Calls to Action* (2015), aimed at redressing the legacy of residential schools and advancing the process of reconciliation. This report includes calls directed at the health units to:

- Increase the number of Aboriginal professionals working in the healthcare field.
- Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
- Provide cultural competency training for all healthcare professionals.
- Ensure that medical and nursing schools in Canada require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, treaties and Aboriginal rights, and Indigenous teachings and practices.

In 2020, the *In Plain Sight* report (Turpel-Lafond, 2020), commissioned by the BC provincial government, brought to light widespread systemic racism in the provincial healthcare systems and put forward recommendations to improve equity in health care, to which the health units were also responding. This included a call for improved cultural safety and increased Indigenous leadership across health services, regulators, and education. Within this provincial landscape, the way that the three health units articulated their relationship with society through their strategic plans and during discussions with participants embodied a perception that the health units have a contract with society and the ability to meet the health needs of the population of BC, improve the health and well-being of society, and address systemic inequities.
The Third Mission Advocacy Role Played by the Health Units at UBC

Participants described their social contract in a way that was closely linked to their education mission related to access, their research mission related to quality improvement, and both missions related to equity and social justice. For example, the Department of Physical Therapy attributed their ability to contribute to access to physical therapy services across the province to their distributed education model. The Faculty of Pharmaceutical Sciences celebrated the way that innovations researched within the unit had the ability to contribute to improved health outcomes. The School of Nursing referenced both the way they trained students and the research conducted by faculty members contributed to equity and social justice. However, my goal was to explore what activities these three health units were engaged in that extended beyond their education and research missions towards these aims.

These units were formed initially as educational units designed to train health professionals and became situated within a university in response to requirements for standardization set by professional associations and regulatory bodies (Harris, 1976). At UBC they later, and increasingly, engaged in research (Cowin, 2017). Their education missions have been inextricably connected to their responsibility to train their respective health professionals to meet the needs of the province, which can arguably be linked to the concept of a social accountability mandate (Jarvis-Selinger et al., 2008). Their research activities include efforts by faculty members with practical professional experiences to contribute to society in meaningful ways. However, the question remained: what activities were these three health units engaged in that extended beyond their education and research missions, reflecting the concept of a third mission?

The concept of an advocacy role that emerged from the thematic analysis of interview and focus group data has often been discussed in relation to individual health professionals advocating for their patients (Mallik, 1997). However, research participants discussed this as a role played by the institution. According
to the World Health Organization, advocacy involves “a combination of individual and social actions
designed to gain political commitment, policy support, social acceptance and systems support for a
particular goal or program” (Stokes et al., 2015, p. e51). The way that participants from all three units
described their relationship with society and an advocacy role diverged from the missions explicitly
articulated in their respective strategic plans. However, each interviewee referred explicitly to an
“advocacy” role for their unit. Revealed as a dominant theme across the interviews, I then explored the
concept of advocacy with focus group participants, showing differences around what this advocacy role
looks like within each unit. While grouped under the theme of advocacy, there were nuances in the way
that each unit enacted this role.

An Emerging Framework for the Third Mission of Health Units - The three cases in this study revealed
different types of advocacy efforts, both extending beyond and integrating with the traditional university
missions of education and research. The ability of each unit to play different types of advocacy roles,
based on how they are situated within the university and provincial landscape, revealed a hierarchy of
third mission activities across the health units. The framework presented in Figure 1 represents a starting
point for depicting this hierarchy and the factors that influence the ability of a health unit to engage at
each level. This preliminary framework depicts the relationship with society that all three units at UBC
were working towards. It highlights differences in how this relationship is actualized based on provincial
policies and institutional and regulatory environments, and internal cultures and perceptions about
demands from external stakeholders. My hope is that it can be used by other health Faculties,
Departments, and Schools to help them reflect on their relationship with society, their social contract,
activities beyond education and research, and how they engage in an advocacy role.
At the most basic level, the health units view themselves as having a social contract to ensure access and meet provincial needs for the profession they have a mandate to educate, which was the focus of the Department of Physical Therapy. If they are not able to fulfill this social contract, then they do not have the ability to engage in other types of third mission activities, despite their desire to do so. At this level, the third mission efforts of the unit intersect closely with their education mission and reflect the concept of a social accountability mandate. Once the demand for the profession is met at a minimum, they can engage in third mission activities that focus on innovations that aim to contribute to improved quality and health outcomes, as reflected in the Faculty of Pharmaceutical Sciences’ third mission activities to integrate pharmacists into primary care. This level of third mission activity leverages the research expertise of faculty members. The ability of a unit to work towards systems impact, demonstrated by the School of Nursing, reflects the professional values that influence the unit and comes from being in a situation where they are not constrained by other aspects of their social contract. Both professional
experiences and research activities contribute to the ability of the unit to engage in third mission activities that aim to have impact across the system. While the third mission activities of each unit cross all three levels to varying degrees, each unit’s activities focus more or less on one of these categories.

**Access** - Participants from the Department of Physical Therapy discussed an advocacy role in working with government to increase the number of seats in their program in order to meet provincial demand for the physical therapy profession.

   So, one of our strongest advocacy works really is advocating with government for an increase in the number of seats. I mean, basically we could double on number of seats and still have everybody walk out into a job. (PT1-I)

The way they discussed this advocacy role reflected the social accountability initiatives discussed in literature focused on the distribution of services to marginalized groups (Jarvis-Selinger et al., 2008; Strasser et al., 2013), also embodying a professed commitment to social justice (Rhodes et al., 2018; Ritz et al., 2014). Participants from the Department of Physical Therapy spoke extensively about the integral relationship with their professional association and regulatory body and this advocacy role. The Department of Physical Therapy worked closely with their professional association to advocate for changes in government funding and practice that would better enable them to meet the physical therapy needs of the province. Organizations such as professional associations and physical therapy professionals are increasingly engaged in advocacy efforts to influence governments and policy in order to ensure physical therapists reach their full potential and impact in society (Stokes et al., 2015). Participants from the Department of Physical Therapy described being part of these collaborative efforts:

   That’s my perspective, there is this shared common goals and vision, and the partnerships are mutually beneficial and really reciprocal. (PT2-I)
McGowan and Stokes (2015) suggested that both academic and clinical physical therapists need to act as leaders of change in order to improve the profile and status of the profession and consequently patient care. They found that leadership within the profession has been an increasing focus for academics. However, they noted that discussions about leadership within physical therapy have not been undertaken in the same way they have been within the professions of nursing and medicine. They cited the Canadian Physiotherapy Association (CPA) definition of a leader as someone who “leads successful and sustainable change, holds multiple lenses and perspectives, strengthens and builds relationships, inspires and engages others to grow, leads across complex systems, asks questions and reflects on and senses what is needed most in a system” (Canadian Physiotherapy Association Leadership Division, cited in McGowan & Stokes, 2015, p. 122). However, leaders from the Department who participated in interviews felt limited by their ability to be more responsive to system needs.

You know, it's when I think of systems, that's to me where it's like, there's so much more we could be doing. And physio has a really critical role in all of that. And so, it's been identified in the Department that yeah, we have a role we need to advocate for this within our profession and broadly. And it seems to happen at individual levels but it doesn't seem to happen at a higher broader coordinated level. (PT2-I)

McGowan and Stokes (2015) argued that both academic departments and clinical organizations need to play leadership roles and petition the government to increase the profile of physical therapy.

Participants discussed how their efforts to meet the demand for physical therapists in the province impacted their ability to consider and advocate for the integration of physical therapists into new and evolving models of care, arguing that if the Department met this demand, they could do more to increase the profile of physical therapists in the province. While they spoke about an advocacy role helping to meet the demand for physical therapists, extending their scope of practice, and the potential to
contribute to new areas of practice, they identified limitations with respect to the ability of the Department to advocate at a systems level. In part, participants attributed this to the fact that they were a Department within a Faculty and suggested that system-level advocacy was usually within the purview of the Dean. The advocacy role of the Department of Physical Therapy was both enabled and limited by these internal and external forces according to participants.

**Innovation** - Participants from the Faculty of Pharmaceutical Sciences talked about an advocacy role in a way that reflected the role the Department of Physical Therapy aspired to make towards innovations in practice. The UBC Pharmacists Clinic was at the heart of this and enabled the Faculty to advocate with government for the role of pharmacists in primary care. They played an advocacy role that focused on the ways in which they thought the pharmacy profession could contribute to improved health outcomes in a way that the Department of Physical Therapy wished they could if they were not constrained by meeting the basic demands for the profession across all regions of the province. This involved developing an innovative model of practice within their campus-based clinic, sharing their successes with government, developing a business case, and then signing a Memorandum of Understanding with government to support the integration of this model into primary care clinics across the province.

The campus-based UBC Pharmacists Clinic was a key activity within the Faculty’s Practice Innovation portfolio and served as a living lab for innovations in pharmacy practice, reflecting the types of knowledge translation activities discussed in much of the third mission literature (Compagnucci & Spigarelli, 2020; Maassen et al., 2019).

So, the practice innovation portfolio is all about stimulating practice change. So, our mandate at the clinic is fourfold. Number one is to provide best-practice care to patients to demonstrate what a pharmacist working at full scope can contribute. And with that message out there, then it
facilitates conversations around practice change. Number two, we contribute to the academic program to help students and learners become more practice-ready when they graduate with practical skills, cases, and things like that. Number three, we're a living lab, we build systems and processes to support pharmacists in practicing in more advanced ways. And the fourth mandate is, quite frankly, to be disruptive, to make people sufficiently uncomfortable that they'll start to let go of some of the old ways that aren't serving them very well and move towards new ways that can serve them and society better. (Pharm3-F)

The Faculty advocated with government and health authorities for the integration of these innovations into primary care delivery models being implemented across the province, using evidence generated through the clinic. The ability of campus-based clinics to serve as living labs for innovations in practice was also experienced by the Department of Physical Therapy, to a lesser extent.

We had a meeting yesterday about our student-led clinic where it's proven to really blossom into this clinic where we are serving the underserved. Like, people are finding us with these really complex health care needs and identifying from that this need to really emphasize skills and competencies around trauma-informed practice. And what other partnerships can we establish on campus, you know, to ensure that our students have the supports they need to offer safe, effective care for the community that they're serving through the PTRC [Physical Therapy and Research Clinic], while also facilitating their learning and ensuring they're developing the competencies to be really that next generation of clinicians that will effectively serve the community and those patient populations. (PT2-I)

While focused on the delivery of practice-based education, their Physical Therapy and Research Clinic developed innovations in virtual care that were then integrated into other parts of the province, helping to meet their social contract to ensure access to physical therapy services across the province.
While initially, the BC Ministry of Advanced Education and Skills Training expressed concerns to the Faculty of Pharmaceutical Sciences that university-led clinics are outside the purview of the institution. In the end, they determined that this was exactly the role that a university should be playing. This may have stemmed from a commonly held view that advocating for the profession is the role of professional associations and regulator bodies. Truong et al. (2010) discussed the advocacy role performed by professional pharmacy organizations, whose formal role is advocacy, in contributing to changes in practices through knowledge translation activities but noted that knowledge translation is not the job of regulatory bodies. Their study identified lack of time and resources, as well as political issues, as key to the inability of regulatory bodies to engage in knowledge translation activities. Their study also commented that professional associations tend to focus on protecting the public by maintaining standards of practice, supporting the argument made by the Ministry of Advanced Education and Skills Training that the UBC Faculty of Pharmaceutical Sciences was uniquely positioned to play this type of role. Truong et al. (2010) found that many professional organizations believed this responsibility should be given to pharmacy faculties.

Authors and this study indicate that collaboration across professional associations, academia, and other professional organizations is needed to successfully advocate for the pharmacy profession, particularly in primary care. Fincham and Ahmed (2012) pointed out that professional contributions to primary care have tended to focus on nurses and physicians and have not recognized the potential role of pharmacists in primary care; this criticism was shared by a number of participants from the UBC Faculty of Pharmaceutical Sciences. This oversight was the impetus for the Faculty’s efforts to advocate for and contribute to the integration of pharmacists into primary care. Fincham and Ahmed (2012) called for this type of advocacy in pharmacy, citing the success of nursing professional associations and schools in
advocating for the integration of nurse practitioners into primary care; Fincham and Ahmed (2012) argued that this success was achieved by working across organizations.

The study conducted by Truong et al. (2010) revealed the unique characteristics of universities that enabled the Faculty of Pharmaceutical Sciences to engage in knowledge translation and advocacy activities, particularly related to their research mission. Truong et al. (2010) described knowledge translation (KT) within this context as:

a relatively new term used to describe a relatively old problem — how to incorporate evidence-based research into clinical practice. KT is defined as the synthesis, dissemination, exchange and ethically sound application of knowledge to improve the health of Canadians, provide more effective health services and products and strengthen the health care system. (pp. 78-79)

They argued that research examining new models of practice and subsequent knowledge translation of findings is imperative for promoting the pharmacy profession and minimizing gaps in care. This requires information sharing with policy makers and actual use of knowledge in practice in order to be effective; according to participants, this was certainly achieved through the UBC Faculty of Pharmaceutical Sciences advocacy and knowledge translations activities.

**Systems Impact** - Participants from the School of Nursing did not discuss an advocacy role in the same ways as those within the Department of Physical Therapy and Faculty of Pharmaceutical Sciences around access and improving models of care. They did not focus on meeting provincial demand for nurses or expanding scopes of practice. Participants acknowledged that they were able to play a unique advocacy role based on the fact that they are one of 17 schools in the province, all working toward a common goal – to meet the demand for nursing – which allowed them to play a leadership role that they attributed to being uniquely situated within a research-intensive university. They discussed contributing to policy
across the health sector and beyond, providing specific examples of faculty members involved in giving testimony in court cases, sitting on human rights tribunals, and influencing legislation. They highlighted an advocacy role that centred on ensuring that nursing perspectives and expertise contributed to policy decisions. They celebrated the successes of their faculty members in providing consultation and advice, offering their disciplinary expertise to improve health equity and social justice. However, they acknowledged that this was sometimes limited by policy makers deferring to physicians, resulting in the need for the School to advocate for the perspectives of nurses.

Paquin (2011) discussed the role of academia in contributing to broader social justice advocacy efforts made by individual nurses and the relationships with professional associations that facilitate this. Like Paquin, participants situated the nursing profession within a strong foundation in critical thinking, advocacy, and relational skills. They identified how the perspectives and knowledge generated through the professional experiences of nurses put them in “a unique position to recognize and identify how social and political institutions, as well as government policy, intersect with the lives and health of the individuals and communities they serve” (Paquin, 2011, p. 65). Paquin (2011) argued that contributions to social justice need to extend beyond individual nurses and are the responsibility of professional organizations, nursing leaders, scholars, researchers, and educators. They recognized the ways that researchers contribute to social justice advocacy by developing and testing interventions that address health inequities and supporting implementation in practice. They suggested that researchers can contribute to the evidence needed to advocate for healthier public policy.

The School of Nursing had similar external relationships to the Department of Physical Therapy and Faculty of Pharmaceutical Sciences – with government, health authorities, and professional associations; however, discussions about their advocacy activities and external partnerships revealed a broader
spectrum of influence spanning from local to global, whereas the Department of Physical Therapy and Faculty of Pharmaceutical Sciences were primarily focused on provincial needs. There is a large body of literature discussing an advocacy role in nursing, with policy-level advocacy regarded as an extension of the patient-level advocacy that is considered an integral part of the nursing profession (Spenceley et al., 2006). According to Ballou (2000), there has been a long-held expectation for nurses to participate in advocacy at the individual, community, and societal levels.

As such, it is not surprising that this emerged as a theme during discussions with participants from the School of Nursing. However, this role was not explicitly articulated in their strategic plan. Spenceley et al. (2006) argued that there has been a disconnect between the expected advocacy role of nurses and what they actually do. They suggested that the concept of advocacy within the health professions has been influenced by the belief that they are uniquely qualified to plead the cause of another. They also introduced social justice as a foundation for the kinds of advocacy role played by nurses, which was also described by participants from the UBC School of Nursing similarly, involving “a moral and ethical imperative to advocate assertively for the marginalized, address inequities in health care and disparities in health, and insist on change” (Spenceley et al., 2006, p. 182). Spenceley et al. (2006) discussed policy advocacy as evidence-informed actions intended to influence systems-level decisions in order to improve health outcomes; however, they discussed this primarily as individual nurses advocating for patients and communities. Smith et al. (2020) analyzed how collective advocacy efforts to contribute to policy changes on the part of nursing at multiple levels and involving multiple faculty members are beneficial for the university, legislators, and other stakeholders.

Staebler et al. (2017) studied the role of policy and political advocacy that university faculty members from the nursing profession have engaged in. They commented on policy advocacy in a way that aligns
with comments from participants from the School of Nursing, who mentioned nurses who saw inequities in the system and issues that needed to be addressed and turned to the university as a place to get the research skills to address them. According to a study by Kung and Rudner Lugo (2015), doctoral-trained nurses are more likely to be involved in policy activities. Staebler et al. (2017) suggested that their ability to assess, redesign, and shape the policy environment enables them to lead change and innovations in healthcare. The goal of their project was to identify strategies that would improve the practices of academics engaging in policy advocacy. While participants from the School of Nursing celebrated the institutional support given to faculty members involved in policy advocacy, Staebler et al. (2017) found that promotion and tenure criteria in nursing rarely included policy and advocacy. The culture of the UBC School of Nursing, contrary to the findings of Staebler et al. (2017), valued the importance of advocacy and engagement of faculty in policy development.

While their advocacy roles differed somewhat – with the Department of Physical Therapy focused on securing additional seats, the Faculty of Pharmaceutical Sciences focused on knowledge translation, and the School of Nursing focused on policy-level advocacy – the analysis revealed institutional factors across all three units that contributed to their unique abilities within a research-intensive university to play the types of advocacy roles they described. They discussed this as a combination of leadership, professional expertise, and institutional support.

Participants also discussed factors that limited their ability to play the types of advocacy roles they described. The Department of Physical Therapy was limited by the need for ongoing efforts to secure additional seats and the fact that other types of advocacy often happened at the Faculty level. The Faculty of Pharmaceutical Sciences was, for a time, limited by the perception that a campus-based clinic to test new models of practice was outside of the remit of a university. The School of Nursing was often
limited by the fact that policymakers deferred to the expertise of physicians. That being said, each was able to overcome these challenges to varying degrees, making a case for the importance of advocacy roles. Further, the literature discussed here makes a case for the types of advocacy roles described by each unit and the important contributions these can make in meeting the health needs of the population they serve, improving the health and well-being of society, and addressing systemic inequities.

The Contribution of Professional Expertise to The Third Mission of Health Units

Participants stressed the relationship between the research activities of the unit and the professional experiences of faculty members in contributing to their advocacy efforts. Literature discussing the third mission of the university makes a strong connection between the research mission and the ability of the institution to contribute to society. Third mission activities often involve knowledge translation or commercialization of research outputs to benefit both society and the institution itself (Compagnucci & Spigarelli, 2020; Pinheiro et al., 2015b; Zomer & Benneworth, 2011). However, there are some distinctive elements to the relationship between the research mission and third mission of the health units.

All three units identified research and other knowledge-generating activities as key enablers of their ability to contribute to society in meaningful ways. However, the combination of professional experiences and research knowledge that contributed to this was unique within the health units. Participants across all three cases described a context within the health units wherein healthcare practitioners with practical experiences saw health challenges that needed to be addressed and joined the university as a way to contribute to addressing these challenges by conducting research that complemented their practical experiences (Paquin, 2011).
The way participants discussed their third mission activities and the relationship with their research activities reflected the different types of research activities that take place within the university discussed by Bourner et al. (2016), who suggest that the advancement of knowledge often includes inventions and unintentional ways of generating knowledge. One participant from the Department of Physical Therapy made this comment:

I found that it sometimes comes down to the right person in the right role, who just has that interest and passion and energy to make something happen that you've been trying to push forward for a long time. Sometimes it's just the changing of the guard and a new way of looking at things or an experience that somebody brings to a different setting to say, ‘Hey, this can happen here.’ (PT3-F)

Participants from all three units discussed activities that take shape at the intersection between professional practice and research, reflecting Bourner et al.'s (2016) idea of society-centred research and its focus on contributing to those outside the university. “Society-centred research” is “problem-focused research” that is practical; “applied research” that uses theories, knowledge, methods, and techniques for a specific purpose; or “engaged research” that supports university engagement with society. A participant from the Faculty of Pharmaceutical Sciences discussed how faculty members brought skills that they acquired outside of academia:

It takes a different mindset than, I think, what we think of in traditional academic or perhaps research portfolios. So, it does require a slightly different skillset. And so, there are things to learn and to draw into the innovation agenda for a university that you can't learn in academia, that have to come from practice. (Pharm3-F)
Historically, the research mission of the university has been grounded in the principles of academic freedom and institutional autonomy. Jones (2014) described Canadian universities as public, secular, degree-granting institutions with the autonomy to create their own missions and mandates. The health units, conversely, conveyed a commitment to be responsive to society in ways that did not focus on this principle of autonomy, reflected in the types of research activities they engaged in. A number of authors attached the ability of universities to contribute to society to the autonomy of the institution and the academic freedom enjoyed by faculty members to conduct research for the sake of knowledge (Chantler, 2016; Dennison, 1997; Kwiek, 2006). However, the social contract, as understood by participants, echoed the principles of a social accountability mandate – to address the priority health concerns of the community they have a mandate to serve. Overall, participants reflected the view of Peels et al. (2019), who, while advocating for a commitment to the epistemic responsibilities of the university, acknowledged that the health units have a greater responsibility to ensure they serve society in a practical manner.

While the health units do conduct some ‘pure research’ that is focused on the advancement of knowledge without concern for immediate social or economic benefit, participants discussed research activities that reflect the concept of engaged research, embodying a commitment “to serve a larger purpose – to participate in the building of a more just society and to make the nation more civil and secure” (Boyer, 1996, p. 22). The research that contributed to their third mission was grounded in a combination of professional practice and evidence generated through scholarly activities, highlighting the impact of faculty members with professional experiences as nurses, physical therapists, and pharmacists on their third mission activities. It is here that discourses of institutional excellence pepper descriptions of the third mission of the university, as the institution celebrates its unique ability to generate knowledge.
**Competing Discourse**

Despite the socially-oriented discourse of a social contract to meet the health needs of the population of BC, improve the health and well-being of society, and address systemic inequities, my critical discourse analysis revealed competing discourses. The University strategic plan was developed after the institution celebrated its centennial, and according to the University President, it was “launched at a time of renewal as we embark on our next century as a leading public university” (*Shaping UBC’s Next Century*, 2018, p. 4). The plan presents UBC as an institution that strives for excellence and to be a leading university within a global market. Research intensive universities like UBC operate in a competitive global market that is driven by university rankings (Ordorika & Lloyd, 2015). Both the strategic plans of each unit in this case study and many comments made by participants embodied the discourse of the university as an institution separate from society that is in the unique position to offer leadership and expertise (Bourner et al., 2017; Pinheiro & Stensaker, 2014). The way that these health units’ relationship with society was described in their strategic plans and by participants did align closely with some of the socially-oriented ways in which the concept of the third mission was discussed in the literature, focusing on knowledge transfer and social engagement activities directed at addressing society’s grand challenges (Compagnucci & Spigarelli, 2020). However, the strategic plans also embodied a common discourse reflected in the third mission literature, whereby universities are seen as being in a unique position to have the power, knowledge, expertise, and position to change and improve society.

The UBC, Faculty of Medicine, and Faculty of Pharmaceutical Sciences strategic plans were facilitated by the same consultant who contributed to the UBC Health strategic plan launched in 2021. The Department of Physical Therapy and School of Nursing strategic plans were written by their unit heads in collaboration with key faculty members. All these plans were developed with input from both internal and external stakeholders, who were identified by the leadership within the respective units. While involved in the
development of the UBC Health strategic plan, I became attuned to the importance of the verbs used to
describe the role of the unit in relation to its stakeholders, as well as the way in which those stakeholders
were defined. There was significant thought and discussion between our leadership team and this
consultant about things like what we were communicating by using the word “lead” versus something
that we would “facilitate.” I experienced the impact that this consultant had on word choice, as she either
suggested similar vocabulary to that found in some other strategic plans she helped develop or steered us
away from language used in other plans as a means to differentiate ourselves. While the impact of this
consultant on word choice must be recognized, like the signature marks of an artist, the ultimate
decisions about word choice rested with our leadership group, as they would have with the leaders from
the health units who were involved in the development of their respective strategic plans and who
participated in the interviews and focus group. Both the resulting strategic plans and comments from
participants that embodied the discourse of an institution separate from society, were influenced by this
consultant, common stakeholder input, and the culture of the institution. This powerful discourse of
excellence and leadership reflects the culture of the organization and how it aims to position itself within
society.

The verbs used in each of the strategic plans articulated a relationship with society that embodied
multiple discourses and power dynamics. For example, the verbs “engage,” “co-create,” and “work with”
communities reflect an egalitarian discourse, where contributions are not valued according to the status
or position of power of those who make them (Flecha, 2000). This sometimes embodies a responsive
element whereby the university commits to adapting to the evolving needs of society. The verbs “assist,”
“mobilize,” and “empower” might be viewed as embodying a more paternalistic discourse, with the
university suggesting it has the power to give others what they need to act. Statements such as “solving
problems of local and global importance” also reflected this discourse, with the university being
presented as being in a unique position to provide knowledge and answers. As they articulated an external role in society, beyond education and research, each strategic plan described “our” partners and communities with whom the unit would work to operationalize their third mission activities. The use of the possessive “our” might arguably have been an attempt to counter the perception of the university institution as separate from society. However, this possessive might also be read as somewhat paternalistic, understood as both an infringement on autonomy with a beneficent or protective intent (Thompson, 2013). This paternalistic discourse was perpetuated by terms such as “affiliated communities,” “beyond the university,” and “the world around us” when referring to external partnerships.

Interview and focus group participants also embodied this discourse, celebrating the unique ability of the university to lead and create change.

And, as I think about what we've been doing at our clinic, I am convinced that there is no other entity or organization, other than UBC, who could have done what we've done. The regulatory bodies, the advocacy bodies, private enterprises, health authorities, none of them could have done what we've been able to do because we are UBC. (Pharm3-I)

UBC, as the oldest baccalaureate education nursing program in all of Canada, and in fact in what used to be the British Empire, the British Commonwealth countries everywhere outside the United States in fact, has both a long-standing history and a sort of commitment to leadership. And so, we regularly are identified, especially as the only research-intensive School of Nursing. (Nurs2-I)

I think as a university program we have a responsibility to be a leader in that, you know, we have a responsibility for excellence in clinical practice and so on. (PT1-I)
The strategic plans of the health units, despite their social contract and commitment to equity, reflected power dynamics and imbalances between the university institution and society, while also ostensibly seeking to foster partnerships with society that might serve to break down perceived hierarchies. They embodied both paternalistic and egalitarian discourses that together positioned their units within the institution as uniquely able to contribute to societal improvement, whether through leadership or partnership. These plans contributed to the image of a powerful institution with the sole ability to “shape,” “change,” and “transform” society. While participants focused on their commitment to being responsive by meeting the health needs of the population of BC, improving the health and well-being of society, and addressing systemic inequities, they used this excellence discourse as a means to justify their ability, as health units within a university, to contribute to society in this way. They described themselves as leaders with the unique ability to generate knowledge through the research activities of the university. This discourse was firmly grounded in their position within a research-intensive university.

Summary

Throughout the discussion of this comparative case study, I have attempted to provide a holistic description and analysis of all three cases. However, readers play an important role in how the findings of a case study are understood (Merriam, 1998). They will bring their own experiences in order to generate generalizations as their own data are added to the information I have presented. In this discussion chapter, I have presented an emerging framework, informed by this comparative case study, that will act as a starting point for further discussion, extrapolation and refinement, and for readers to compare my findings with their own cases and draw comparisons. The goal of this comparative case study has been for readers to be able to make general theoretical statements about social structures and processes related to the relationship between health Faculties, Departments, and Schools and society. My aim was to
describe the social contract and advocacy roles discussed above in a way that will enable readers from other health units and institutions to apply their own experiences to the case study and build on the concepts presented.

This case study highlights how the relationship between health units and society is influenced by how these units are situated within the university and by the broader provincial landscape. Physical Therapy is a Department within a health-related faculty (Faculty of Medicine), the only educator of physical therapists in the province; student learning takes place at distributed sites across the province, and attracts a moderate amount of research funding in 2019/2020 – just over $4.5 million. Their relationship with society has been focused on ensuring access to physical therapy services across the province’s vast regions, with a specific commitment to meet the needs of rural and Indigenous communities. Pharmaceutical Sciences is its own Faculty, the only educator of pharmacists in the province, and attracted over $10 million in research funding in 2021. Their relationship with society has been centred on knowledge translation of innovations developed within the Faculty in order to contribute to improved health outcomes. Nursing is a School in a non-health related Faculty (Faculty of Applied Science), one of 17 schools of nursing in the province, uniquely situated within a research-intensive university, and attracted $3.8 million in research funding in 2019/2020. Their relationship with society is grounded in a broad commitment to equity and social justice and contributing nursing expertise to multiple facets of society.

Each case pointed to unique societal and institutional forces driving the relationship between the health units at UBC and society, which differed somewhat from the dominant drivers of the third mission discussed in the literature. At the core of this relationship was the concept of a social contract between the health units and society. This contract was influenced by the responsibility of each unit for training
health professionals to meet the needs of society, in addition to their position within a publicly funded university. The emerging framework extrapolated throughout this chapter provides a preliminary lens for understanding how the concept of a third mission is operationalized by different health units based on constraints faced by the different health units. Finally, the competing discourses discussed throughout this dissertation highlight potential tensions between the relationship the health units aim to have with society and how it might be perceived by society.
Chapter VII – Concluding Remarks

In this final chapter, I reflect on the implications of the findings, possible recommendations, the limitations of this research, opportunities for further research, and connections to my professional practice. I discuss what I have learned about the role the health units at UBC see for themselves in society, beyond education and research; how this might be more meaningfully reflected in the strategic visions they articulate; what UBC Health can learn from the health units at UBC across which they facilitate collaborations; and how this might influence my professional practice as I work to advance the strategic mission of UBC Health.

Research Implications

Participants discussed features of the university institution generally, and the health units specifically, that influenced their relationship with society. Participants across all three units talked about the importance of institutional support for faculty members involved in advocacy work and other externally focused activities as being key to their units’ impact in society; they felt they were giving these activities full recognition. However, as leaders from within the health units, it is not surprising that participants spoke about the institutional support that enabled them to engage in the activities described throughout their interviews. What they shared in this regard will have also been influenced by my positionality within UBC Health, a unit that participants work closely with. They will have likely wanted to present the successes of their unit and showcase their activities in a positive light. They highlighted the formal recognition of faculty members involved in advocacy work as being important. As leaders, it would be hard to argue that advocacy-related work was core to the institution without the allocation of resources and institutional support.
Conversely, scholars have regularly criticized lack of institutional support as a barrier to externally focused university activities (Boyer, 1996; Staebler et al., 2017). Further, authors have noted that the third mission often conflicts with the traditional education and research missions of the university, receiving insufficient funding in comparison to the other two; this results in a situation where third mission activities have been superficially embedded within university structures (Compagnucci & Spigarelli, 2020; Maassen et al., 2019). According to Maassen et al. (2019), the types of activities described my participants are generally weakly institutionalized, resulting in a lack of national programs and funding opportunities.

These authors, writing about the third mission of the university, stressed that an understanding of this mission, and how it is operationalized, is of strategic importance because it influences how it is supported within the institution. Compagnucci and Spigarelli (2020) and Maassen et al. (2019) argued that it is important for universities to effectively communicate their third mission priorities and place in society to external partners, as these partnerships, like those with the Ministry of Health and health authorities, are key features of the third mission. They stressed the need to structurally embed the third mission in university management, governance, and organizational structures. This research highlights the need to think critically about how units do so.

**Recommendations**

Both the third mission and the university’s social contract should be integrated into the strategic plans and frameworks of the institutions (Maassen et al., 2019). However, units should be critical of how they do this, as power relationships between the university and society are at play. While the advocacy-related activities that I have enumerated in the discussion chapter have been valued within their respective unit, these activities are not explicitly reflected in their strategic plans. As communication tools and guides for
setting priorities and allocating resources, strategic plans are important documents for influencing the activities that take shape and are implemented across the university. Within my professional practice, where I am responsible for the advancement of the strategic objectives set out in the UBC Health strategic plan, I have become attuned to the power of these plans in influencing what gets done and receives resources. Activity proposals that get approved by UBC Health must articulate how they align with the priorities in our strategic plan to be structurally supported.

The health units need to make their third mission explicit to give it strategic weight, ensure supports and resources are allocated and make sure that it is institutionalized within university structures (Maassen et al., 2019). In order to support their third mission activities, specifically their advocacy role, the health units should continue to recruit and support faculty members with professional experience who have burning questions and a desire to address the complex challenges facing both the health system and society (Paquin, 2011). Individuals within the institution need to develop both advocacy and leadership skills, which can start at the pre-licensure professional program level through the education mission of each unit (McGowan & Stokes, 2015). These activities also need to be given equal weight, alongside education and research, within tenure and promotion. The concept of ‘service’ within promotion and tenure structures needs to be expanded to include third mission activities such as advocacy. New ways of doing research that reflects approaches such as the “scholarship of engagement” (Boyer et al., 2015), and those that integrate professional experience, need to be acknowledged, supported, and valued. The strategic missions of the health units need to be communicated to both internal and external partners through their strategic plans, so they collaborate both internally and externally and allocate adequate resources to actualize these important socially-oriented goals that are becoming increasingly important throughout society. Finally, units need to take a critical look at the language they use to communicate
their relationship with society and reflect on the power imbalances this perpetuates that do not align with their professed commitments to social justice and equity.

**Research Limitations**

This research started with a critical discourse analysis involving strategic plans. However, these documents capture a single moment in time and were influenced by external drivers, institutional forces, and the leaders who led their development a number of years prior to this analysis. Being responsive to society was professed to be at the core of the third mission described in the literature, the social contract of the health units described by participants, and the advocacy role played by the health units. As such, there may be limitations to my focus on strategic plans that might not reflect the current role that leaders from the health units discussed for their respective unit in society, beyond education and research. It could be argued that strategic plans are well suited for planning for the education and research mission of the university over the next five to ten years, but that the third mission might need to be articulated in different ways in order to be truly responsive to society. Here, an analysis of other ways that the strategic priorities of the institution are articulated might be warranted. For example, an analysis of newsletters that celebrate the initiatives that the university wants to share with both internal and external partners would provide insight into the priorities of the institution. University Board and Senate minutes would provide insight into what is valued by the institution and priorities for resource allocation. That being said, strategic plans remain a key mechanism for communicating strategic priorities to internal and external partners and determining resource allocation.

Beyond how it was articulated, I also sought to identify how the relationship between the health units and society was operationalized. To do so, I conducted interviews and a focus group with what might be perceived to be a relatively small number of participants from each unit. However, I was able to speak
with, arguably, all the individuals best positioned within each unit to speak to the institutional role of their respective unit beyond education and research. Participants were Deans, Associate Deans, Department Heads, Directors, and Associate Directors who were involved in the development of their respective strategic plans and were responsible for their operationalization. As leaders within the health units, it is not surprising that participants celebrated their success and deemed that they were at capacity with respect to their advocacy activities. To suggest otherwise might be perceived as admitting failure in their leadership. Again, my positionality will have influenced what they told me. However, participants also spoke extensively about the efforts of individual faculty members. While my focus was on the role of the institution, organizations are comprised of human actors and individual actions. As such, faculty members not in senior leadership positions might have answered my questions very differently. For example, community engagement, which is articulated explicitly as a third mission in the UBC, Faculty of Applied Science, and School of Nursing strategic plans, was not discussed by participants. Other faculty members who were involved in community-level activities, rather than institution-level priorities, may have focused on these types of activities.

Participants’ answers to my questions were very likely influenced by my positionality. At the time, I was Assistant Director of Strategic Initiatives for UBC Health, a unit that facilitates collaborations across the units included in my study. I was known to participants and we have sat on some of the same committees and advisory groups. It would have been almost impossible for them to engage in a discussion during the interviews or focus group and see me solely as a graduate student. They would have had my organizational affiliation in the back of their minds. However, I am comforted by the consistency of the themes that emerged across interview and focus group participants from the same unit. The fact that I was not in a position of power over research participants enabled me to conduct this research the way that I did.
Finally, I decided to focus on three health units at UBC. While I chose them for specific reasons based on the way that they are positioned within the organizational structure of UBC and the province, my ability to generalize about the health units at UBC or elsewhere is limited. However, the emerging framework presented in the discussion chapter offers a mechanism for understanding the relationship between other health units and society; the drivers influencing that relationship based on the belief that all health units have a social contract to meet the needs of society; and the intersections of this external third mission role with education and research missions of the university. For example, the Department of Occupational Therapy, which is in a similar position to the Department of Physical Therapy as the only educator of the profession with a distributed program, may be focused similarly on access to care. The Faculty of Dentistry, with a professional program that trains professionals for private practice, may have a relationship with society similar to the Faculty of Pharmaceutical Sciences that is focused on innovations in practice. The commitment to social justice that influenced the relationship between the School of Nursing and society might also be reflected in the activities of the School of Social Work, whose profession embodies similar values. That being said, the goal of this and other case studies is not to generalize but to shed light on a particular context. Through the descriptions of the social contract and corresponding advocacy role of the health units in this comparative case study, my goal is to provide a mechanism for other health units to consider their relationship with society, beyond the education of health professionals and health-related research. With no case study of the third mission of UBC more broadly, nor non-health units at UBC, it is difficult to determine whether the themes that emerged related to a social contract and an advocacy role are unique to these units, the health units generally, or are reflective of trends within the university more broadly.
Opportunities for Further Research

Despite my desire to identify collective opportunities across the health units at UBC related to the third mission, participants across all three units struggled to identify such opportunities. This appeared to stem from a perceived need to ensure disciplinary perspectives were valued by decision-makers over those of other units, the perception that there was competition for resources to support additional seats across the different units, and a view that they were doing all they could with respect to their third mission activities. While participants did not identify collective opportunities, discussions across all three units included reference to team-based and primary care, suggesting that these might be starting points for further research in terms of collective opportunities. Having been involved in interdisciplinary initiatives at UBC for over a decade, this is an area of research that I would be particularly interested in exploring further.

I am interested in exploring further the following comment by a participant from the Department of Physical Therapy during the focus group:

We need to look broader than just being a siloed 
Okay we’re going to provide the physical therapy services and that’s it. Obviously, we need to be part of the bigger picture. So, we are you know, we need to be working with other professions providing our perspective to other professions, because if we’re really going to push healthcare forward, we need to look at new models of care, we need to look at new models of how do we do things, how have we been doing things. And that may mean that the role of physical therapy changes and changes dramatically. But we can’t do that in isolation in our silo, you know; we need to be with other health care professionals to really, and other professionals too, but primarily healthcare professionals to say, okay, how do we collaboratively as a group, meet the needs of health care of Canadians and primarily and globally as well but primarily Canadians, and those in our province. (PT1-I)
Smith et al. (2020) argued that “multidisciplinary contributions to policy discussions are key to advancing policy and impacting the health and health practices of our population” (p. 582). I would find a study about the potential of policy teams, a concept introduced by Smith et al. (2020), valuable. They acknowledged that it is a concept that is not well developed in the literature, and I am interested in exploring this concept further. Smith et al. (2020) have suggested that “in the context of advancing health-related policy, a policy team may be defined as a group of two or more professionals interacting, with a stable affiliation, working collectively on a common policy interest or goal while perceiving themselves as part of a team” (pp. 582-583). I imagine this to be a concept that would benefit UBC Health as it engages the related units at UBC around issues of common concern. Further research to explore the potential of multidisciplinary policy teams working collectively to meet the health needs of the population of BC, improve the health and well-being of society, and address systemic inequities would be valuable from my perspective and for my professional practice.

My research questions and analysis were particularly focused on the institutional level role of the university in society. The advocacy role discussed in this dissertation was introduced by participants who were leaders involved in organizational strategic priorities. However, institutions are comprised of people, and strategic priorities are advanced by a collection of individual actions. Accordingly, participants described their advocacy role in terms of faculty member contributions and the external relationships involved. I would be interested in pursuing further study to understand the commitment to and the enablers and barriers for individual faculty members involved in operationalizing the advocacy role of their unit. Smith et al. (2020) suggested that “time constraints, lack of resources, insufficient peer support, scarcity of mentors, role ambiguity, frustration, and apathy are possible barriers” (p. 583). They also discussed the way that competing priorities around teaching, research, and service impact the ability
of faculty to engage in policy work. The advocacy role discussed in this dissertation extends the notion of service that is part of tenure and promotion structures and often focuses on internally focused activities such as committee work to one that is more externally focused. This might include a focus on exploring activities related to community engagement that were notably absent from discussions with leaders from each unit. There is value in looking at how advocacy is reflected and valued in the service piece of tenure and promotion.

The perceptions of the external stakeholders around the professed advocacy role of the health units are also of interest to me. The advocacy role of professional associations has been well established (Orban et al., 2022; Paquin, 2011; Smith et al., 2020) and it may be argued that the advocacy role operationalized by the health units at UBC is beyond their scope and mandate. From my perspective, fully understanding the relationship of the health units with society requires further research into the perceptions of each of these partner groups about their desired role for the health units within a research-intensive university.

Finally, the fourth mission of the university and its relationship to the third mission is of interest to me. Articulated as “People and Places” in the UBC strategic plan, this is understood as “the mutually reinforcing groups of people and locations (physical and virtual) that endow UBC with its special qualities and define how our work is accomplished” (Shaping UBC’s Next Century, 2018, p. 38). According to the UBC strategic plan, the university “seeks to promote and protect this interaction through our deep commitments to Indigenous peoples” (Shaping UBC’s Next Century, 2018, p. 39). The Faculty of Pharmaceutical Sciences described “strengthened culture, governance and operational infrastructure” under “People and Place” (Catalyst for Change, 2017, p. 28). The Faculty of Medicine’s fourth pillar was “Organization: creation of a working environment that inspires innovation, strengthens academic and operational affiliation, and fosters agility” (Building the Future, 2016, p. 7). The way that this fourth
mission is described in the institutions’ strategic plans suggests a strong connection with the third mission that emerged through my research.

The fourth mission, as articulated in these strategic plans, is focused on the university as an institution and physical place. UBC Vancouver is situated on the traditional, ancestral, unceded territory of the xʷməθkwəy̓əm (Musqueam), an area now known as Point Grey. This campus, situated on a peninsula, is often viewed as a community unto itself. This fourth strategic mission focuses on the university ‘community’ that exists both as a physical space, as well as something that extends across the province based on distributed programs like the Department of Physical Therapy’s and other university activities. There is increasing recognition that the university, as a place and institution, needs to reflect societal demands for equity, diversity, and inclusion. There is a strong element of social justice reflected in how the fourth mission of the university is articulated in the UBC strategic plan, suggesting it would be valuable to conduct an analysis of the fourth mission as a way to further understand the relationship between the institution and society.

Collective opportunities, the perspectives of individual faculty members, the perceptions of different partner groups, and the concept of a fourth mission in relation to the third mission of the university are all areas of research that I would like to explore further. I believe that these will contribute to a better understanding of the relationship between the health units at a university and society.

Connections with My Professional Practice

While an advocacy role was not an explicit concept articulated in the strategic plans of the health units, it has since emerged as a strong theme in the UBC Health strategic plan that was launched in May 2021, shortly after the data collection and analysis conducted within this research. While absent from the
Faculty of Pharmaceutical Sciences strategic plan, advocacy was alluded to in one goal in the School of Nursing plan and a couple of indicators in the plan of the Department of Physical Therapy. The School of Nursing strategic plan articulated a goal to “build leadership capacity within and beyond UBC in practice, education, research and policy development” ([En]Vision 2020, 2016, p. 7). The Physical Therapy strategic plan included two related indicators: “use of data collected in the Diversity Survey to influence policy more broadly and advocate for broader representation (geographically and demographically)” (UBC Department of Physical Therapy Strategic Plan, 2018, p. 11) and “use of research outputs to effectively engage communities, guide clinical practice, and inform healthcare policy” (UBC Department of Physical Therapy Strategic Plan, 2018, p. 15). However, the theme of advocacy is reflected throughout UBC Health’s inaugural strategic plan.

UBC Health defines its purpose as “connecting people, ideas, and actions to advance health outcomes, equity, and systems” (Better Health Together, 2021, p. 8). In his opening message to the strategic plan, the Vice-President Health described UBC Health as a unit that “enables systematic collaboration across health-related units and interests at the university and provides a coordinated interface with community, sector, and government partners across British Columbia” (Better Health Together, 2021, p. 3). This plan was developed with extensive input from leaders across the health units, including participants from the units that participated in this study. UBC Health has a mandate to facilitate collaboration across these and other health units within the institution and the Vice-President Health outlines that:

This is an important role, as complex and interconnected threats to health and health equities are increasingly dominating public discourse. Continuing to support the evolution of public policy and health systems towards integrated approaches that emphasize individual and collective wellbeing is a challenge of global importance and urgency.

(Better Health Together, 2021, p. 3)
The strategic objectives outlined in this plan seek to “address inequities and improve the systems that produce health” (Better Health Together, 2021, p. 3). The plan includes activities that “contribute to policies and service delivery that shape health...[and] facilitate and encourage effective advocacy for continuous improvement in the health ecosystem” (Better Health Together, 2021, p. 3).

This newly launched strategic plan, which was so heavily informed by leaders from across the health units, may demonstrate how the themes that emerged during this research will eventually be reflected in the strategic plans of the health units. However, as I work with leaders within UBC Health and from across the health units to operationalize the strategic objectives outlined in this plan, we struggle to ascertain the level of advocacy that a unit like UBC Health can play, based on its position within a research-intensive university and as a facilitator of collaboration across the health units. This may be connected to the challenge participants had in identifying collective opportunities related to the advocacy role of the institution.

During the Strategic Summits, discussed in Chapter I, that were the first part of the engagement process that contributed to the UBC Health strategic plan:

- stakeholders spoke about how having a voice within UBC Health will help build their motivation to engage. They shared ideas about ways in which UBC Health can act as a collective voice and cautioned about the need to balance that collective voice with the autonomy of faculties, departments, schools, and programs. (Jarvis-Selinger & Wood, 2019, p. 1)

While I remain unsure about the collective opportunities related to an advocacy role, I am confident that this role and the commitment to meeting the health needs of the population of BC, improving the health and well-being of society, and addressing systemic inequities will be
increasingly embodied within the strategic plans of the health units across the institution. As they do so, my hope is that they will think critically about how they both articulate and operationalize their role.

Looking to the Future

The health units at UBC frame their relationship with society as their obligation to ensure access to services provided by the health professionals they have a mandate to train. They also profess a commitment to improvements in service delivery by developing new knowledge and translating that knowledge to society in order to improve health outcomes. In doing so, they reflected a commitment to society beyond the health sector, as well to equity and social justice. While discussing a social contract that reflects a responsibility to be responsive to society, the health units within a university also described themselves as leaders with the unique ability to generate knowledge and change practice through the education and research activities of the university. This discourse is firmly grounded in their position within a research-intensive university.

The third mission activities identified through this research have been described as advocacy, with different units enacting this advocacy role in unique ways. While their advocacy roles varied somewhat, this research reveals institutional factors that contribute to their perceived ability, as health units within a research-intensive university, to play the types of advocacy roles they described. However, this research also reveals factors that limit their ability to play different types of advocacy roles. That being said, the units in this comparative case study were able to overcome these challenges to varying degrees, making a case for these types of advocacy roles and the important contributions they believe these roles can make in meeting the health needs of the population they serve, improving the health and well-being of society, and addressing systemic inequities.
As they continue to engage in the types of advocacy roles described in this dissertation, units need to be more explicit and critical about these activities and their desired impact. In 2020, the COVID-19 pandemic both spotlighted and accelerated existing issues related to access, quality, and equity in health. Across the university, efforts to respond to the Truth and Reconciliation Commission of Canada (TRC) *Calls to Action* (2015), the *In Pain Sight* report (Turpel-Lafond, 2020), and issues of equity, diversity, and inclusion (EDI) called for by groups fighting for gender and racial equality, have continued to gain momentum and drive activity across the university. However, as the university engages in work related to the TRC and EDI, and as this gets reflected in strategic documents, which participants suggested will happen, it will be important to also consider the discourses embodied in these communications and how they get translated into institutional change.

While, arguably, this research reveals how the university and health units present the institution as uniquely positioned to address issues of equity and social justice, there is an ongoing propensity for discourses that perpetuate the image of the university as separate from society. Members of the university community should think critically about how they describe their relationship with society and articulate an advocacy role, as this will then influence how they engage in discussions about “what they are expected to accomplish for society, how they are to be made more accountable to society, and what kind of relationship they should have with core organizations and actors in society” (Maassen et al., 2019, p. 8). Beyond articulating a commitment to equity and social justice and a role in advocating for these principles, the health units need to avoid the paternalistic discourses related to excellence and power that continue to appear throughout their strategic plans.
Universities are powerful institutions in society. They have the influence to change practice through their education and research activities, and their ability to do so is rarely questioned. The advocacy efforts discussed throughout this dissertation extend this power relationship. Health units celebrate the combination of research and professional expertise that they believe gives them the authority to advocate for strategies to meet the health needs of the population, improve the health and well-being of society, and address systemic inequities. As they do so, they should embody a more egalitarian and socially-oriented discourse that aligns with the missions and commitments they articulate for the institution. The university and its health units, as they face the challenge of responding to both the effects of the pandemic, as well as to long-standing inequities, have an opportunity to leverage the power of their advocacy role and facilitate ways to help society think differently about how health is defined and valued, and how the health units can support equity for individuals, communities, and societies. Words have power and influence action. Units within the university, as advocates for equity and justice, need to think critically about how they articulate and operationalize their relationship with society.
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Appendix A - Interview Invitation

Dear ______________,

I am a doctoral student in the Department of Educational Studies (EDST) at the University of British Columbia pursuing an EdD in Educational Leadership and Policy. I am contacting you with the hope that you might be willing to participate in an interview, in your capacity as a leader within one of the health units at UBC.

My dissertation research focuses on the role of health units in society, beyond the education of healthcare professionals and health-related research. Starting with a comparative case study approach of three specific health units at UBC (nursing, pharmacy, and physical therapy), my goal is to explore the way in which these programs define their role beyond education and research; how they articulate that role through their strategic plans; how they operationalize that role; and the drivers, as well as the dominant and competing discourses, that influence the way they do so.

I am inviting you to participate in a 60-minute one-on-one interview at a mutually convenient time and location. The interview will be recorded and transcribed, and analyzed in conjunction with data obtained from other interviews and a preceding document analysis of various publicly-available institutional documents, such as your unit’s strategic plan.

If you choose to be interviewed, you will not be identified by name—I will provide a pseudonym or a more generic title for you. I will also send you a copy of the transcribed interview for your review and revision/clarification if necessary. At any point, you can withdraw your consent to participate and your comments will not be included in the dissertation. You can also choose to receive an electronic version of my dissertation once it has been defended and approved. For your information I have attached a
backgrounder summarizing the research and a consent form to fill out and return. If you have any questions you can contact me at ********** OR my supervisor, Dr. Judith Walker at **********.

I look forward to speaking with you soon! Regards, Victoria Wood, Doctoral Student | Department of Educational Studies | University of British Columbia
Appendix B – Backgrounder

UBC Health is setting out its strategic priorities, which include three areas of focus - education, research, and health systems - and many of the health units at UBC are starting to revise their strategic plans over the next two years, at a time when universities around the world are engaged in fundamental discussions about their role in society, what they are expected to accomplish for society, and how they are to be accountable to society (Maassen et al., 2019).

There is a large body of literature that discusses the relationship of universities with society and their role beyond education and research in contributing to society, which is often referred to as the ‘third mission’ of the university. However, this mission is highly contextual and not discussed specifically in relation to health units, thereby not providing a foundation from which the health programs at UBC may draw. Health units do often refer to a ‘service mission’ and the World Health Organization (WHO) suggests they have “the obligation to direct their education, research, and service activities towards addressing the priority health concerns of the community, the region, or nation they have a mandate to serve” (Boelen et al., 1995, p. 3). However, some authors suggest that in recent decades, the notion of a third mission has replaced the traditional, rather vague notion of university services to society. While the notion of ‘service’ is often connected to the tenure track process, whereby individual faculty members are evaluated on their contributions in three areas - research, teaching, and service to the university; the notion of the ‘third mission’ is about the institutional role of the university in society.

The goal of my doctoral research is to explore the role of the health units at UBC in contributing to society, beyond the education of healthcare professionals and health-related research. Specifically, I am interested in how UBC’s health units articulate a third mission on an institutional level; what is driving this mission; what strategic initiatives within these programs are used to operationalize this third mission; and
what leaders across the health units at UBC think this mission could be. Most importantly, my research aims to move from ‘what is’ to ‘what could be’, by exploring what leaders from different health units think the collective opportunities and possibilities are related to their role in society beyond education and research.
Appendix C – Consent Form

The third mission of UBC’s health disciplines: A role in society beyond education and research

Principal Investigator:  Judith Walker, PhD

Department of Educational Studies

University of British Columbia

Co-Investigator:  Victoria Wood, MA

Department of Educational Studies

University of British Columbia

Purpose: The purpose of this study is to explore the role of the health disciplines at UBC in contributing to society, beyond the education of healthcare professionals and health-related research. You are being invited to take part in this research study because you have experience at a senior level in setting direction, developing and communicating vision and implementing strategic direction in a health discipline at UBC.

Study Procedures: You are being asked to participate in a [60-minute one-on-one interview or 120-minute focus group] that will be audio recorded for transcription and data analysis. Any needed follow-up will be done by email. You will be provided with a written [transcript of your interview/summary of the focus group] and have the opportunity to edit, remove text or provide feedback.

Confidentiality: If you agree to participate in this study, your identity will be kept strictly confidential through the use of a pseudonym. Participants will not be identified by name in any reports of the completed study. The completed consent form will be kept separate from the data. All documents will be
identified only by code number, stored and secured in compliance with UBC’s Behavioural Research Ethics Board policies and kept for five years in accordance with UBC policy. The only other individuals who may have access to the data are the members of my supervisory committee: Dr Judith Walker; Dr Sandra Jarvis-Selinger; and Dr Lesley Bainbridge.

**Potential Risks:** There is the potential risk that, given the small sample and community size, certain comments may be traceable back to you. However, this research is not meant to evaluate your performance; rather, as experts, you are being asked to discuss an important topic relevant to your portfolio. The intent is to gather a deeper understanding about how your discipline articulates and operationalizes its role in society.

**Potential Benefits:** The benefits of participating in this study include an opportunity to share and discuss your understanding, values and beliefs about the role of your program in society and what you think that could be. It is hoped that the results of this study will help current and future leaders in the health disciplines envision the role of the institution beyond education and research.

**Remuneration/Compensation:** There is no monetary compensation for participating in this research.

**Use of the Results:** The results of this study will be presented in my doctoral dissertation for the Department of Educational Studies at UBC. They may also be used in publications or presentations for professional conferences and in articles for professional journals or other publications.
**Contact Information:** If you have any questions or concerns about this study or wish to have additional information before or during your participation, please contact me at ******* OR my supervisor, Dr. Judith Walker at **********.

**Contact for concerns about the rights of research subjects:** If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598 or if long distance e-mail RSIL@ors.ubc.ca or call toll free 1-877-822-8598.

**Participant Consent:** Your participation in this study is completely voluntary. You may refuse to participate or withdraw from the study at any time without providing any reason and without consequences. Your signature below indicates that you agree to participate in this study, agree to be audio-recorded, and have received a copy of this consent form for your own records.

Participant Signature  | Printed Name  | Date
Appendix D – Interview Questions

I will use semi-structured interviews that do not adhere rigidly to a pre-determined set of questions. Questions and prompts will be informed by the document analysis so leaders can respond to and build on the findings from this analysis. This semi-structured approach will allow me to delve into specific statements and topics in more detail as they arise. These are draft interview questions that may change during the research process. After summarizing the information provided in the backgrounder and ensuring informed consent, participants will engage in a semi-structured interview, during which the following questions will be used as a guide. Probing questions will be used to explore specific topics further, as they emerge.

1. What health discipline are you from and what is your role within the faculty/department/school? *(you will not be identified by name or title in the transcript)*
2. How would you describe the relationship between your faculty/department/school and society?
   a. How would you define the society with whom this relationship exists?
3. How does your faculty/department/school contribute to society?
   a. What kind of change or improvement does your faculty/department/school strive to influence?
4. What are some of the strategic priorities your faculty/department/school has that you would describe as something other than education and research?
   a. What kinds of activities are part of this?
5. What strategic priorities does your faculty/department/school have that are specifically about contributing to society?
   a. What kinds of activities fall within this?
   b. How are these priorities linked to the education and research mandates of your faculty/department/school?
6. What do you think the role of your faculty/department/school could be in society?

7. Are there any documents I should review? Any other people I should speak with?
Appendix E – Focus Group Invitation

Dear ______________,

I am a doctoral student in the Department of Educational Studies (EDST) at the University of British Columbia pursuing an EdD in Educational Leadership and Policy. I am contacting you with the hope that you might be willing to participate in a focus group, in your capacity as a leader within one of the health programs at UBC.

My dissertation research focuses on the role of health disciplines in society, beyond the education of healthcare professionals and health-related research. Starting with a case study approach of three specific health disciplines at UBC (nursing, pharmacy and physical therapy), my goal is to explore the way in which these programs define their role beyond education and research; how they articulate that role through their strategic plans; how they operationalize that role; and the drivers, as well as the dominant and competing discourses, that influence the way they do so. By engaging leaders outside these three disciplines through a focus group, my goal is to explore the collective opportunities and possibilities across the health disciplines at UBC related to their role in society beyond education and research.

I am inviting you to participate in a 120-minute focus group on [insert date] at [insert time] at [location]. The focus group will be recorded and transcribed, and analyzed in conjunction with data obtained from interviews and a preceding document analysis.

If you choose to participate, you will not be identified by name. I will also send you a summary of the focus group for your electronic feedback. At any point, you can withdraw your consent to participate and
your comments will not be included in the dissertation. You can also choose to receive an electronic version of my dissertation once it has been defended and approved.

For your information I have attached a backgrounder summarizing the research and a consent form to fill out and return. If you have any questions you can contact me at ********* OR my supervisor, Dr. Judith Walker at **********.

Regards,

Victoria Wood, Doctoral Student | Department of Educational Studies | University of British Columbia
Appendix F – Focus Group Protocol

After summarizing the information provided in the backgrounder and ensuring informed consent, participants will engage in a focus group that builds on the findings from the document analysis and interviews. The final focus group protocol and questions will be determined after the analysis of interviews. A summary of the focus group analysis will be sent to participants for additional comments or input.

Generally:

1. A draft description of the third mission of the health disciplines at UBC, based on the document analysis and interview data, will be presented at the beginning of the focus group.

2. Participants will be asked as series of questions based on the document and interview analysis, which may include:
   a. How does this description of the third mission of the health disciplines at UBC reflect what you think it is in reality in terms of how it is both articulated and operationalized?
   b. What you think the third mission of the health disciplines at UBC ‘should’ be?
   c. What influences what the third mission is in reality?
   d. How do you think the health disciplines at UBC could operationalize your ideal for the third mission?
   e. What would need to change for the health disciplines move towards your ideal third mission?