LEADERSHIP, COMMUNICATION AND HEALTHCARE:

UNDERSTANDING THE ROLE OF COMMUNICATIONS IN BUILDING COLLABORATIVE HEALTHCARE TEAMS

By

CHRISTINA PELLEGRINI, B.J., M.A. (c)

Supervisor: Dr. Terence (Terry) Flynn

A Major Research Paper/ Project

Submitted to the Department of Communication Studies and Multimedia

in Partial Fulfillment of the Requirements

for the Degree

Master of Arts

in Communication and New Media

McMaster University

Table of Contents

Introduction

Communication is imperative in all aspects of society and miscommunication can cause significant damage, however, in healthcare, effective communication can make the difference between life and death (Palanisamy & Verille, 2015). Good, effective communication ensures that all parties, including doctors, nurses and other allied health professionals understand the "plan of care" which will reduce the risk of errors (Leonard, Graham & Bonacum, 2004, p. i86). Conversely, poor communication or lack of communication can cause procedures to go awry and is closely associated with "high patient morbidity and mortality" (Rabøl, McPhail, Østergaard, Andersen & Mogensen, 2012, p. 129). In order to provide adequate care to those in need, healthcare has adopted a model focused on teamwork and collaboration (Liedtka & Whitten, 1998; Davoli & Fine, 2004; Leonard, Graham & Bonacum, 2004; San Martín-Rodríguez, Beaulieu, D'Amour & Ferrada-Videla, 2005). This can be attributed to: financial constraints (Davoli & Fine, 2004), the increased specialization of healthcare professionals (Gawande, 2012) and ample research that has proven that "effective teamwork is associated with reduced medical errors," (West & Lyubovnikova, 2013). Moreover, as it will be argued in this paper, effective teamwork and collaboration require communication (Davoli & Fine, 2004).

Through the research identified, communication is one of the key factors that is imperative for teamwork and collaboration (Suter, Arndt, Arthur, Parboosingh, Taylor & Deutschlander, 2009; Battilana, Gilmartin, Sengul, Pache, & Alexander, 2010; Lake, Baerg, & Paslawski, 2015; Palanisamy & Verille, 2015). However, the challenge is how professionals and key stakeholders working within interdisciplinary healthcare teams, who have valuable information to contribute, effectively communicate their opinions to ensure that patients are receiving timely, necessary and consistent care. Although corporate communicators, including

hospital presidents and vice presidents, are equally worthy of discussion and analysis, this paper is limited to those involved in managing front line care providers.

Those responsible for managing front line care providers, often those in manager or director positions, must ensure that these providers are equipped with the proper resources and are aware of changes being implemented from the top. These changes, as well as the execution of daily tasks must be communicated among the teams. Despite the fact that communication is essential to healthcare, it has not been until recently that interdisciplinary communication among colleagues has been taught. In the past, communication in healthcare focused on the communication between healthcare providers and patients (Suter et al., 2009) and healthcare professionals have seldom been trained together (Baker, Day & Salas, 2006). It is imperative that front line care providers have the necessary skills to engage with one another. In addition, it is essential that the directors leading these teams, have the necessary skills to facilitate this engagement, inspire their subordinates and create a positive team environment in which these teams can flourish and thrive to deliver the best care possible to those who need it the most. In short, "collaboration has been widely viewed as one of the primary vehicles through which hospitals can meet the extraordinary challenges they face in today's environment" (Liedtka & Whitten, 1998, p. 185).

This project was inspired by the document *Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) 2015-16 Annual Business Plan*, released June 2015 and *Patients first: A proposal to strengthen patient-centred health care in Ontario* which was released December 17, 2015. Both documents highlighted major changes in healthcare focusing heavily on collaboration between healthcare providers. For example, the *HNHB LHIN 2015-16 Annual Business Plan* states that "integrated service delivery means the system will focus on

patient-centered care. This includes supporting a new model of care to improve care for high-needs patients, with an initial focus on seniors and patients with chronic conditions" (2015, p. 12). Although both documents focus heavily on the integration between the LHINs, community care and public health, there are still underlying questions that remain. For instance, even within provincially governed organizations, like local hospitals and Long Term Care Centres (LTCs), how is collaboration achieved and how is it facilitated?

Through the literature reviewed, there has been extensive research conducted on both healthcare leadership and interdisciplinary healthcare teams respectively. This particular project was unique because it focused on leaders within the HNHB jurisdiction asking for their subjective opinions and utilized in-depth interviews. Through this qualitative approach, two major themes emerged from the data, which will be discussed in greater detail. The driving question behind this paper is: **What role does communication play in effective leadership in healthcare within an interdisciplinary team setting?**

Literature Review

To begin, it is important to understand that healthcare is moving towards interprofessional teams (Liedtka & Whitten, 1998; Kenny, 2002; San Martín-Rodríguez, et al., 2005; Kvarnström, 2008; Lake, Baerg & Paslawski, 2015). With that being said, it is important that these teams are able to work cohesively to provide adequate care for those in need. Furthermore, these teams must have a leader that is able to guide them effectively (Elwell & Elikofer, 2015). This literature review will provide a theoretical framework by defining and examining the necessary components of effective communication within teamwork. Then, it will provide a brief historical context of professionalization by examining the role that unique professional identity plays in teamwork. It will do so by highlighting the importance of the role

of leadership in teamwork by considering: role appreciation and understanding. Emotional intelligence and its relationship to leadership and communication will also be discussed in greater detail.

Effective communication within teamwork in healthcare

Throughout this section effective communication strategies will be discussed, with a focus on spoken communication.

To begin, poor communication can have detrimental effects, such as poor patient care delivery, an increase in errors and a lack in team confidence and morale (West, Borrill, Dawson, Brodbeck, Shapiro & Haward 2003; Leonard, Graham & Bonacum, 2004; Haeuser & Preston, 2005; Suter et al., 2009; Battilana et al., 2010; Rabøl et al., 2012; Palanisamy, & Verille, 2015; Lake, Baerg & Paslawski, 2015). Lake, Baerg & Paslawski (2015), in their book *Teamwork, Leadership and Communication*, argue that good communication can lead to positive outcomes and a strong sense of team engagement. They define communication as "the act of exchanging information through a shared system of signs: words, gestures, and other behaviors" (Lake, Baerg & Paslawski, 2015, p. 47). However, despite people's best intentions, what they say and how others receive their message are rarely flawless. Although communication is, at times, imperfect, there are ways to mitigate these misinterpretations. The chance of a miscommunication increases the larger the team is. West & Lyubovnikova (2013) argue that the ideal number of people working within a team is between 8 and 12. Lake, Baerg & Paslawski (2015) argue that in a dyad it is more easily recognizable if information has been misinterpreted and it is easier to "repair failures" in most instances (p. 47). However, since most teams in hospitals are comprised of teams larger than a dyad, it is imperative that teammates engage in additional effective communication strategies.

Leonard, Graham and Bonacum (2004) argue that in order to mitigate miscommunication, professionals must acknowledge that they are trained differently. For instance, nurses are "taught to be very broad and narrative in their descriptions" (p. i86). Conversely, physicians are trained to be concise, summarizing the situation in a "headline" (p. i86). In order to bridge this gap, tools such as Situation, Background, Assessment, Recommendations (SBAR) are particularly useful. (Leonard, Graham & Bonacum, 2004; Pope, Rodzen & Spross, 2007; Boaro, Fancott, Baker, Velji, &Andreoli, 2010). SBAR is a communication strategy that is used when a nurse is speaking to a physician about an at-risk patient over the phone. The 'S' refers to situation, meaning that the health professional should introduce themselves (Pope, Rodzen & Spross, 2007; Boaro et al, 2010). Then, the 'B' refers to the background, meaning that the nurses should provide the background of the situation, by providing context, such as when said patient was admitted. Then, the nurse should offer an assessment (the 'A') of the situation. Pope, Rodzen and Spross (2007) argue that words like, "might be or could be" are useful (p. 41). Furthermore, if the situation is dire, the nurse needs to indicate that. Finally, the recommendation (the 'R') needs to be stated. Prior to ending the call, the nurse should provide the physician with a recommended course of action, such as asking them to see the patient or moving the patient to another department. In short, in healthcare, effective communicators must be specific in terms of what they are trying to say and be wary of their audience to ensure they are all speaking a language that all parties involved can understand.

There is ample literature that explains how to effectively communicate to ensure that one's voice is heard. Haeuser and Preston (2005) have identified five different strategies of effective communication, which include: persuasion, planning together, openness and collaboration, communicating difficult news effectively and building relationships. Firstly, the

person being persuaded is the one in control. In order to persuade someone effectively, the communicator must identify a common ground and justify their reasoning to show how the ultimate goals can be achieved. Dianna Booher (2015), a business communications expert, argues that persuasion is largely about thinking. The communicator needs to consider their audience and brainstorm ways in which they should adjust their message accordingly to persuade effectively. The second strategy is to ensure that planning occurs together rather than independently to reduce excluding people and ensuring that all parties are present to address their concerns. In order to achieve openness and collaboration, the team should work less like a hierarchical structure and those initiating the change should try to encourage a two-way conversation to clarify any confusion. If there is bad news that needs to be communicated, those communicating the message should be honest about mistakes and avoid scapegoating others. Those delivering the difficult news should try to anticipate people's reactions so that they can plan accordingly. Finally, relationships should be built before the crisis occurs because these interpersonal relationships become a way of bridging gaps. After all, effective communication "is an essential element of the healthcare environment" and is potentially life-saving (Palanisamy & Verille, 2015, p. 9).

According to Leonard, Graham and Bonacum (2004), healthcare professionals need to ensure that they are speaking the same language. They discuss that recently there has been a common language that has developed in aviation and that healthcare needs to follow suit. CRM (crew resource management) has been linked to positive aviation flight crew performance which Leonard, Grahan & Bonacum (2004) believe offer some valuable insights to healthcare. They argue that effective communication is "getting everyone in the same movie" (p. i86). When people are 'in the same movie' they will be exposed to the same information. Moreover, with the

increasing complexity of care, developing a fundamental language, standard tools, and empowering certain occupations that might perhaps feel inferior (such as nurses), will all help provide a safe environment, meaning it will help improve patient safety. However, "for this cultural change to be successful, leadership and physician involvement is critical" (Leonard Graham & Bonacum, i90). In short, Leonard, Graham and Bonacum, (2004) argue that often "poor outcomes are accompanied by fundamental communication failures," (p. i87) and in order to mitigate those risks, the development of a common language is imperative.

West and Lyubovnikova (2013) are concerned with teamwork within healthcare in the United Kingdom. They state that "the fact is that healthcare teams are often very ineffective, with research showing that 70 percent of medical errors can be attributed to poor teamwork" (p. 135). As indicated earlier, an organization cannot simply put a group of people together, refer to them as a team and assume that they will work well together (Liedtka & Whitten, 1998; Kenny, 2002; West & Lyubovnikova, 2013). Policy is necessary, but front line providers' perspectives need to be considered, because often what is put in place is a utopic vision and it is executed differently from when it is being written up (Kenny, 2002). In their research West and Lyubovnikova (2013) identify a variety of characteristics that effective teams have including: a mutual problem they are working towards, the make-up of the team and the support they have.

The key is that teams need to have a common goal in place that they need to achieve otherwise they could work independently. "Being clear about values, contribution and goals will help nursing to avoid being caught in the crossfire between medical power and economic flexibility," (Kenny, 2002, p. 35). The second characteristic, team composition, is important because the group of people working together must have the combined knowledge among them to complete and execute the task. Additionally, West and Lyubovnikova (2013) argue that the

team size does play a role and the team should not consist of more than 12 members. If there are more than 12 members there might be multiple people responsible for the same role, which will likely create competition, or team engagement (from those specific roles) may decline. Finally, the team requires the necessary support from their organizational structure. "Team, rather than individual, efforts should be acknowledged through a reward system that encourages team members to work collaboratively and recognizes their task interdependence" (West & Lyubovnikova, 2013, p. 138).

Additional effective communication strategies include being concise and direct while communicating with others. Booher (2015), suggests that whether it is a meeting with a small group or a keynote speech, the speaker needs to ensure that they choose one point, theme or idea and allow that one aspect to be their "road map" (p. 45). In addition, she states that "repetition on multiple channels of communication breaks through the protective shield that most people wear" (Booher, 2015, p. 50). By adhering to these suggestions, communicators, who have valuable information to contribute, will be heard more clearly.

Brown, Lewis, Ellis, Stewart, Freeman and Kasperski (2011) argue that conflict within a team is inevitable, highlighting potential solutions to these conflicts by stating that the director's role within these teams is less about the clinical aspect and more about being present, exercising good listening skills and not being judgmental, which includes "open and direct communication," (p. 9). Baker, Day and Salas (2006) argue that teamwork is an essential part of high-reliability organizations (HRO) such as hospitals. They state that a "team consists of two or more individuals, who have specific roles, perform interdependent tasks, are adaptable and share a common goal" (p. 1578). With that being said, it is important that each of the members of the team is performing their necessary duty to ensure cohesion and smooth sailing. Moreover,

Liedtka and Whitten (1998) also remind us that "while collaboration cannot be mandated or imposed it can be supported" (p. 185). This in turn emphasizes the importance of leadership in healthcare, and their role in facilitating role understanding, which will be covered in greater detail in the following sections.

Leadership and its role in facilitating understanding and role appreciation in professionalization

The following section will address the unique challenges that healthcare professionals may face while collaborating, in terms of their training, their values and their philosophies as well as the challenges that their leaders have in facilitating interdisciplinary communication. The importance of effective communication and role appreciation within a team will be discussed in greater detail.

Pippa Hall (2005) argues that there is often some difficulty with collaboration, especially when it involves professionals that have unique training and approaches towards care. After the industrial revolution, capitalism fostered competition and with this grew the development of the 'profession'. A *profession*, as Hall defined it is "an occupational monopoly over the provision of certain skills and competencies in a market for services" (2005, p. 188-89). By limiting the number of people that could practice these skills, the professions became niche, and mentors (of the specific occupations) taught their students in a particular way, applying and emphasizing particular philosophies.

After the industrial revolution, healthcare was organized around the needs of those providing the care (Hall, 2005). It was only recently that healthcare shifted to address the needs of the patient. Each healthcare profession has a distinct schema, or approach to a problem. With collaborative care, the issue becomes trying to assimilate these different approaches. There are also the unique values that are held by professions (Maccoby, 2007; Baxter & Brumfitt, 2008;

Col, Bozzuto, Kirkegaard, Koelewijn-van Loon, Majeed, Jen Ng & Pacheco-Huergo, 2011). For example, physicians normally assume a more authoritarian role, whereas social workers and psychologists want the patient to assume more responsibility for their health and their actions. "Traditionally, areas such as preventative health […] have not held much attraction for physicians as they do not have obvious live-saving outcomes, thus merit little attention" (Hall, 2005, p. 191). Additionally, it is important for all professionals to remember that often the patients' needs are extremely complex and require the expertise of multiple professionals. Atul Gawande, a surgeon from Boston, discussed the changing environment of healthcare and stated that in the 1970's, two clinicians would check on a patient during their stay at the hospital, whereas nowadays that number has increased to 15 clinicians (Gawande, 2012).

In the past, both physicians and nurses have tended to work from within their own professional silos, rather than being more patient oriented (Liedtka & Whitten, 1998; Baker, Day & Salas, 2006, Baxter & Brumfitt, 2008). Conversely, if roles and responsibilities are not established, people might burn out or their expertise might be underused (Hall 2005; Suter et al, 2009). Throughout the literature reviewed, a key theme that was repeated was that professionals need to put aside the mentality that their role is the most important (Hall, 2005; Suter et al., 2009). The focus should be on the patient's needs, which often requires a variety of professional involvement. Additionally, another dimension is that the majority of communication skills taught to these professionals are generally focused on communicating with the families or the patient, rather than interdisciplinary communication (Suter et al., 2009). Thus, it is imperative that leaders facilitate role understanding to ensure effective collaboration. Moreover, in order to mitigate burnout, role confusion and to help facilitate role appreciation, a "transformational leader allows a certain amount of individualized focus for each team member, so that each feels

important and necessary to the team overall" (Prati, Douglas, Ferris, Ammeter & Buckley, 2003, p. 28).

Suter et al., (2009), conducted 60 in-depth interviews that focused on establishing the important competencies involved in collaboration. Through this research, two key themes emerged: communication and an appreciation of each other's roles. These two themes are somewhat intertwined as well. For example, if there is a lack of communication there might be some confusion about the roles of the individual parties involved. Additionally, this can make relationships within the group and with the patient more difficult to develop and this could lead to more misunderstandings (Suter et al., 2009). The researchers argued that to ensure there was clear understanding between the group members, the group members need to adjust their language and avoid using technical or professional specific jargon. Also, Suter et al. (2009) emphasized the importance of setting clear expectations of who is responsible and accountable for what among the group. Frankel, Leonard and Denham (2006) consider accountability within teamwork in great detail. They define accountability as "based on a relationship of two or more parties in which the product of one party—individual or group—is evaluated by another party" (2006, p. 1693). Frankel, Leonard and Denham (2006) state that there are three components of accountability including: the person who is being held accountable knows they are expected to do something, they clearly understand what is expected of them and they are aware of how they will be evaluated. In short, if there is poor communication and a lack of delineated expectations within the healthcare industry, the results can be fatal in the most severe circumstances (West et al., 2003, Hall, 2005; Haeuser & Preston, 2005; Suter et al., 2009; Palanisamy & Verille, 2015).

Furthermore, Worchel, Rothgerber, Day, Hart and Butemeyer (1998) looked at social loafing within group settings. Social loafing can be defined as "the tendency to reduce one's

effort when working collectively compared with coactively on the task" (Karau & Williams, 1993, p. 683). Worchel et al., (1998) argue that those who do not have a strong identity within their team, such as teams that have not clearly delineated roles, were not as motivated to achieve team goals. He considered Social Identity Theory (SIT) and argued that in some instances, when people have a very strong social identity to a particular group, they have even become martyrs or given extensive resources for the sake of that particular group. Through this research, Worchel et al. (1998) argued that people are less inclined to be productive in a team setting if they are working with "a collective group of unrelated individuals" (p. 395). However, this completely changes when group members see themselves as a group and working towards a common goal. Interestingly, Worchel et al., (1998) found that the productivity was higher when the team was working towards a common goal, rather than a personal incentive. If the group was told that they would continue to work together in the future, they would be more inclined to rely on one another, which would further foster interdependence.

In addition, Svan Lembke and Marie Wilson (1998) argue that a team should be considered its own individual unit. This research drew heavily on Social Identity Theory (SIT) and examined how SIT plays a significant role in shaping teamwork. Lembke and Wilson (1998) provide two major contributions to this area of study: the role that membership characteristics play within teams and the distinct thought process of the team unit. The first contribution argues that those included in the team must think like the team and understand their role within the team. Furthermore, team goals, team design and task requirements play a big part in shaping team norms. Once everyone understands their role and their contribution to the team, their team identity, which differs from their individual identity, will be more explicitly understood, by themselves and by their colleagues.

The second contribution is that the team 'unit' has its own thought process "a process different to the mere sum of team member's cognition." (p. 941). When a team is working together, the individual team members should be encouraged to voice their opinions, to avoid uniformity or 'groupthink' (Lake, Baerg & Paslawski, 2015). This team thought process is a process that is driven by the collective goal or objective. Through their findings, Lembke and Wilson (1998) state that managers "have to change the way they present information to potential team members in order to achieve optimum team conditions" (p. 941).

Jeanne Liedtka and Elizabeth Whitten (1998) argue that collaboration does not just happen; it is not adequate to simply put a group of individuals together and expect that they will work well. Also, it is ineffective to simply implement a collaborative policy from the government or management and expect the team to thrive together. They state that "true collaboration originates in the mind of the collaborator rather than the structure of the organization" (Liedtka & Whitten, 1998, p.185). Additionally, they argue that team goals play a big part in shaping team norms and those who do not have a strong identity within the team, such as a delineated role, are not as motivated to achieve team goals (Worchel et al.,1998).

Through Liedtka and Whitten's (1998) research they interviewed and obtained information via questionnaires from physicians, nurses and hospital administrators. They found that although all three groups might be resistant to change, this resistance has derived from different factors. For instance, nurses expressed anxiety in relation to change because they were unclear about what their new roles would be (lack of job identity/stability), whereas physicians tended to view collaboration as reducing their authority. These findings further reinforce that trust, a common goal and a sense of personal accountability are important while working as and within a team. In short, it is clear that each of the professions identified has a strong sense of self in their role and

are hesitant to change.

Collaboration is necessary to achieve and deliver care in the changing healthcare landscape – with fewer financial resources and increased professionalization – however, as Liedtka and Whitten (1998) argue this collaboration requires support from the organizational culture. In summary, if roles are clearly defined in healthcare settings and teamwork is emphasized, it is clear that common goals can be achieved and that teams will rely more heavily on one another. However, it is clear that communication plays a key part in defining roles and fostering interdependence. The following section will discuss this in greater detail.

Leadership and communication

This section will briefly look at leadership within healthcare. To begin, it is imperative to define exactly what type of leadership this paper is concerned with, considering there has been extensive research done on leadership within the past 30 years or so (Conger & Kanungo, 1998). Michael Maccoby (2007), a psychoanalyst and anthropologist, in his book entitled, *The Leaders We Need*, argues that there are many definitions of a leader. His definition is rather simple: a leader is "someone that people follow" however that statement poses two additional questions: why and how? (p. xvi). Maccoby argues that, "leaders are most effective when they and their followers become collaborators who share a common purpose" (2007, p. xvii). At the core of this statement is that the key competency necessary for a leader, in the current environment, is their ability to understand their followers (p. 70). By understanding their subordinates, they have the potential to improve communication and collaboration.

Additionally, the modes of production have changed. "In every field, knowledge has exploded, but it has brought complexity, it has brought specialization," (Gawande, 2012). Our society puts significant emphasis on knowledge workers, like those working in healthcare.

Today, as a result of technological innovation, people are able to disseminate information at the click of a button to audiences worldwide. Through increased medical specialization, people are able to live longer and healthier lives. These same people "want healthcare organizations to perform what in the past would have been thought miraculous" (Maccoby, 2007, p. 94). As a result of changed modes of production people need to be led by "role models who engage them as colleagues in meaningful corporate projects, ideally creating a collaborative community" (Maccoby, 2007, p.11).

Additionally, Mary Atikson Smith (2011) focuses on the role of leadership specifically looking at nurse management. Smith (2011) argues that healthcare is becoming increasingly more complex and in order to meet the increasingly unique needs of patients and "adapt to change" nurse managers must display a transformative leadership style (p. 44). Smith (2011) sums up this transformative leadership style into four traits: effective communication, being inspirational, being trustworthy and engaging all the relevant stakeholders. She argues that an effective communicator is a person that is able to modify their language based on who they are talking to. They consider and respect the way people from diverse cultures communicate when they are interacting with people from those cultures; they avoid sarcasm, they ask rather than tell and avoid talking "down" to the people they are managing. They must do this by monitoring themselves and looking at their staff to see how the staff reacts to their (the leader's) statements. Also, these leaders must be less defensive and "more receptive to criticism and change" (p. 47). Successful leaders also regularly meet with their staff in-person and listen to the staff's concerns and feedback. Inspirational leaders are people who can reflect on themselves and are constantly willing and able to learn. A trustworthy leader, according to Smith (2011) is someone who is honest, "up front" and sets realistic expectations for their team. Finally, a leader who is able to

consider and engage all relevant stakeholders, especially during times of change, should promote teamwork. With a group of people working together to serve the needs of the population, these front line staff see people's needs and by collaborating they might have unique ways of doing things. In short, "teamwork is at the core of success" (Smith, 2011, 50).

Emotional intelligence within leadership and its ties to communication and teamwork

In this section, emotional intelligence (EI) will be examined in relation to its role in leadership. To begin, Daniel Goleman, Richard Boyatzis and Annie McKee (2002) define EI as "how leaders handle themselves and their relationships" (p. 6) and argue that generally "people take their emotional cues from the top. Even when the boss isn't highly visible" (p. 8). Furthermore, followers tend to view their leader's reaction as "the most valid response" and they tend to mimic their own response to that of their leader (Goleman, Boyatzis & McKee, 2002, p. 9).

In an organizational setting, such as a hospital, emotional and behavioral intelligence is imperative (Collins, McKinnies & Collins, 2012; Delmatoff & Lazarus, 2014). Despite the fact that some leaders might dismiss or downplay the importance of emotional intelligence, perhaps considering it "squishy", there seems to be a trend that leaders "are finding a strong value and return on investment in not just understanding emotional intelligence but incorporating it into their leadership style" (Delmatoff & Lazarus, 2014, p. 246). They argue that emotional intelligence must be translated into behavioral intelligence because experiencing emotions happens from within: then these emotions must be translated into something that can be projected outwards. They go on to argue that the process begins with self-awareness, or an understanding of how their own personal behavior affects others (p. 247). Leaders need to consider the way that others will react to changes and modify their execution style accordingly.

In short, they argue that leaders encounter a variety of people and in order to ensure they are able to get through to all of them they need to use different approaches and avoid using a "one size fits all approach to management" (p. 248). Moreover, as stated by Lake, Baerg & Paslawski (2015) "skilled communicators are mindful of the connotative meaning and potential ambiguity when they choose which words they use" p. 53). Through the literature reviewed, it is quite obvious how vital EI is for a leader to communicate effectively and persuasively.

Prati et al., (2003) argue that emotional intelligence is foundational and an essential trait for an effective leader. That being said, with the constantly changing environments in the workforce, employees need to be able to adapt to these changes, which can be facilitated more easily through effective leadership (p. 21). Prati et al., (2003) also state that communication is a key part of teamwork and argue that people with high levels of emotional intelligence "are able to communicate effectively and empathize with others," (p. 22). As mentioned earlier, effective communication is necessary in the healthcare environment where people's lives are in the hands of their healthcare providers.

Prati et al. (2003) explain that a key aspect of emotional intelligence is self-awareness. As mentioned earlier, there are certain rules that society has deemed acceptable and unacceptable. Emotionally intelligent people are aware of those rules and through emotional regulation, (a self-awareness of their own and other's emotions) are able to restrain themselves and do not display 'unacceptable' emotions to the public. Emotionally intelligent people use feedback, are self-aware and are able to regulate themselves. For instance, if someone does something and they are ridiculed they experience embarrassment. Emotionally intelligent people are able to accept the feedback and use that feedback to change their behavior in the future and modify their actions because they understand how "their actions are received in social settings" (p. 24).

Both George (2000) and Prati et al., (2003) argue that there are four key aspects of emotional intelligence. It is important to point out that each of these aspects are closely related to one another. The first is a self-awareness of their own and other's emotional states. It is the ability to understand their emotions and communicate them in a way that will "meet their needs and accomplish their goals or objectives" (George, 2000, p. 1034). People with high EI can accurately communicate how they are feeling using language, which helps build and foster interpersonal relationships among others (Prati et al., 2003). Also, related to this first aspect, George argues that empathy plays a large role in emotional intelligence. If people have the ability to situate themselves in another's situation, they show EI and are often able to provide effective support for that person (George, 2000; Prati et al., 2003).

The second aspect, according to George (2000) and Prati et al., (2003) is that someone with EI is highly knowledgeable about emotions, "meaning the leader is able to predict emotional reactions in various scenarios" (Prati et al., 2003, p. 25). These people have the ability to anticipate how others are going to react to a particular situation, which once again, is closely tied to empathy. Additionally, a leader with high EI will also understand that when they are not in a positive mood they will come across negatively to their subordinates. For instance, George (2000) argues that a leader in a bad mood who decides to postpone a meeting with their subordinates to discuss future changes "until they are feeling better intuitively realizes how their ability to enthusiastically communicate information about the changes and garner their followers' support is influenced by their current feelings" (p. 1037).

The third aspect of EI as indicated by George (2000) and Prati et al., (2003) points out that people with high EI are often able to use emotions effectively. They are able to use emotions properly and understand that positivity in the workplace fosters creativity and people who think

positively have a stronger sense of self-efficacy (George, 2000; Prati et al., 2003). By exercising positivity, they facilitate an environment that is more supportive and fosters innovation (Prati et al., 2003).

The final aspect is those leaders with high EI have the ability to manage their own emotions and the emotions of their team members (George, 2000; Prati et al., 2003). A person with high EI will "excite or enthuse people or make them feel cautious and wary [which] is an important interpersonal skill and a vehicle of social influence" (George, 2000, p. 1038). This final point shows how these four aspects are closely related because if a person is unable to express their emotion, be knowledgeable about emotions or use them in a constructive way then they would be unable to excite their subordinates. For example, consider Goleman, Boyatzis and McKee's (2002) scenario from their book, *Primal Leadership* in which they discuss a situation that occurred at the British Broadcasting Corporation (BBC) in England, where an experimental news division was being shut down and 200 people lost their jobs (p. 3). The organization sent one executive to deliver the bad news but this executive focused on the success of their competitors and was bragging about his recent trip to the Cannes. Goleman, Boyatzis and McKee (2002) explained that not only were the 200 or so people upset with the message, they were upset with the messenger. Conversely, the following day, another executive was sent to talk to the employees. This executive's approach was very different as he acknowledged the importance of journalism, and that journalists have rarely had security in their field but have passion. Moreover, he expressed his gratitude for their dedication. Not surprisingly, the outcome was entirely different and the crowd "cheered" for this leader at the conclusion of his speech. (p. 4).

Additionally, laughter is a way to develop trust with subordinates and facilitate an immediate connection, when used at the appropriate time in the appropriate context. "A good

laugh sends a reassuring message: We're on the same wavelength, we get along. It signals trust, comfort, and a shared sense of the world…" (Goleman, Boyatzis & McKee, 2002, p. 11). Moods impact how people work, and "upbeat moods boost cooperation, fairness and business performance" (Goleman, Boyatzis & McKee, 2002, p. 11). Goleman, Boyatzis and McKee (2002) who referred to a study from Yale on moods and business management, state that laughter is contagious and signals a level of comfort and trust. Therefore, provided the humour is used at a sensible time and in a sensible context, if people laugh with someone it means they trust them.

Prati et al., (2003) argue that leaders must be motivational in a variety of ways such as being persuasive and displaying positivity. People learn from their leaders (Goleman, Boyatzis & McKee, 2002; Delmatoff & Lazarus, 2014) and positivity is contagious (Prati et al., 2003). For instance, it should come as no surprise that, in healthcare, environments are constantly changing. Additionally, as mentioned by Prati et al., (2003) and Heather Pullen, a 20-year health communications practitioner (personal communication, January 8, 2016) people, specifically in healthcare, tend to be resistant to change. If a leader is able to express enthusiasm for a new program or regime by communicating to their team in an "upbeat manner", these people will be more in favour of the change (Prati et al., p. 29). However, as indicated by George (2000) these leaders have to be able to anticipate how their subordinates will react as well as be able to effectively express how this change will positively benefit them, by appealing to their emotional side. Moreover, these leaders must be persuasive by being able to appeal to their subordinates' logical side. By explaining the problems with the current system, they might be able to mitigate the resistance (Booher, 2015).

Conversely, leaders who are unable to contain their emotions and exhibit a lack of emotional constraint tend to be seen as ineffective leaders who lack effectiveness. This is true for

any situation, but it is imperative that leaders are able to maintain their "cool" during a crisis. For example, Sandra Watt, Chief of Organizational Development at the Thrive Group, spoke about enterprise risk management at a presentation hosted by the Thrive Group, entitled *Crisis Management: The Human Factor* (May 4, 2016). Watt stated that a leader must stay calm and collected especially during a crisis because their actions very much impact the actions of their subordinates.

One of the practical implications that Prati et al., (2003) identify is the importance of gauging potential employees' emotional intelligence in the recruitment process. By considering this aspect and carefully selecting new people to join their team they might be able to mitigate workplace burnout or conflict. This is especially important within healthcare where there is ample stress and pressure because these professionals are directly dealing with the lives and care of others. In short, emotional intelligence plays a role even in the selection process because it is imperative that these leaders are able to select team members that will work collaboratively.

Research Problem and Methodology

Due to fiscal cuts (Davoli & Fine, 2004), increasing professionalization (Gawande, 2012) and the push from the government for collaboration, (*Patients First: A proposal to strengthen patient-centred health care in Ontario*, 2015) directors, managers and chiefs in a hospital setting play an increasingly important role in facilitating and encouraging teamwork. This paper seeks to identify what these leaders value the most in terms of communication and collaboration traits. Through qualitative interviews, with a sample of managers and directors from a range of hospitals and a Long Term Care (LTC) centre, which the author has access to in the Hamilton Niagara Haldimand Brant (HNHB) region, the researcher sought to discover what traits they valued the most and which strategies they used to facilitate this teamwork.

Research Problem

The main research problem that this project has examined is:

What role does communication play in effective leadership in healthcare within an interdisciplinary team setting?

In order to address the main question this research project has two overarching research questions with six sub-questions that were posed to health professionals involved in communication roles:

RQ1: How do you facilitate role appreciation among team members?

- How do you ensure accountability among team members?
- How do you build up competencies?
- How do you educate a team on working together? How do you foster empathy among them?

RQ2: What role does emotional intelligence play in communication?

- How do you adjust your communication so that all parties involved can understand your message?
- How do you overcome personality differences while working with a team? How do you overcome professional differences?
- What does effective communication mean to you?

Methodology

Research Design

In order to answer all the questions addressed above, this research project was approached by using a qualitative study. In-depth interviews were conducted to see what leaders (including chiefs, managers and directors) of unique collaborative teams had to say. Please refer to Appendix B for an interview guide. The questions included in the interview were derived from

the literature.

Review of the Methodology

In-depth Interviews

In-depth interviews have a lot of benefits including obtaining a great deal of material in a short period of time from a wide group of people (Bryman, Bell & Teevan, 2012). By asking open-ended questions, these interviews function less like a structured interview and more like a conversation providing the researcher with a large quantity of information (Taylor & Bogdan, 1998). However, this method can be intrusive and often the participant will provide the interviewer with a response they think he or she might want to hear (Taylor & Bogdan, 1998). In order to mitigate this, the researcher tried a few strategies such as: immediately developing a rapport with the participants (Weerakkody, 2009), not being judgmental and ensuring confidentiality in all circumstances (Taylor & Bogdan, 1998). Additionally, since the interviews were semi-structured, if the participant made a comment that was unclear to the researcher the researcher would follow-up with comments or questions to try to further understand their participant's point of view. The researcher was struck by the richness of these responses, hence the reason why a single method was utilized.

Essentially, the main question the researcher was attempting to answer was: **What role does communication play in effective leadership in healthcare within an interdisciplinary team setting?**

Participants and Data Collection

In this study, the principal investigator restricted their research to the Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) jurisdiction for two

reasons: its convenience to the author and its interesting demographics[1]. The sample of participants obtained was convenient given that the researcher is from the area. The HNHB LHIN also accounts for 11% of Ontarians, making it the third largest LHIN in the province which serves over 1.4 million residents, and covers nearly 7,000 square kilometres in area. (*HNHB LHIN 2015-16 Annual Business Plan*, 2015). Additionally, the population within the HNHB LHIN jurisdiction is aging, which is also why this jurisdiction was of particular interest. Generally speaking, as people age, the incidence of comorbid diseases or chronic conditions rises (Chappell & Hollander, 2013) and require the expertise of a variety of healthcare professionals (Chappell & Hollander, 2013). Moreover, they are "projected to have amongst the highest numbers of seniors of all LHINs in Ontario from 2011 to 2017 [which is expected to grow] from more than 230,000 to over 275,000 in 2017" (*HNHB LHIN 2015-16 Annual Business Plan*, 2015, p. 6).

Prior to conducting the interviews for the purpose of this project, background interviews were conducted with three local healthcare communications directors to gain a better understanding of the healthcare environment and to determine points of interest, such as the challenges of communication within an interdisciplinary healthcare setting. Additionally, the principal investigator attended a local healthcare event, entitled *Crisis Management: The Human Factor Managing a Crisis in Health Care Settings* hosted by the Thrive Group on May 4, 2016, to further establish sensitive points in the healthcare sector and to meet with potential participants.

Following this, seven local healthcare communications directors were contacted. These communications directors were asked to forward the principal investigator's recruitment email to

[1] Due to these unique demographics this sample is not representative of other regions in Ontario or across Canada

their list of contacts of people who would be relevant to the study (please see Appendix A). This study focused exclusively on the institutional side rather than front line providers to observe the role that communication plays in leadership within healthcare. The principal investigator sought professionals with titles such as "chief", "director" or "manager". Upon receiving the recruitment email, professionals who were interested would contact the investigator to coordinate a time and date that would work for them to participate in the study.

In-person interviews were conducted between May 26, 2016 and June 23, 2016 and took place in the participants' offices. Thirteen in-depth interviews were conducted in total, ranging from 35 minutes to 90 minutes (see Table 1 for basic participant information; refer to Appendix B for the interview schedule). Prior to the interview, participants were reminded of the scope of the study and were asked to sign a consent form. Additionally, they were asked if the interview could be recorded. Of the thirteen participants, twelve gave permission to be recorded. The interviews were recorded using a program called *Audio Note Notepad and Recorder* and field notes were taken by the investigator during the interviews. The protocol for recruitment and interviewing participants was reviewed by the McMaster University Research Ethics Board (MREB).

The interview questions were derived from the literature. The interviews were semi-structured in nature, meaning, "the researcher has a list of questions or fairly specific topics to be covered (an interview guide), but the interviewee still has a great deal of leeway in deciding how to reply" (Bryman, Bell & Teevan, 2012, p. 166). The questions were open-ended which are particularly advantageous because the respondents can offer their subjective opinion and offer unique answers that the researcher might not have considered otherwise (Weerakkody, 2009; Bryman, Bell & Teevan, 2012). The first three questions focused on the participant's role and

what their job entails. The remaining eight questions asked participants to consider their experiences working in a collaborative team setting and how they handled certain situations. Additionally, if they only gave a brief response, the researcher used Weerakkody's strategy of using "probing questions" such as 'can you walk me through a scenario and how you handled the situation?' to gather more information. (Weerakkody, 2009, p. 174). Ultimately, through these qualitative interviews the researcher's focus was on "measuring the attitudes" of the participants to identify themes and patterns in their responses (Creswell, 2003, p. 20).

From the recordings, the interviews were transcribed and common themes that emerged from the data were examined and used for the purpose of this study. As Taylor and Bogdan (1998) argue, "qualitative data analysis is an intuitive and inductive process" (p.141), which is best learned through experience and reading up on how other theorists have organized their data. The framework of this paper was organized in a manner similar to Suter et al.'s (2009) study, where the findings (the participant's quotes) are presented and explained. These quotes were carefully selected because they are the exemplars of the responses given and painted the most vivid picture. Throughout the interview process, the researcher sought to identify recurring themes, vocabulary and patterns. From there, as stated by Taylor & Bogdan (1998), typologies were developed to classify the information derived from the data collection. The first was a table identifying basic participant information. Then, a table that compared participant responses was created. Additionally, their responses were coded and detailed quotes were selected. In the results section, the statements obtained during the interview section of the study will be examined in greater detail.

From the table below, of the thirteen participants, eight participants are female and five participants are male. Also, seven have the word "director" in their job title. Additionally, eleven

of the thirteen participants are from a hospital setting and two are from a LTC setting. To ensure confidentiality, their names and the names of their organizations have not been included in the study.

Table 1: Basic Participant Information

Participant Code Number	**Gender**	**Role/ Title[2]**	**Type of Organization**
001	Female	Director	Hospital
002	Male	Deputy Chief of Staff	Hospital
003	Female	Director	Hospital
004	Female	Chief of Organizational Development	Long Term Care
005	Male	Manager	Hospital
006	Female	Project Management Specialist	Hospital
007	Male	Manager	Hospital
008	Female	Director	Long Term Care
009	Female	Director	Hospital
010	Female	Director	Hospital
011	Male	Senior Vice President	Hospital
012	Male	Director	Hospital
013	Female	Director	Hospital

Results

Two major themes that emerged from the interviews were: the responsibly of a leader to facilitate role understanding; and, the role of emotional intelligence (EI). EI includes the ability of a leader to be able to anticipate how their subordinates will react to their message and to tailor these messages accordingly.

Throughout the results section, the answers that the respondents gave will be presented. The responses that were the most effective and concise at conveying the message will be stated. In the discussion section these results will be further analyzed and discussed.

[2] Since the participants can be easily identified by an official title the participant's work titles and their specific departments have been excluded. Instead, their broader role, such as manager, chief or director has been used instead.

Facilitating Role Understanding and Appreciation

The question posed was "How do you ensure accountability among team members?" All participants felt the care of the patients must be a providers' top priority. In order to ensure accountability, a director said: "I never want to hear someone say 'that's not my job'. So I tell them we work in healthcare, it's everybody's job. Patient care is everybody's job. It might not be your job but you need to find someone who can help that patient" (Participant 001).

Six of the thirteen participants (46.2%) felt that they should also be held accountable for their own actions and that their subordinates should call them out if they had not done what they had promised to or intended to do within a certain time frame.

Additionally, ten of the thirteen participants (76.9%) felt that SBAR (Situation, Background, Assessment and Recommendation) was an extremely important way for healthcare providers to communicate their message because it provides a great deal of context in a relatively short amount of time. A Project Management Specialist stated:

> *We are supposed to be a culture of no blame, no shame, no naming, but I mean, if something happens, especially if it is something critical you try not to shame and blame but ultimately stuff happens. If it is a nurse who ultimately didn't do something and again making sure organizationally that people are clear about accountabilities and expectations of their roles, then maybe the nursing care was deficient. Well yeah, we're supposed to have no shaming or blaming but if there are gaps in somebody's practice, you have to do something about it. If you look at commonalities of incidents, is communication an issue that we actually need to look at […] and make changes. One of the things we implemented a few years ago was SBAR communication as a tool for communicating and we have adopted that SBAR template. We use it for ethical issues and in clinical settings*. [The participant mentioned that she was writing up a paper about a procedure that physicians have to follow]. *We do it in SBAR. So it gives them a bit of what the situation is, what is the background, the action and the recommendation, so it's a nice way to communicate things. (Participant 006)*

All thirteen participants unanimously agreed that face-to-face communication was essential in the healthcare environment. It was the preferred method of communication to execute tasks and answer questions. For example, consider this director's response. She

explained that even if one person was absent from the meeting their absence would be felt and that she would have to go back and re-engage that professional. She stated that:

> *The effectiveness is the team meeting as a whole and actually communicating the things that need to be transferred as far as information gathering and planning for that patient for the best outcome […] There are pieces that each interprofessional brings to the table that needs to be considered and included in making a decision for a plan of care and for the best possible outcome for the patient. (Participant 003)*

When asked "How do you build up competencies?" five participants (38.5%) stated that they had been trying some new strategies in order to ensure roles were clearly communicated to team members. For example:

> *Just in the last 18 months or so I have started doing action minutes. So when we walk out of a meeting I say these are the actions, and whose taking this one and this is mine and this is yours just so people know that there are accountabilities and there are timelines attached to those accountabilities when we walk out of the room, as opposed to just this discussion. Which is what, in the past I might have done, where you discuss something and you expect that people get it and they go away and do it, but then you realize a week later that they didn't get it and they haven't done it. (Participant 012)*

Additionally, another director claimed that she builds up competencies by pairing people up by using the "buddy system" so that people will be able to aide one another. Also, she gets people on her team to consider what their weaknesses are and identify areas where they feel they need to improve. Then, she also identifies some gaps that a particular subordinate needs to improve and looks for opportunities for them to fill their gaps and improve on their weaknesses. She felt that people will be more engaged if they are involved in their learning plan. For example, if people are not good with project management and there is an upcoming task, she will pair the amateur project manager with a confident project manager so that the amateur learns. Then, it is her role to provide each of them with ample support (field notes).

Another way to ensure accountability is to educate the team on working together. The following question was asked: "How do you educate a team on working together? How do you foster empathy among them?" And a director responded:

> *If it's a new team that you are bringing together […] you can do the education, but the empathy piece, - I think one of the ways to engage people and get everybody on the same wavelength is to share patient stories or previous experience of team members. Real live storytelling is one of the most effective ways to bring the team together, to a common goal. […] Understanding the burning platform, I guess. (Participant 003)*

Additionally, this particular anecdote, by another respondent, was particularly insightful on the issue:

> *The whole walk a mile in their shoes is pretty helpful. […] I do feel that it is my job to provide that perspective of the other person. I think a big part of leadership, at the level that I'm at is a bit of advocating for the underdog's voice such that everybody's opinion is heard and respected.* (She meets with her 12 subordinates individually for about an hour each week). *What I do with that time is to try to coach them through perspectives of others, and really trying to get them to have that wider view because it is very easy to have a narrow focus when you have your unit. […] Some days I feel like I'm a peacemaker, if I was being honest, but other days it's more a high-functioning facilitator. (Participant 013)*

Moreover, all the participants agreed that by training professionals together they got a better sense of each other's roles. For instance,

> *People can have a lot of empathy for a sick person in a bed, but less empathy for their colleagues. I find that there are very distinct differences between the generations around empathy and compassion and the language that they use. The purpose of these* [interprofessional units] *is to do just that. We don't segregate the students, so we have spiritual care, nursing, occupational therapy, physiotherapy, social work, nutrition, pharmacy students and medical students and we put them all together and we teach the team to work for the betterment of the patients. So we teach the team to work managing interprofessional relations. It is going really well, I think we can fall back onto our old patterns of taking discipline specific paths for education, but this unit really has changed to understanding the needs of the patient. (Participant 012)*

This director (participant 12) was the only participant who mentioned a noticeable gap between the older and the younger generations, so as a follow up to the previous statement, this

participant was also asked: "Are older generations more resistant to this change?". This director's response was:

> *They are more discipline focused. So, for example, old nurses are very 'nursey'. They hold onto some of the things that they were taught or what they have experienced, but younger nurses – I'm using nursing as an example because of the distinct contrast – think of the patients in a different way. […] The newer team members, no longer feel that it is - unless you tell them – they no longer – and I'm generalizing, this is not everybody – no longer consider mobilizing patients to be part of their job. In the past the nurse was the pharmacist, the physiotherapist […] The younger nurses do […] but they are not of the mindset of getting a patient out of bed and walking them because that is a physiotherapist's job. That I see is becoming a bit of a challenge, and a barrier to good comprehensive care. That is relatively new. It's because we have introduced all these professional disciplines. If you didn't work in an environment where you have all those people you wouldn't know that getting a patient up is your role. (Participant 012)*

Now, the role that emotional intelligence plays within leadership will be more closely examined.

Emotional Intelligence

The importance of EI was apparent in all of the interviews conducted. Although only nine of the thirteen (69.2%) participants used the term outright, it was evident through their descriptions. As an example, this director responded to "How do you adjust your language/communication so that all parties involved can understand your message?" as follows,

> *People receive things differently, hear things differently, focus on different words, different body language, […] so when I meet with people individually I really let them drive the conversation because I don't know what people take away when I walk out of the room. Some people are not as focussed as other's maybe at that minute […] and they come out with a different perception than what was intended. So it is important to have that one on one where you can really see people you can make sure when you look at them that they understand what the actions are. (Participant 012)*

Additionally, this participant, Chief of Organizational Development for a local LTC centre describes the value of connecting with their subordinates to ensure that their message is clearly communicated.

> *People come with their set of own personal values, and if you cannot connect with those values they will close you down and they won't hear what you are saying because they won't see you as understanding their world. [..] So it is very important that you come in being able to make that connection. And if you can make that connection with your audience, then they are going to hear what you are trying to teach them […] whereas, if you make that connection, it can be exactly the same content* [that you are teaching] *but they will hear it because you have just connected with them. (Participant 004)*

Perhaps due to the serious nature of hospital and LTC settings only two participants (15.4%) included in this study suggested using laughter or humour as a means of connecting with their subordinates, as had been suggested from Goleman, Boyatzis and McKee (2002). For example, when trying to keep her group's attention, Chief of Organizational Development for a local LTC said:

> *I use humour, lots of humour in how I communicate […] putting people at ease*. [In her position she has to be able to build trust really fast] *so by using humour, talking about my family and my cats. Communication is a lot about making that connection really fast so you have to understand who you are talking to. (Participant 004)*

Likewise, as a means of further connecting with her team, this director said, "[During meetings] I try to add humour where appropriate. I try to make it personal. […] I am someone that prides themselves in connecting with their team and, with that, knowing your team" (Participant 013).

The question: "How do you overcome personality differences while working with a team? How do you overcome professional differences?" was asked to the participants. Four of the thirteen participants (30.8%) used the term 'emotional intelligence' when trying to overcome such differences, however, only one participant (7.7%) considered how their own emotions could impact their subordinates. For example, consider this director's response.

> *For me, a big part of it is again having that emotional intelligence. So really to be able to understand. It is one of the Ontario Hospital Association course offerings that I have sent some of my direct reports to because they have gotten themselves in trouble with conversations. I think it is that emotional intelligence to understand where that person is coming from but really to self-reflect on what your own approach is when there is a*

> *heated issue and how you react and trying to put it into context […]. I have seen a lot of turn over with leaders in the organization because* [leaders] *just can't take it and they just haven't built up some of the skills, they think too hard about things, they just can't take it and they personalize it. You really have to learn about how to box up an issue and set it aside so that you can do what you need to do and then come back to it and think about it more rationally. (Participant 003)*

Furthermore, the question "What is effective communication?" was asked during the interview. Since this question was central to the research paper and all of the respondent's answers were equally insightful, the table below (Table 2) includes all of their responses.

Table 2

Participant Code #	**Role/ Title**	**Participant's response to the question: "What does effective communication mean to you?"**
001	Director	"It needs to be prompt. If people communicate something to me either electronically or a telephone message if they have taken the time to communicate to me, I'm going to get back to them. [It should be] Respectful, clear, is two-way and is purposeful. […] Communication is to deliver a message that is important and meaningful either to the recipient and the sender. And that it is meaningful in a way that it could have an impact on either individual or it could have an impact on others around them. Communication has a big impact all the way around."
002	Deputy Chief of Staff	"It should be heard. And the most effective way is person-to-person, face-to-face. Very effective communication is personal. It should be heard and understood. There is no use in me communicating to someone in a manner that goes way over their head. Through this communication process I want to see that this person is understanding what I am trying to communicate. And it is two-way. It is not just me pontificating to you what you should be doing, it is about me understanding why you are doing what you are doing."
003	Director	"Effective communication to me means that our team is present, physically and able to provide face-to-face communication about a problem or a concern. That in my view is the most effective, the face-to-face, the team being together as a group, rather than the email that you send out, the one offs."
004	Chief of Organizational Development	"I think effective communication is about clarity. You have to be clear about the message you want the receiver to hear. You have to be honest. I use a lot of 'where I'm at' statements. There is a lot of validating. […] Also, knowing your receiver. Knowing your audience and them being able to communicate in a way they understand."
005	Manager	"It means the information is clear, it's easily understood. What's said or written is not open to interpretation. It is clear and concise. I think effective communication includes timeliness, of information and responses to information. Also, it's giving people the time to listen to them. It would be easier in a hospital to kind of get into a hierarchy like 'I'm the manager,

		here's what it is, go to it.' But it is with providing people with the opportunity to share their thoughts, ideas and concerns. As a manager if I want my staff to feel they can share things in a non-judgmental way. So if I make an error I will go and apologize to that person, even if they are in a room of people because I think that encourages better communication. [Because the staff will think] Oh really he doesn't care that he made a mistake well then okay, I made one too."
006	Project Management Specialist	"Effective communication is everyone feeling that they have had the opportunity to verbalize whatever topic we are talking about. That they are respected in doing that. So people aren't sitting eye rolling and cutting them off because they don't agree. […] People need to feel heard and validated."
007	Manager	"To me to know that communication has been effective, everybody who the communication was intended for should be able to give you some idea of what the outcome was or intended to be and has enough information to make the decisions they need."
008	Director	"It means that if there's a message that I need to deliver to someone that that person will understand it the way that it needs to be understood."
009	Director	"Messages are said and received in a clear and concise format that people are able to understand. And that in those messages there needs to be some compassion because every time you send or receive a message it's part of how you are building relationships and relationships are how we get everything done."
010	Director	Open, transparent, frequent, honest, non-threatening, two-way. (field notes)
011	Senior Vice President	"Telling the truth even if it is a bad message. […] Don't take the approach that they cannot handle the truth. And then it's repeating the message. Also, try to get a feedback on whether [the communication] is working or not. Have some sort of a measurement internally about, don't just do it and then assume it's working have some follow-up on it and evaluation if you can that you are actually reaching the audience you intended to reach."
012	Director	"I really value open, transparent communication in order to foster innovation and allow people to have a voice and get ideas on the table. And have good debate and discussion. Create a culture of constructive criticism where we can challenge each other. Also, I'm a very meticulous written communicator. So, if something goes out of my office it needs to be very thoughtfully written, reviewed multiple times and it needs to be consistent. Consistent language that is appropriate to the audience."

013	Director	"I'm a big relationship builder. I'm a big face-to-face communicator. Although I do reach to email or text messaging for ways for delivering what I would consider one-way communication or to communication to a mass group of people. I'm a believer that email serves the purpose to go out to a large group of people to set the facts straight, but I don't believe that that is the end of the communication process, that's just the beginning. There needs to be follow-up at multiple levels, with face-to-face to assume that people really Understand the context of the message […] Also non-verbal cues. In leadership it is important to understand non-verbal cues. I'm not offended by non-verbal cues that are non-engaging, I'm more curious. It usually means a of lack of understanding and so that makes me believe it is an opportunity to communicate more, explain more, until the person comes to a physical presentation of 'yeah I get it'. So that follow-up is essential."

Based on the responses included above, one can conclude that in general participants felt that in order for communication to be effective their message needed to be understood. Although only five of thirteen participants (38.5%) used the term "understood" or "understanding" within their description of effective communication, all respondents felt that it was their responsibility to clearly convey their message so that their recipients understood what was expected of them, meaning that their message was stated in a manner that was not open to interpretation. Also, considering the responses above, only four of the thirteen participants (30.8%) used the word 'clear' within their definition of effective communication.

Additionally, when talking about effective communication, all participants considered face-to-face communication the most effective, however there are certain circumstances in a healthcare setting where meeting with each of their subordinates face-to-face to convey every message would be nearly impossible. In order to convey less important messages, these leaders tended to rely on alternative means of communication. Although, this can have adverse effects. For instance, this director stated: "I have colleagues who text. You can make big mistakes doing that because you don't see that feedback. People don't get the nuances and the words don't sometimes communicate what you would hope they do" (Participant 012). This further reinforces

that feedback, which is most easily attained face-to-face, is necessary for communication to be effective.

Furthermore, they all agreed that it was the leader's responsibly to understand their subordinate's point of view, however only four participants (30.8%) used the term 'two-way' outright when they were asked what effective communication meant to them (one of them mentioned the term later on in the interview). By giving their subordinates the time to express their thoughts, justify their actions or admit to having made a mistake, the chance of miscommunication could be mitigated. These respondents felt that effective communication must be two-way and it is the leader's role to understand why their subordinate is doing what they are doing, which closely relates to the role that emotional intelligence has in communication.

One participant's final response in the interview was that the importance of effective communication meant ensuing that the message is properly expressed. This manager referred to a situation that had taken place between a manger and his subordinates in the UK. This participant felt that communication can be misconstrued and people will take offence. Simply put, the importance of how others receive your message is equally important as the message itself.

> *There was a manager, in the UK, […] and the manager works in the palliative care unit. And the manager sent out a message to the staff. And the message was that there should be joy and fun in dying. When I read the article and I read the message, and again I am reading it as a manager, the manager's intention was while there's bundles of sadness when you lose somebody, don't forget that there is happiness, there's joy in life, not in the moment. […]* [The article was called Death by Chocolate]. *It was just somebody's experience about wanting to try different candies before they died. Sounds like a reasonable idea. But what the manager's intention and what the message was,* [differed greatly] *and then somebody released it to the media, from the team, because they were upset about it. The message was well intended. The content was poorly presented and then misconstrued. And then it became a big negative. [...] There is risk in everything that we send out and one poorly worded, poorly communicated, but well intentioned message can undo oodles and oodles of really good stuff. (Participant 005)*

As mentioned earlier, often an emotionally intelligent leader should be able to gauge a person's ability to work well with the team and uphold a certain level of professionalism during the interview process. Although, only three participants (23.1%) mentioned this in their interviews. Perhaps this can be attributed to varying roles, and some of the participants might be less involved in the hiring processes as their study counterparts. For instance, this participant, the Deputy Chief of Staff, felt that during the hiring process, the leader should be responsible for carefully selecting a team member who is willing to collaborate with the rest of the team.

> *In an ideal world, as I grow as a leader, my approach has changed. There were many things that ten years ago I wouldn't do that I do now. When it comes to team members, I think the most important part is selecting the right people for a team you wish to have.* [In his department they work 12 hour shifts]. *[…] So when you are hiring and you set expectations you need to be able to explore, as well as you can, ahead of time does this person appear, on paper at least, to be a fit for our department? Does this person bring the skill set that we require to deliver the service that we wish to deliver? Then, during the interview process you try and tease those things out and then when you do hire you set those expectations right off the bat. (Participant 002)*

In the following section the responses from above will be analyzed and discussed in further detail. Then, the limitations of the research will be addressed as well as recommendations for future research.

Discussion

Communication is central to leadership in healthcare. Since the participants held a variety of titles, were from different organizations and managed different teams, some of their approaches differed, however, clear communication was necessary for them to foster a collaborative work environment. As mentioned earlier, through the in-depth interviews there were two main roles that emerged from the research that communication plays in leadership. These include: facilitating role appreciation and understanding and the role of emotional intelligence within leadership. These themes further reinforced what was found in the literature,

regarding leadership and communication within healthcare. The remainder of the discussion will be broken down into the following sections: role appreciation and understanding (RQ1), and emotional intelligence (RQ2).

RQ1

Communication is necessary for teamwork and collaboration (Suter et al., 2009; Battilana et al., 2010; Lake, Baerg, & Paslawski, 2015; Palanisamy & Verille, 2015). This can be done though facilitating role appreciation and understanding, which was is a key theme that was found in both the literature and during the interviews with all thirteen participants. Returning to Suter et al., (2009)'s discussion, role understanding can be defined as "set[ting] clear boundaries and demarcations or the ability to strike a balance between interdependence and professional autonomy" (p. 48).

All thirteen participants within the health sector under analysis felt that within their healthcare setting there was certainly a hierarchical structure that existed between physicians, nurses and allied health professionals. One way to mitigate this hierarchy was for leaders to convey to their staff that caring for patients was everybody's responsibility, regardless of their job title, by building up competencies. In order for collaboration to occur successfully the patient should be kept at the centre of their collaboration (Kenny, 2002; Baker, Day & Salas 2006; Suter et al., 2009). To mitigate this hierarchy, if healthcare providers understand what each other's roles are they are less likely to think of themselves as superior and appreciate how others are assisting in caring for patients as well. Furthermore, considering the complex needs of patients, especially because the HNHB jurisdiction has more seniors, and seniors have a higher incidence of comorbid and chronic diseases (Chappell & Hollander, 2013), respondents suggested that these teams need to work together to ensure the patient is receiving the highest quality of care,

tailored specifically to their needs.

A key finding of this research was that these leaders are not here to micro manage their subordinates but to facilitate this teamwork and to foster empathy among them. There are ample strategies to do that.

Firstly, in order to engage with each other, strategies like storytelling as well as SBAR (Situation, Background, Assessment and Recommendation) are effective to bring professionals together who come from unique professional backgrounds. By focusing on storytelling, such as sharing patients' stories, or previous experiences that they have had while working as a team, it can effectively bring the team together and define a common goal. Also, ten of the thirteen participants claimed that SBAR had been extremely effective, and also became a way of empowering the nurses. Although nurses cannot make the official order, their recommendations were very useful for the doctors. As argued by Leonard, Graham and Bonacum (2004) and stated by the participants, SBAR is useful because nurses and doctors communicate differently. For instance, nurses are more vivid in their descriptions and doctors tend to be concerned with the headline or the main problem. This strategy is a way of fostering empathy among them. Two of the three remaining participants, that did not mention SBAR, did not work in the hospital setting, they worked in the LTC setting. Perhaps a communication strategy similar to SBAR would benefit nurses, personal support workers and additional support staff in LTCs to mitigate the differences between unique professionals delivering care to clients in Long Term Care facilities. Also, the other participant that did not mention SBAR was in more of a leadership role whose focus differed from that of the other participants.

Additionally, there are ample benefits of training people together. Strategies like pairing people up, to foster an understanding of what others do is an effective way to help team members

learn. This helps to foster the "walking a mile in their shoes" analogy so that healthcare professionals can see what others within their team are doing. As mentioned earlier, role appreciation and understanding are imperative for a team to function well (Baxter & Brumfitt, 2008; Suter et al, 2009) as well as to avoid social loafing (Worchel et al., 1998) so that all team members have something that they are contributing to the team. Training people together was a strategy used in both hospital settings and LTC settings.

In addition, holding people accountable helps avoid social loafing. In order to hold people accountable, allocating tasks or responsibilities must be done in a manner that is two-way, clear and not open to interpretation. This means that tasks are stated in a manner that is clear to all parties involved. In order to be clear, leaders should meet with their subordinates in-person to allow these professionals to ask questions, voice their opinions and so that people feel valued as part of the team (Prati et al., 2003). Moreover, by being available and approachable, subordinates are more inclined to feel comfortable talking to their leaders about their concerns.

Additionally, it is imperative that if a task is not completed, subordinates are held accountable for their actions or lack thereof. For example, if they do not execute a task, leaders must speak to their subordinates but prior to this taking place, the subordinates should be fully aware of what is expected of them (Frankel, Leonard & Denhem, 2006). Ensuring that group members are held accountable, by focusing on patient care delivery, was something that all participants, in both hospital settings and LTC settings felt was necessary. Six participants felt that people in leadership positions, such as themselves, should be held accountable for their actions as well. If they are unable to meet a deadline, they should be upfront about it with their subordinates. Transparency is key in this situation and if leaders are more open to admitting their shortcomings and mistakes, they will be able to facilitate this among team members.

Facilitating a relationship prior to an adverse event is key because then it becomes a way of bridging gaps, as was found in both the literature (Hauser and Preston, 2005; Booher, 2015) and in the in-depth interviews. Participants also felt that this was key, not only among their subordinates, but also between themselves and their subordinates. Some participants used this strategy as a means of developing trust so that if an adverse event took place, their subordinates would feel comfortable enough approaching them and communicating the problem. In order for them to work as a team they need to be open, even if they have made a mistake, which is more easily done if they trust one another (Baker, Day and Salas 2006, p. 1588).

Booher (2015) stated that repetition on multiple channels is key to ensuring people understand the message. While the participants in the study agreed with this statement, they all thought that clearest channel to communicate a message was face-to-face. If face-to-face communication was impossible due to time or distance constraints they opted for alternatives, such as phone or Skype to receive feedback. If they needed to resort to email, the participants felt that it was necessary to ensure they would be available to meet in-person to clarify any questions. This was agreed upon in both the literature and among participants.

However, perhaps the pendulum has swung too far in the opposite direction, because there are certain limitations of training professionals together. Although it was only mentioned by one participant, something that was particularly insightful that the one director mentioned was the generational gap and the shifting mentalities of younger generations. This is perhaps something that is worthy of further research as more professionals enter the work force having been trained with other healthcare professionals. Generally speaking, they may think that certain jobs are not their responsibility because during their training they were told that certain jobs were the responsibility of another health professional.

RQ2

Emotional intelligence plays a large part of leadership because even when a leader is not very visible, subordinates take cues from management (Goleman, Boyatzis & McKee, 2002). As mentioned earlier there are four aspects of EI, according to George (2000) and Prati et al., (2003). These four aspects of EI play a significant role in leadership, including how they deliver messages, connect with subordinates and resolve conflicts.

The concept of self-awareness was a reoccurring theme in both the literature and in the interviews. Self-awareness of leaders own and other's emotional states was the first aspect of EI that was addressed by George (2000) and Prati et al., (2003). People with high EI can accurately communicate how they are feeling using language, which helps build and foster interpersonal relationships among others (Prati et al., 2003). All participants felt that this was necessary and that self-awareness included sending clear messages, in both written and oral format, as well as adjusting language when necessary. In both the literature and the interviews, managers and directors stated that people receive messages differently which can be attributed to their unique training and personalities. They all stated that it was necessary to be able to adapt and change their communication so that all partied involved understood the message, which was evident through *Table 2*. Although, as mentioned earlier, only five participants used the term 'understood' or 'understanding' in their description of effective communication. However, based on the responses given, all respondents felt that it was their duty to clearly convey their message so that their recipients understood what was expected of them, meaning that their message was not open to interpretation. This did not differ between the hospital and LTC settings.

The second aspect of EI is being highly knowledgeable about emotions (George, 2000; Prati et al., 2003). For instance, a leader who is in a bad mood might have an adverse effect on

their subordinates, and so they will refrain from delivering a message or postpone a meeting (if possible) until they are in a better frame of mind. Of the thirteen participants, only one participant mentioned how being in a bad mood might affect the way they view a situation. In order to mitigate this, this participant mentioned that, time permitting, they would deal with the situation once their mood had improved and they have given themselves some time to reflect on the situation.

As previously mentioned, the third aspect of EI is that people with high EI are able to use such emotions effectively and understand that a positive work environment fosters innovation (George, 2000; Prati et al., 2003). Leadership in healthcare is about being inspiring and then communicating that to subordinates. This includes being inspiring both in the execution of daily tasks as well as being adaptable to change and then communicating that optimism to subordinates. By connecting with their team, they will be able to inspire them even more. Even while trying to overcome personality or professional differences it is important to do so in a manner that does not discourage either party (or parties). Additionally, although policy is necessary, front line provider's perspectives need to be considered, because often what is put in place is an ideal and it is executed differently than when it is being written up (Kenny, 2002). In order to reduce this utopic view from what is actually taking place, leaders who value their team's feedback facilitate a more positive work environment and, in turn, a more innovative work environment. Furthermore, by being approachable, subordinates are more inclined to feel comfortable talking to their leader.

The final aspect is those leaders with high EI have the ability to manage their own emotions and the emotions of their team members (George, 2000; Prati et al., 2003). A person with high EI will be able to not only manage their own mood, but the moods of others (George,

2000). With that being said, an emotionally intelligent leader exercises compassion as a leader. A leader with high EI should be able to transform those thoughts into words and to express themselves clearly while considering other's feelings, perspectives and points of view. For example, returning to the manager's response about the incident in the UK (between a manager and his subordinates working in the palliative care unit), in order to ensure effective communication (so that responses are not misconstrued) the leader should reflect on how others will receive their message and carefully consider that prior to delivering a message, both verbally and in writing. This communication should be as clear as possible to avoid miscommunication. However, in the response to 'What is effective communication?' only four of the thirteen participants used the word 'clear'. Furthermore, leaders with EI should also be able to grow as a leader by adapting to certain situations, as well as connecting with others to form a relationship immediately. Although, in this study, only two participants mentioned using laughter (when it is suitable) as a means of connecting with their team. Perhaps this can be attributed to the fact that laughter might not be the most effective strategy in a hospital or LTC setting.

In summary, all four of these aspects of EI are related because it is important that leaders take the time to understand their subordinates, consider their mood, the environment in which they are delivering the message and ensure that their message is as clear as possible. Additionally, these leaders should carefully consider who they add to their team. By selecting new team members carefully, they might be able to mitigate loafing, conflict or burnout. However, only three participants mentioned the importance of gauging potential employees 'fit' with the rest of the team during the recruitment process. This might be because of the differing roles that these leaders had and perhaps some were not as involved with hiring people.

Conclusion

This paper has argued that in leadership two things are key: fostering role appreciation among their group and exercising emotional intelligence as a leader because "it is clear that leaders drive values, values drive behaviours, and behaviours drive performance of an organization" (Frankel, Leonard & Denham, 2006, p. 1707). Miscommunication can have adverse effects in other sectors but it can have detrimental outcomes in healthcare (West et al., 2003; Leonard, Graham & Bonacum, 2004; Haeuser & Preston, 2005; Suter et al., 2009; Rabøl et al., 2012; Lake, Baerg & Paslawski, 2015; Palanisamy, & Verille, 2015). That being said, communication is central to leadership (Goleman, Boyatzis & McKee, 2002; Maccoby, 2007; Smith, 2011).

Through the in-depth interviews the two main themes that emerged that were central to communication in healthcare leadership were: fostering role appreciation and understating and exercising emotional intelligence. Often, as stated in the literature review and during the in-depth interviews, if the leader can ensure that their subordinates are "in the same movie" (Leonard, Grahan & Bonacum, 2004, p. i86) and are aware of their responsibilities as well as others, the chance of a situation going awry is significantly reduced (West & Lyubovnikova, 2013). There are strategies, such as SBAR (Situation, Background, Assessment and Recommendation) which can be implemented by leaders, that provide a framework for nurses and doctors to discuss the status of their patients and alert physicians about high risk patients.

Not only are leaders responsible for facilitating role appreciation among their team, they should exercise emotional intelligence while communicating with their subordinates. In healthcare, professionals might have differing views on how tasks should be completed or how resources (both financial or physical) should be allocated. Often the team manager is the one

responsible for conflict resolution (Brown et al., 2011). If there are changes being made or an issue (argument or crisis) that needs to be resolved, an emotionally intelligent leader should be able to anticipate their subordinate's reactions (George, 2000; Prati et al., 2003). Finally, as stated by Prati et al., (2003) it is imperative that leaders use their insight during the hiring process when they are trying to gauge how well potential employees will work with their team. In short, teamwork is here to stay, due to financial constraints (Davoli & Fine, 2004) and an increased specialization in healthcare professions (Gawande, 2012), so there should be more research conducted on collaboration in teamwork and the role that leadership plays in this collaboration.

In future studies, researchers might want to adopt more of an ethnographic approach in order to observe and record what is actually taking place. For instance, by sitting in on meetings and observing how leaders compose themselves in different situations with subordinates, one could substantiate whether the expressed sentiments regarding communication approaches in individual interviews are actually articulated and put into practice in the workplace. Additionally, due to time constraints, there were only thirteen interviews conducted. Future researchers should try to involve more interviews with more participants, including a wider selection of participants from the local LTC communities or by conducting interviews in other LHIN jurisdictions within other regions of the province. In addition, another possible direction to consider is the communication between hospitals and community health organizations, especially in the HNHB jurisdiction, which houses the highest number of seniors in Ontario (*HNHB LHIN 2015-16 Annual Business Plan)*. There are ample documents that the government of Ontario has released, such as the *Patients first: A proposal to strengthen patient-centred health care in Ontario*, where

they are discussing things that they would like to improve and there are a variety of stakeholders with valuable information to contribute.

Limitations

For this research project there are a few noteworthy limitations. To begin, the study was to some degree subjective, based on relatively few interviews. Although in-depth interviews provide a great deal of information within a short time span, these participants might have been providing responses that they thought the researcher might want to hear (Taylor & Bogdan, 1998), or making certain claims to make their particular organization look good. Moreover, their responses and their actions may differ and due to time constraints the researcher was unable to observe their interactions with subordinates one-on-one or in a team setting.

As mentioned earlier, in-depth interviews can be intrusive. In order to mitigate this, the researcher tried a few strategies such as: developing a positive rapport with the participants (Weerakkody, 2009), not being judgmental and ensuring confidentiality in all circumstances (Taylor & Bogdan, 1998). However, some participants might not have wanted to share certain stories because often people are identifiable through the stories they tell.

Since this was a convenience sample the results cannot be generalized to all jurisdictions (Bryman, Bell & Teevan, 2012). Even within the individual hospitals and LTC's there were noticeable differences. Finally, due to time constraints, there were only two participants that were from LTC settings. In the future it would be best if there were more participants recruited from LTC centres to compare their responses with the responses provided with those in hospital settings.

Works Referenced

Baker, D. P., Day, R. & Salas, E. (2006). Teamwork as an essential component of high-reliability organizations. *Health Services Research*, *41*, 1576-1598. doi:10.1111/j.1475-6773.2006.00566.x

Battilana, J., Gilmartin, M., Sengul, M., Pache, A. & Alexander. (2010). Leadership competencies for implementing planned organizational change. *The Leadership Quarterly*, *21*, 422-438. doi:10.1016/j.leaqua.2010.03.007

Baxter, S. K., & Brumfitt, S. M. (2008). Professional differences in interprofessional working. *Journal of Interprofessional Care*, *22*(3), 239-251. doi-10.1080/13561820802054655.

Boaro, N., Fancott, C., Baker, R., Velji, K., & Andreoli, A. (2010). Using SBAR to improve communication in interprofessional rehabilitation teams. *Journal of Interprofessional Care*, 24(1), 111-114. doi:10.3109/13561820902881601

Booher, D., (2015). *What more can I say? Why communication fails and what to do about it*. New York: Penguin Group.

Brown, J., Lewis, L., Ellis, K., Stewart, M., Freeman, T. R., & Kasperski, M. J. (2011). Conflict on interprofessional primary health care teams – can it be resolved? *Journal of Interprofessional Care*, *25*(1), 4-10. doi:10.3109/13561820.2010.497750

Bryman, A., Bell, E & Teevan, J. (2012). *Social research methods, 3rd Canadian edition*. Toronto: Oxford University Press.

Chappell, N. & Hollander, M. (2013). *Aging in Canada*. Toronto: Oxford University Press.

Creswell, J. W. (2003). *Research design: Qualitative, quantitative and mixed methods approaches second edition.* Thousand Oaks: Sage Publications.

Conger, J. & Kanungo, R., N. (1998). *Charismatic leadership in organizations.* Thousand Oaks: Sage Publications.

Col, N., Bozzuto, L., Kirkegaard, P., Koelewijn–van Loon, M., Majeed, H., Jen Ng, C., & Pacheco-Huergo, V. (2011). Interprofessional education about shared decision making for patients in primary care settings. *Journal of Interprofessional Care 25*(6),409-415. doi:10.3109/13561820.2011.619071

Collins, S. K., McKinnies, R., & Collins, K. S. (2015). Leadership characteristics for health care managers. *Health Care Manager*, *34*(4), 293-296. doi-10.1097/HCM.0000000000000078

Davoli, G. & Fine, L. (2004). Stacking the deck for success in interprofessional collaboration. *Health Promotion Practice*, *5*(3), 266-270. doi: 10.1177/1524839903259304

Delmatoff, J., & Lazarus, I. R. (2014). The most effective leadership style for the new landscape of healthcare. *Journal of Healthcare Management*, *59*(4), 245-249.

Elwell, S. M & A. Elikofer. (2015). Defining leadership in a changing time. *Journal of Trauma Nursing*, *22*(6), 312-314. doi-10.1097/JTN.0000000000000165

Frankel, A. S., Leonard, M. W., & Denham, C. R. (2006). Fair and just culture, team behaviour, and leadership engagement: The tools to achieve high reliability. *Health Services Research*, *41*(4), 1690-1709. doi:10.1111/j.1475-6773.2006.00572.x

Gawande, A. (2012, March). Atul Gawande: How do we heal medicine? [Video file]. Retrieved from https://www.ted.com/talks/atul_gawande_how_do_we_heal_medicine?

George, J. (2000). Emotions and leadership: The role of emotional intelligence. *Human Relations, 53*(8), 1027-1055. doi:10.1177/0018726700538001

Goleman, D., Boyatzis, R., & McKee, A (2002). *Primal leadership: Learning to lead with emotional intelligence.* Boston MA: Harvard Business Review Press.

Haeuser, J.L., & Preston, P. (2005). Communication strategies for getting the results you want. *Healthcare Executive 20*(1), 16 PMID: 15656222.

Hall, P. (2005). Interprofessional teamwork: Professional cultures as barriers. *Journal of Interprofessional Care 19*(1), 188-196. doi:10.1080/13561820500081745

Karau, S., J., & Williams, K., D. (1993). Social loafing: A meta-analytic review and theoretical integration. *Journal of Personality and Social Psychology*, *65*(4) 681-706. doi: 10.1037/0022-3514.65.4.681

Kenny, G. (2002). Interprofessional working: Opportunities and challenges. *Nursing Standard 17*(6) 33-35. Retrieved from: http://go.galegroup.com.libaccess.lib.mcmaster.ca/ps/i.do?id=GAL%7CA95598859&v=2.1&u=ocul_mcmaster&it=r&p=AONE&sw=w&asid=4706cfd725a86116558b449120e3285d

Kvarnström, S. (2008). Difficulties in collaboration: A critical incident study of interprofessional healthcare teamwork. *Journal of Interprofessional Care*, *22*(2), 191-203. doi: 10.1080/13561820701760600

Lake, D., Baerg, K., & Paslawski, T., (2015). *Teamwork, leadership and communication: Collaboration basics for health professionals*. Edmonton, AB: Brush Education.

Lembke, S., & Wilson, M. (1998). Putting the "team" into teamwork: Alternative theoretical contributions for contemporary management practice. *Human Relations, 51*(7), 927-944. doi:10.1177/001872679805100704

Leonard, M., Graham, S. & Bonacum, D. (2004). The human factor- the critical importance of effective teamwork and communication in providing safe care. *Quality and Safety in Health Care, 13* (Suppl.1), i85-i90. http://doi.org/10.1136/qshc.2004.010033

Liedtka, J. M., & Whitten, E. (1998). Enhancing care delivery through cross-disciplinary collaboration: A case study. *Journal of Health Care Management, 43*(1), 185–203. Retrieved from http://libaccess.mcmaster.ca/login?url=http://search.proquest.com/docview/206722919?accountid=12347

Maccoby. M. (2007). *The leaders we need and what makes us follow*. Boston, MA: Harvard Business School Press.

Palanisamy, R., & Verille, J. (2015). Factors enabling communication-based collaboration in interprofessional healthcare practice: A case study. *International Journal of e-Collaboration 11*(2), 8-27. http://dx.doi.org.libaccess.lib.mcmaster.ca/10.4018/ijec.2015040102

Pope, B., Rodzen, L., & Spross, G. (2008). Raising the SBAR: How better communication improves patient outcomes. *Nursing 38*(3):41-3. doi: 10.1097/01.NURSE.0000312625.74434.e8.

Prati, L. M., Douglas, C., Ferris, G. R., Ammeter, A. P., & Buckley, M. R. (2003). Emotional intelligence, leadership effectiveness and team outcomes. *International Journal of Organizational Analysis* (2003), *11*(1), 21-40. Retrieved from http://web.b.ebscohost.com.libaccess.lib.mcmaster.ca/ehost/pdfviewer/pdfviewer?sid=6f9a8fd0-3fa8-4b51-9f17-f78de9b9d3d0%40sessionmgr107&vid=1&hid=123

Rabøl, L. I., McPhail, M. A., Østergaard, D., Andersen, H. B. & Mogensen, T. (2012). Promoters and barriers in hospital team communication: A focus group study. *Journal of Communication in Healthcare, 5*(2), 129-139. doi:10.1179/1753807612Y.0000000009

San Martín-Rodríguez, L., Beaulieu, M., D'Amour, D., & Ferrada-Videla, M. (2005). The determinants of successful collaboration: A review of theoretical and empirical studies. *Journal of Interprofessional Care, 19*(S1), 132-147. doi: 10.1080/13561820500082677

Smith, M. A. (2011). Are you a transformational leader? *Nursing Management, 42*(9), 44-50. doi-10.1097/01.NUMA.0000403279.04379.6a

Suter, E., Arndt, J., Arthur, N., Parboosingh, J., Taylor, E., & Deutschlander, S. (2009). Role understanding and effective communication as core competencies for collaborative practice. *Journal of Interprofessional Care 23*(1), 41-51. doi: 10.1080/13561820802338579

Taylor, S., J. & Bogdan, R., (1998). *Introduction to qualitative research methods (3rd Ed.).* New York: John Wiley & Sons.

The Ministry of Health and Long-Term Care. (2015). *Patients first: A proposal to strengthen patient-centred health care in Ontario* (Catalogue no. 020380 ISBN no. 978-1-4606-7171-9) Toronto, ON: Canada. Queen's Printer for Ontario.

The Ministry of Health and Long-Term Care and Local Health Integration Network (2015). *Hamilton Niagara Haldimand Brant LHIN Annual business plan 2015-2016*. Toronto, ON: Canada. Queen's Printer for Ontario.

Watt, S. (2016, May 4). *Enterprise Risk Management*. Thrive Group: Burlington ON.

Watts, S. & Stenner, P., (2012). *Doing Q methodological research theory, method and interpretation*. Thousand Oaks, CA: Sage Publications Inc.

Weerakkody, N. (2009). *Research methods for media and communication*. Sydney: Oxford University Press.

West, M. A., Borrill, C. S., Dawson, J. F., Brodbeck, F., Shapiro, D. A., & Haward, B. (2003). Leadership clarity and team innovation in health care. *The Leadership Quarterly, 14*(4-5), 393-410. doi:10.1016/S1048-9843(03)00044-4

West, M. A., & Lyubovnikova, J. (2013). Illusions of team working in health care. *Journal of Health Organization and Management*, *27*(1). doi:10.1108/14777261311311843

Worchel, S., Rothgerber, H., Day, E. A., Hart, D., & Butemeyer, J. (1998). Social identity and individual productivity within groups. *British Journal of Social Psychology, 37*(4), 389-413. doi:10.1111/j.2044-8309.1998.tb01181.x

Appendix A

Email Recruitment Script
Sent on Behalf of the Researcher
by the Holder of the Participants' Contact Information

Christina Pellegrini, M.A. (c)
Masters Candidate in Communication Studies and New Media
Study Title:
Identifying Effective Communication Strategies Within Collaborative Healthcare

---

Sample E-mail Subject line: Invitation: Participate in a two-part study on communication and collaborative care

Dear Employees,

Christina Pellegrini, a McMaster student, has contacted us asking us to tell our employees about a study that strives to identify and evaluate the role that communication plays in collaborative health and community care institutions within the local Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) region. The study is a component of her major research paper (MRP). The MRP is a core requirement for the completion of her Master of Communication and New Media degree at McMaster University. The following is a brief description of her study.

If you are interested in getting more information about taking part in Christina's study please read the brief description below and **CONTACT CHRISTINA PELLEGRINI DIRECTLY** by using her McMaster email address. pellegrc@mcmaster.ca . Christina will not tell me or anyone at said company who participated or not. Taking part or not taking part in this study will not affect your status or any services you receive here at said company.

Christina Pellegrini is inviting you to take part in a two-part study. The first part of the study is a one-on-one interview about collaboration, communication, leadership and teamwork in healthcare involving professionals like yourself. She hopes to learn what communications attributes healthcare professionals, like you, value the most. A total of 15 professionals will be interviewed for this study. The interview is expected to last between 60-90 minutes. Interviews will be conducted during the months of May and June. She will work out those details with you.

[3]During the second part of the study you will be given small cards with specific communications attributes on them (approximately 40-50 cards) and then you will be asked to rank them from the most valuable to the least valuable with a chart that she will provide. You will be asked to record your responses for her on the chart in handwriting. This component of the interview will take approximately 30 minutes. If you do not have time following the in-depth interview to complete this sorting, an envelope with instructions on how to complete the sort will be left with you. She will then follow up within seven days to arrange a mutually agreed upon time to pick up the

---

[3] Please note the Q-Sort part of the study was excluded from the paper because the Q-Methodology software (PQ Method) was not working.

completed material. Your results will be compared to other participants. You are in no way obligated to participate in this part of the study.

Ms. Pellegrini has explained that you can withdraw from the study at any time during the interview or not answer questions but can still be in the study. She has asked us to attach a copy of her information letter to this email. That letter gives you full details about her study.

In addition, this study has been reviewed and cleared by the McMaster Research Ethics Board. If you have questions or concerns about your rights as a participant or about the way the study is being conducted you may contact:

McMaster Research Ethics Board Secretariat
Telephone: (905) 525-9140 ext. 23142
Gilmour Hall – Room 305 (ROADS)
E-mail: ethicsoffice@mcmaster.ca

Sincerely,

Appendix B

Interview Guide:

1. What is your profession? What does your job entail?
2. Can you describe your current role on the team? Who is on your clinical team?
3. What does effective communication mean to you?

   For the following questions please consider your experiences working in a collaborative team setting:
4. What would be the ideal way for you to set expectations/responsibilities of each of the team members involved?
5. How do you ensure accountability among team members?
6. How do you adjust your language/communication so that all parties involved can understand your message?
7. How do you achieve and maintain the team's attention?
8. Does hierarchy exist in your environment? If so, how do you maintain it/ flatten it?
9. How do you educate a team on working together? How do you foster empathy among them?
10. How do you prepare for ensuring effective collaborative communication? How do you build up competencies? (ex. Testing out scenarios)
11. How do you overcome personality differences while working with a team? How do you overcome professional differences? (eg. Doctor vs nurse, clinical support vs care support)
12. [4]After an adverse event occurs are there discussions that take place, such as a debriefing or an after actions review, to review the communicative actions taken by the team?

[4] Due to time and space constraints, the responses to this question were excluded from the study