Fostering Change in Organizational Culture Using a Critical Ethnographic Approach

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Healthcare organizations are striving to meet legislated and public expectations to include patients as equal partners in their care, and research is needed to guide successful implementation and outcomes. The current research examined the meaning of customer service as related to the culture of care relationships within a Canadian hospital in southeastern Ontario. The goals were to better understand these expectations, develop shared meanings and influence cultural change from the perspective of the organization's employees about their interactions with patients, families and work colleagues, and to generate ideas and groundswell for change. An ethnographic approach within the critical research paradigm was used over the course of a three phase study, where direct care healthcare providers (Phase 1), mid-level leaders (Phase 2) and senior leaders (Phase 3) volunteered to explore their values, philosophies and suggestions for change in the organization's care relationships. This paper describes Phase 2 of the overall research project. A mixed methodology was used where mid-level leaders were individually surveyed and then participated in a focus group and/or interview to discuss these concepts. Mid-level leaders indicated that providing excellent customer service was important in their own work with many customers including staff, patients and their families, students, volunteers and outside agencies. They believed that this in turn led to improved partnerships for care, health service transitions and linkages, customer satisfaction and health outcomes. The majority stated that the organization's culture would support change related to customer service relationships and opportunities for this were explored. Keywords: Critical Ethnography, Customer Service, Heath Care Relationships, Hospital Culture, Mixed Methodology, Organizational Change, Patient and Family Centred Care, Relationship Centred Care, Shared Decision Making

Over the past thirty years there has been a socially mediated paradigm shift to relocate the patient from that of a passive recipient of care to that of an active participant in their healthcare journey (Curran, 2007). Writings related to this philosophy permeate clinical (Bissell, May, & Noyce, 2004; Légaré et al., 2011), consumer (Atkins, 2010; Conlon, 2007; Gerteis, Edgman-Levitan, Daley, & Delbanco, 1993) and health policy (Denis, Davies, Ferlie, & Fitzgerald, 2011; Romanow, 2002) literature, and are becoming more evident in recent legislation (Accessibility for Ontarians with Disabilities Act, 2005; Excellent Care for All Act, 2010) as well as current news media (Dan Sherman and the Canadian Press, 2011; Picard, 2011). There are many conceptual representations of a more customer-oriented healthcare, including *collaboration* (Curran, 2007; D'Amour,

Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005; Dalton, 2003), *patient participation* (Cahill, 1996, 1998; Eldh, Ekman, & Ehnfors, 2006; Martin, 2008), *partnership* (Casey, 2008; Coulter, 1999; Hinojosa, Sproat, Mankhetwit, & Anderson, 2002; Sahlsten, Larsson, Sjostrom, Lindencrona, & Plos, 2007), *shared decision-making* (Gravel, Légaré, & Graham, 2006; Légaré et al., 2008; O'Connor et al., 2003), *patient/family centered care* (Blickem & Priyadharshini, 2007; Dewing, 2004; Epstein & Street, 2007; Gerteis et al., 1993) and *relationship centered care* (Nolan, Davies, Ryan, & Keady, 2008).

These terms are inter-related, and at times are used interchangeably, but they do describe distinctly different concepts. Cahill (1996) conducted a conceptual analysis around patient participation and extended a hierarchical model based on this research. In her model, she represented the inter-related concepts of patient involvement, collaboration, participation and partnership in a pyramid. Patient involvement and collaboration were placed at the bottom of the pyramid, as foundational actions for patient engagement, but were described as limited to uni-directional, clinician to patient communication. These two concepts acted as precursors to patient participation, which depicted a two-way relationship with greater equality in power, and was positioned in the center of the pyramid. Patient participation required a narrowing of the knowledge gap between the clinician and the patient and enlisting the patient in activities that they saw as beneficial to their own care. All three concepts were precursors to the penultimate goal of patient partnership, defined as the productive association directed towards a joint venture and based on mutual trust, respect and equality.

Extending from Cahill's model (1996), other conceptual frameworks were considered. Shared decision-making warranted attention as it has been much examined in recent literature (Gravel et al., 2006; Légaré, Stacey, & Forest, 2007). It is defined as a process whereby patients are supported to become involved in decision-making to reach healthcare choices together with their practitioners (Légaré et al., 2008). Similar to partnership, it includes elements of mutual trust within a relationship where interactions influence each other; however, in practice, decision-making is often not equally shared. At best, practitioners will take a lead role based on patient needs, however, clinician-as-expert models of decision making still exist, so it is a goal to work towards (Makoul & Clayman, 2006). Patient and family-centered care has continued to demand much research in such areas as identifying its dimensions (Hobbs, 2009), values (Epstein & Street, 2011) and patient-centered practice attributes (Pelzang, 2010). A recent literature review determined the fundamental principles of patient-centered care as a patient-provider relationship that promotes patient involvement and the individualization of care (Robinson, Callister, Berry, & Dearing, 2008). It is frequently linked with shared decision making in its enactment (Pelzang, 2010). Relationship centered care has been positioned as going beyond patient-centered care in that it focuses on respect for personhood while de-emphasizing autonomy and individualism, as this may not be appropriate in all populations, such as in gerontology (Nolan, Davies, Brown, Keady, & Nolan, 2004). It emphasizes the view of human beings as belonging to a network of social relationships and recognizes that the quality of relationships is significant for health care (Beach, Insui, & The Relationship-Centered Care Research Network, 2006).

Involving patients in communications and decision-making about their own health has been shown to improve outcomes in patient satisfaction (Niedz, 1998), in patient

perceived enhanced recovery (Williams & Irurita, 2004), and in patient communication behaviors (Rao, Anderson, Inui, & Frankel, 2007). In one study examining nurse-patient communication in a hospital setting, the care providers often demonstrated conversational dominance and missed patient cues, leaving the patients with unanswered questions or issues (Barrere, 2007). Minore, Boone, Katt, Kinch, and Cromarty (2003) concluded that improved communication and interpersonal supports on the part of healthcare providers could ameliorate patients' decreased personal choices and negative healthcare experiences in research of how client health choices influenced cancer care in Northern Ontario. Chloë Atkins, in her autoethnography entitled *My Imaginary Illness* (2010), described reactions of disbelief, dismissal and even hostility from her healthcare providers to the point where she felt "vilified by her physicians" (2010, p. xxvi). In addition to a terrible misdiagnosis, her story is one of extreme erosion of communication and trust within healthcare relationships. Others' stories recount the need for improved collaboration and communication (Conlon, 2007; Wente, 2011), with the hopes that their stories will lead to improvements in access, quality and safety of care, and even enhanced healthcare provider morale and reduced burnout (Blickem & Priyadharshini, 2007; Canadian Medical Association, 2008; Curran, 2007). This literature begs the question as to how care relationships within the healthcare milieu can be improved.

Healthcare managers play an essential role in building and communicating a coherent and compelling vision for organizational change and in linking this vision to hospital operations (Ball, 2009; Kerfoot & LeClair, 1991). They are responsible for leading staff through change processes and routinely meet staff resistance and therefore must plan accordingly (Kotter & Schlesinger, 2008). Managers must first understand and model the change themselves, anticipate staff reactions and tailor contingent strategies for individual employee needs while maintaining positive working relationships and trust (Goh, 2002). Ball (2009) states that healthcare managers and leaders need "to help design functional meaning into the way the delivery of healthcare will operate in the future" (p. 1) with a view toward public interest as well as that of the organization.

For these reasons, Phase 2 of the research engaged healthcare mid-level leaders at a publicly funded healthcare organization in discourse about the customers they and their staff serve and in defining their values, beliefs and recommendations about improving relationships for care. In Phase 1, healthcare providers providing direct patient care, and in Phase 3, senior leaders from within the organization were similarly consulted about customer service and care relationships. The research phases were sequentially undertaken from April 2009 to December 2010, each building on the findings presented from the previous study phase. This paper discusses Phase 2 methodology and findings. The questions that guided the study follow.

First was the central question for the overall research project: What changes in the organizational culture may lead to improved care relationships?

There were then three sub-questions for Phase 2:

1. What do mid-level healthcare leaders value and believe about customer service and relationships for care within the organization?
2. Is the concept of customer service relevant to the mid-level leaders in their work and to what extent?

3. What ideas for change did the mid-level leaders identify as likely to lead to improvements in relationships for care and as being applicable to the organization?

Key Concepts

The following concepts will be defined as to their use in this paper: patient, patient and family, customer, customer service, healthcare provider, mid-level leader, organization.

"Patient" refers to a person who is formally registered through the provincial health database as receiving in/outpatient services. The phrase "patient and family" is used throughout the manuscript, and refers to the patient and his/her choice of family, close friends or personal caregivers, who lent support in the care process.

"Customer" often connotes a business transaction. The Canadian Oxford dictionary (2004) defines customer as "a person who buys goods or services from a store or business" and it may connote negative associations as evidenced by the second definition: "a person one has to deal with *(one tough customer)*" (p. 287). This definition is limited to the situation where a pair of resources is exchanged (e.g., money for goods). In healthcare, provider/patient interactions are a heterogeneous exchange. Products such as empathy, information and hands-on care from the provider may be exchanged for satisfaction, decreased illness or improved function on the part of the patient (Hirschman, 1987). It is with this broader understanding of the complexity of the marketing exchange that the term "customer" is used and it is applied to include the many situations where exchanges can occur within the health service continuum, not only that between the patient/family and care provider, but also between co-workers, supervisors, external care partners and others.

"Customer service" is a phrase that is commonly used in marketing and the media and is broadly defined as service which exceeds the customer's expectations (Baird, 2000; Lee, 2004). It has not been widely associated with the provision of health services in Canadian hospitals. It is however a concept which is commonly used in this regard in the United Sates (Leebov, 2008). The use of this phrase in healthcare is further explored in this research.

"Healthcare provider" refers to the individual who is employed by the organization and has the mandate to provide personal healthcare services. It does not refer to an informal caregiver, for example, one requested or paid personally by the patient to provide assistance. "Mid-level leader" describes an individual who holds a role at the director, manager, educator or similar level within the organization. The healthcare organization will simply be referred to as "the organization."

Author Location and Reflexivity

As a direct care physiotherapist for twenty years, healthcare manager for over ten years at the research site, health service consumer, and now a health researcher, the first author, Rosemary, believes that building positive working relationships with the patient and their family and with co-workers contributes to successful health outcomes. These outcomes might include improvements in patient and staff satisfaction, safer

environments and a sense of well-being, even in the face of very difficult circumstances. It occurred to her that mid-level leaders, along with the healthcare providers with whom they work, may have considerable insights into promoting greater equality and balance in care relationships. She thought that by discussing the concept of customer service, shared understandings might be developed between and with individuals and groups and that this in turn may lead to organizational change directed towards fostering positive relationships for care. As she was an employee within the organization and had worked in different managerial roles with different groups, she had in-depth knowledge of the organization and most of the participants knew her. This led to her ready acceptance as participant/observer/researcher. This paper contributes in part to Rosemary's doctoral research while enrolled at Queen's University. Margo, Professor in the School of Rehabilitation Therapy, was her research supervisor, and Yolande, Professor in the School of Business, advised her on ethical, methodological and writing decision points throughout the process.

Methods

Research Philosophy and Approach

The goal of Phase 2 of the research project was to understand and represent mid-level leaders' beliefs and values about care relationships and to capture their ideas to effect change within the organization. Both qualitative and quantitative methods of inquiry were used in the study. The qualitative inquiry was primarily predicated on the critical research paradigm which is derived from emancipatory interests where social structures and actions are influenced by exploring values, views and practices from socially constructed norms and processes (Higgs, Titchen, Horsfall, & Armstrong, 2007; LeCompte & Schensul, 1999). The critical paradigm expressed a research philosophy that provided a foundation for acquiring knowledge through discourse and critical debate (Higgs et al., 2007). The authors' research interests were founded on a desire to understand the meaning and applications of customer service with the goal of improving relationships for care through questions and focused conversations. An overview of the study's research foundations including paradigm, philosophical tradition and methodologies is presented in Table 1.

Table 1. Reviewing Research Foundations Including Paradigm, Philosophical Tradition and Methodologies*

Research Paradigm	Philosophical Stance	Research Goals	Research Approach	Data Sources	Data Analysis	Report Writing	Quality Control and Review
Critical	Historical Realism- society and culture shape practice; Interests: 'what ought to be, ideals'	To describe mid-level leader change ideas for enacting care relationships with individual and shared discourse	Critical ethnography; Mixed methodology	Participant researcher and key informant observation; Survey; Focus group; Interview; Critical debate; Journaling; Audit trail	Sharing knowledge and experiences individually and within participants; Review and reflection of individual, group and organizational actions; Critical debate, Member checking; Presentations and writing internally to the organization and externally to varied national and provincial audiences; Confirmation between authors; Negative and exceptional cases	Contextual Experiential Descriptive stories; Reflective Critique Thematic with recommendations for change; Ideas to further organizational growth in relationships for care	Ethicality, Volunteer participation; Participants involved in research design; Data collection and analysis; Triangulation of data collection and analysis; Coding confirmed between authors; Detailed outline of research processes; Participants and others see and report change and opportunities for change

*Note: Table derived from (Higgs et al., 2007, p. 38)

The ethnographic research tradition is a scientific approach used to identify and solve complex social problems by examining cultural patterns within a community (Schensul, Schensul, & LeCompte, 1999). It is guided by and generates theory, can be used to modify formative theory, is most often conducted and applied locally focusing on a community or culture and frequently uses both quantitative and qualitative research methods, often triangulating methods to enhance findings (Schensul, Schensul et al., 1999). A critical ethnography is an applied ethnography with the goal to inform and effect change in culture, the results of which can become the basis for development and/or evolution of practice, interventions, policies and models (Creswell, 1998). Thus the critical ethnographic tradition met the central research goal of the current study which was to describe opportunities for growth in culture through shared understandings, norms and practices related to customer service relationships, at individual, group and organizational levels.

Study Site and Participant Sample

The study site was a mid-sized hospital in South Eastern Ontario. Phase 2 participants comprised a sample of volunteers recruited from mid-level leaders at the research site. To guide this process, two internal mid-level leaders were invited to act as key informants throughout the study. Each of these had performed a variety of clinical leadership roles, had a formal research background and had worked in the organization for over thirty years and thus held significant present-day and historical organizational knowledge and readily understood the research processes. With their input, inclusion and exclusion criteria were established. Inclusion criteria were that all invited participants held a clinical portfolio as a director, manager, educator or similar middle leadership role and formally reported on the research site. These criteria identified leaders working with the healthcare provider participants in Phase 1 as they were best situated to understand and elaborate further on Phase 1 findings. Excluded were mid-level leaders with clinical portfolios reporting outside of the research site or any that did not hold clinical portfolios. Recruitment invitations were sent electronically to all mid-level leaders who met the inclusion criteria. The invitation outlined the research goals and methods, and was sent approximately one month in advance of data collection in respect for busy schedules and to enhance participation. Those receiving the invitation were familiar with the study as the first author had formally and informally presented information to them on a number of occasions in the 6 months prior. An invitation reminder was sent approximately two weeks after the initial invitation and included more detailed information about the study, informed consent and confidentiality and survey forms.

The university and organization's ethics review committees approved the research study. Verbal and written information about the study and its intended use were given to the participants, including assurances regarding voluntary enrollment and confidentiality. Participants had to sign informed consent and confidentiality agreements before enrolling in the study. To protect anonymity, numeric codes replaced identifying information on all transcripts and demographic questionnaires. Identifying numeric codes were stored separately from the collected data and all information was kept in locked or in password-protected electronic files.

Research Design

The overall research project followed three sequential phases (Table 2). Phase 2 is discussed in this paper and sought mid-level healthcare leaders' views about customer service and relationships for care. Phase 1 (Brander, Paterson, & Chan, 2012a) and Phase 3 (Brander, Paterson, & Chan, 2012b) are discussed elsewhere.

Table 2. Study Phases Illustrating Timelines, Participants and Research Processes and Cycles

Preliminary	1	2	3
Timelines Sep 2008 – Mar 2009	Apr 2009 – Sep 2010	Sep 2010 – Oct 2010	Oct 2010 – Dec 2010
Participants	Healthcare Providers	Mid-level Leaders	Senior Leaders
Processes and cycles Prepare resources Grant application Ethics applications	Plan and Recruit Data Collection Analysis Write grant final report	Analysis Plan and Recruit Data Collection Analysis Begin writing	Analysis Plan and Recruit Data Collection Analysis Write dissertation and manuscripts
Data collection	• 2 groups of 3 semi-structured focus groups, n=10, 5/group • 2 semi-structured interviews, n=4, 2/group	• Survey, n=1 • 1 semi-structured focus group, n=13 • 1 semi-structured interview, n=1	• 3 semi-structured interviews, n=3

Phase 2 began with further analysis of data from Phase 1, with the plan of bringing deeper understanding and representations of care providers' views to key leaders and decision-makers within the organization for discussion. The first author met with the Chief Nursing Executive Officer/Vice President of Programs to review Phase 1 findings (Brander et al., 2012b), options for dissemination and application of results. It was decided to share study findings with mid-level leaders, to seek their views on customer service and relationships for care, and to add to the ideas for organizational change generated in Phase 1. In consultation with the two mid-level leader key informants, the data collection strategy was developed which included an individual survey to the mid-

level leader participants followed by a group meeting comprised of a presentation of findings from Phase 1 and a focus group discussion.

Survey Design and Development

The purpose of the survey was to explore the individual opinions of the mid-level leaders, prior to the focus group. To begin the survey design, the first author reviewed literature on survey development (Portney & Watkins, 2009) and appreciative inquiry (Preskill & Catsambas, 2006). A written survey strategy outlined the target audience, purpose, guiding questions, format, and analytic methods and a draft survey pointed towards the research goals and questions. The two mid-level leader key informants provided initial feedback on survey planning and later participated in the survey. The draft survey was pilot-tested for readability and application by one other mid-level leader who later participated in its completion, and one outside peer-researcher. The survey took less than 10 minutes to complete. Pilot feedback indicated that four of the questions (2, 4, 10a and 11) were better presented with a Likert-type five-item response choice so that participants were provided with greater latitude to express their opinions beyond the original dichotomous scale. Additional feedback indicated that the survey was very readable, the questions "made you think" and that a take-home survey format would allow more time and consideration of the questions. This led to the decision to electronically send the final survey ahead of the focus group meeting, with the request to complete it and all other forms and bring them to the lunch meeting. The final survey consisted of 16 questions and offered Likert-scale (4), numerical (1) and open-ended (11) response choices (Appendix A).

Focus Group Design and Implementation

A focus group strategy and semi-structured interview guide (Appendix B) complemented the preliminary survey. Two mid-level leaders consulted on the focus group design and interview questions as well as acted as participant-observers during the process. The hour and a half long focus group meeting was a relaxed business format, held in an easily accessed and familiar room to the participants where they enjoyed a complimentary lunch.. Once the consent, confidentiality, demographic and survey forms were gathered, the first author presented a 15-minute overview of the Phase 1 research and findings. The discussion of the previous findings guided the focus group these were projected on a large screen for reference and to stimulate conversation.

The meeting was audio recorded and the two key informant participant-observers completed field notes during the meeting. The first author also completed field notes prior to and immediately after the meeting.

Analytic Methods

Survey responses to Questions 1, 4, 10(a) and 11 were recorded on a 5-point Likert-type scale of Disagree, Somewhat Disagree, Neutral, Somewhat Agree and Agree. Responses to Question 7 were recorded on a five-point Likert-type scale of 0, 1-5, 5-10, 10-15, and greater than 15 times per day. Non-responses were also tabulated. The other

eleven questions had open-ended response choices and were reviewed and coded for similarity and differences in concepts (LeCompte & Schensul, 1999).

Focus group data was transcribed from audio-recordings. Transcripts were cleaned while listening to the audio-tape for accuracy, keeping close reference to the research goals and questions. Transcription errors were corrected, and pauses, laughter, tone of voice and nature of the conversations were noted in the transcript margins to add detail and depth to the data. Ethnographic analysis for survey and focus group text followed the constant comparison and inductive method as described by LeCompte and Schensul (1999). They used the metaphor of assembling a jigsaw puzzle, where the edge pieces are found and linked first (conceptual analysis), then similar patterns and colors are grouped together (categorical and thematic analysis) and lastly and over time, by working through the relationships and fit of the pieces, the complete picture of the puzzle comes into view (cultural analysis). This analogy guided the analysis, which was initially completed by the first author. Similar concepts were grouped into larger categories and themes with a particular focus on the change ideas generated. Exceptional and/or surprising cases were noted. Microsoft Word tables were used to collate and compare survey and focus group findings. Observational field notes were triangulated with the transcript and survey data, with reference to the research questions during the analysis. The first author maintained and reviewed her audit trail, journal and reflexivity notes in an effort to separate her own biases from the analysis and maintain quality. The second and third authors coded transcripts intermittently and coding was discussed collectively to build consensus and confirmation throughout the analysis.

Ensuring Quality

The four criteria of credibility, dependability, confirmability, and transferability as described by Lincoln and Guba (1985) will be reviewed to illustrate the trustworthiness of the study.

Credibility. Clearly defining research objectives and questions and reviewing these throughout the study enhanced credibility. Data collection strategies were conducted according to well-established and published sources (Schensul, LeCompte, Nastasi, & Borgatti, 1999; Schensul, Schensul et al., 1999). Similarly, the analysis was based on detailed reference to documented methods of analysis for ethnography as described by LeCompte and Schensul (1999). The first author's familiarity with the research site and culture and her acceptance as a participant/observer/researcher strengthened data collection as participants indicated that they spoke freely in the focus group/interview and she was able to understand the contexts and nuances described based on her emic knowledge. Prolonged engagement with subject matter, analyzing participant verbatim scripts and triangulation of data collection methods such as using an observer during focus groups, audiotapes for transcription, and maintaining field notes and files of relevant data from the research site were a consistent practice. Thick description of the culture was achieved by the variety of sources and great detail accumulated in the data. Research planning and debriefing with participant stakeholders occurred as the study progressed, such as with mid-level leader key informants. Reflective and audit trail notes were maintained throughout the study to assist with the evaluation of study design, progress, and analysis. Peer scrutiny of the project occurred longitudinally, as

presentations of research plans and findings were provided within the organization, and also at peer-reviewed conferences.

Transferability. In order to enable other researchers to evaluate the extent to which results can be applied in another similar context, the researchers fully described the methodological details, participants and the research site (Krefting, 1991; Streubert & Carpenter, 1999).

Dependability. Informally presenting summaries and recommendations back to participants (member-checking) and formally presenting findings at scientific conferences for peer review enhanced the documentation of study processes (Lincoln & Guba, 1985; Shenton, 2004).

Confirmability. The first author wrote a reflexivity statement at study onset and maintained a detailed audit trail and reflective research notes which were reviewed throughout and with triangulation of coding and analysis between all three authors, thereby reducing the effect of investigator bias (Krefting, 1991; Shenton, 2004). The first author made every effort to be aware of and to set aside biases during the data collection and analysis.

Organization of Findings

Results are presented under Demographics and Survey and Focus Group Findings. As the analysis of the survey and focus group/interview occurred separately and then were re-analyzed conjointly, the findings are presented together. Three main categories of information emerged in response to the three research questions and evidence for these are provided in frequencies of responses and quotations from the text below. An exceptional occurrence is also described.

Findings

Demographics

Thirteen of the 14 mid-level leaders volunteered to participate. Thirteen completed the survey; twelve participated in the focus group and one in an individual interview due to a scheduling conflict with the focus group time (Table 3). All participants had considerable relevant experience (17 years or more). The majority had received formal patient and family centered education and only one had had a recent personal experience related to care from the organization.

Table 3. Demographics of the Mid-Level Leader Participants

Independent variable	Mid-level leaders	
Data collection Tool	Survey	Focus Group/ Interview
Female/Male	13/0	12/1
Age range in years (Mean)	42-61 (47.6)	
Professional experience in years (Mean)	17-38 (29.4)	
Highest educational credential	3 College Diploma, 7 Bachelor's, 3 Master's	
Received Patient & Family Centered Care education	9	
Self or family member as a patient in organization within previous 12 months	1	

Mid-level Leader Survey Results and Focus Group Findings

There was a high response rate for completed surveys (93%, 13 of 14) and for focus group/interview participation (93%, 12 for focus group plus 1 interview of 14). Three categories of data emerged in response to the research questions: 1. Representation and meanings related to customer service and relationships for care; 2. Relevance of customer service in the mid-level leaders' work and; 3. Strengths and opportunities for organizational change.

Representations and meanings related to customer service and relationships for care. The strong majority (85.6%) indicated that customer service is a concept that belongs in healthcare and strong sentiments validated this in textual responses, for example, "It is the cornerstone of what we do," "The patient-client is a consumer in the healthcare field," and "The concept is what I believe should guide all healthcare practices." One respondent indicated that she disagreed and said, "I don't like the term. It signifies to me if you don't like the product you can get your money back." It appeared that it was the terminology that was the issue in this case as she indicated that "Relationship Centered Care" was a better conceptual framework.

A number of responses indicated that in order for the healthcare employee to clearly understand care delivery needs and goals, patients and families had to be involved in the choices and decisions about their own health and care. Aligned with this was a resounding response (92.3%) that declared that providing good customer service linked with partnering in healthcare. The majority of mid-level leaders said that partnering with clients, having them directly involved in sharing information and planning and setting goals, was directly associated with positive experiences, good outcomes and improved satisfaction. Working together with all stakeholders for smooth transitions across the

healthcare continuum was mentioned repeatedly and depicted their belief in the need for partnerships with external as well as internal customers. The mid-level leaders identified a great variety of internal customers: patients, colleagues, staff, family members, volunteers, visitors, students, other departments and administration (managers, senior leadership and Board members), and external customers: partnering organizations, referral sources, third party payers and The College of Nurses.

Some mid-level leaders suggested alternative concepts representing healthcare relationships and "patient (person or client) and family-centered care" was identified most often. "Relationship-centered care" and "therapeutic relationships," as described in the Registered Nursing Association of Ontario (RNAO) Best Practice Guideline (2006), were also proposed. Some mid-leaders felt it was important to include newer constructs related to accountabilities for relationships and care provision (i.e., that the healthcare provider was part of the "patient's team," or acted as participants in the "patient's plan of care"). These represented movement away from traditional biomedically oriented labels depicting system ownership such as "the healthcare team or plan," "the medical record or chart," and "the nursing (or other discipline's) care plan."

Relevance of customer service in the mid-level leaders' work. Customer service was reported as very relevant in the hospital culture by the mid-level leaders. The majority (92.3%) indicated that providing customer service was a large part of their regular work, and estimated that it occurred daily, more than 15 times per day (61.5%), ten to fifteen times per day (15.4%), and five to ten times per day (15.4%). One respondent did not respond and may have chosen not to answer, not understood or missed the question. One unsolicited comment stated, "It is the only thing that must be present to provide care that meets my standards."

Mid-level leaders said they were able to provide good customer service when they were responding to patient concerns, compliments or complaints, staff, other managerial or department needs or to external partners. Many said it was difficult to provide good customer service with unmanageable workloads and limited resources, and cited absenteeism, conflict, poor performance, poor communication and out-dated practices as contributors. One manager stated:

> *I feel like the patient as director is not yet embedded in our culture, is a telling theme. It's a multi-faceted approach that is needed...I'm disappointed to see that it is not yet embedded in culture. It shows how enormous, how much work we need to do to realize that cultural change.*
> (Mid-level leader [MLL] focus group)

Strengths and opportunities for organizational change. Survey data, largely from questions 8, 9 and 12 which asked about facilitators and barriers to customer service and suggestions to enhance partnership in care, were triangulated with focus group data to garner ideas for change. Key themes that enabled mid-level leaders to perform well in customer service relationships along with examples of change ideas (CI) are listed in Table 4.

Table 4. Customer Service and Care Relationships: Mid-Level Leader Themes with Example Change Ideas

Theme	Example Change Idea
Being present	1. The patient/family would be present at the multidisciplinary conference when his/her information is being discussed.
Communicating well	2. Healthcare workers would become more comfortable in talking with patients and families about what we can and cannot do, for example, when discussing goals or expectations.
Taking action	3. Nurture flexibility and individualism while maintaining consistent and excellent quality of care.
Having and recognizing each others' expertise and know-how	4. Build partnerships by recognizing and seeking each other's expertise; e.g., with patient and families and their role in the care process.
Collaborating	5 a. All key committees would have patient/family participation. 5 b. Develop awareness of traditional biomedical models, which depict hierarchical and authoritative leadership and decision-making.
Ownership and accountability	6. Encourage ownership and accountability for both staff and patients/families. Ask "What happened because I did this or didn't?"

Being present on the part of the mid-level leader was characterized by "walking the hallways," "listen and address concerns," being available "in my office and via phone or computer work" and "complete work for others in a timely manner." Being present on the part of the patient and family was also seen as important area for change, with suggestions for this to occur more routinely at team meetings and at hospital committees where decisions are made.

> *The patient (would) come to the multidisciplinary conference. The conversation (would happen) with the patient, not always about the patient. I think the timeliness and outcomes (of the meetings) would improve so much.* (MLL focus group, CI #1)

Communicating well was frequently noted and described in different situations: communicating regularly and in a straight-forward way; informing a staff member in crisis of important resources, e.g., of the Employee's Assistance Program; listening to and addressing concerns. One example recanted was that of difficult conversations with patients and families about goals and expectations:

> *I think we can improve on where we are not meeting the patient's goals or expectations; it is how we communicate with the patient about that. Sometimes we feel there is a failure on our end or we don't have the resources and then we don't communicate about it. We just don't go*

there…We need to become more comfortable talking to people about what we can do and what we may not be able to do. (MLL focus group, CI #2)

Taking action was evident in the verbs used throughout the examples: respond, ensure, inform, work with, promote, facilitate, investigate, complete work and provide. There were many concrete examples and the past tense was often used which indicated that these actions were occurring in the organization.

I provided data within very tight timelines to support a service review. (MLL survey)

It was so impressive when the group got together, talked about each individual patient, met with the patient, and the patient had a piece of the conversation and worked on resetting expectations. (MLL focus group)

Another story was a sign-post for the complexity inherent in changing culture and the reactions and consequences related to these.

We had a lot of discussion on one floor where a nurse did something extra for a patient because that patient was very needy and was criticized by her coworkers pretty severely for doing that. It was done out of compassion for that patient's needs on that particular day. So I think she was providing good customer service. I understand that everyone needs to be on the same page but the page needs to include what happens on that day. (MLL focus group, CI #3)

This story reflected the view that consideration of individual needs and situations must be part of decision-making when planning and maintaining quality care standards.

A theme of **having and recognizing each others' expertise and know-how** was evident in examples such as when clinical mid-level leaders provided "opinions on finance" and "new information to staff about delirium and a new screening tool." A partnership in recognizing each other's expertise was recommended:

Most of our patients don't know what the possibilities [for care] are. That's what we can bring to the table, the expertise and knowledge so that we can help our patients bring all the pieces, what's important to them, the context of their life and how that will fit in. We have a partnership. (MLL focus group, CI #4)

There was also strong evidence depicting the importance of **collaborating with patients, family and with staff** which appeared to be embedded within the culture. One phrase repeatedly used by the mid-level leaders was "working with" individuals, staff and teams. A suggestion for augmenting collaboration was provided.

My vision of a patient-centered organization would be that on all key committees, or at key decision-making times, there would be an

> *opportunity for the patient or family to comment. So that procedures or*
> *policies would not be set in place without asking, "What does that do for*
> *me as a patient or family?"* (MLL focus group, CI #5 a)

Somewhat incongruent were phrases depicting permission or an imbalance of power, as in "allowing teams to make decisions," "give more knowledge," "allowing students to be paired." Vestiges of biomedical models of care within the culture were reflected in the conversations, but were recognized and corrected at times, as in, "Giving information… not just giving information, helping the person to understand." Although authoritative phrases such as these appeared infrequently in the data, they provided evidence of expert models remaining somewhat embedded in the workplace as well as a desire to reconsider these old models in efforts to change norms (CI #5 b).

Ownership and accountability was another theme that arose when discussing productive care relationships and an opportunity for change. One participant stated that accountability needed to be on the part of all involved in the care relationship:

> *I think one element that tends to get lost, both on the side of the patient*
> *and staff is ownership. We own what we do. We own the responsibility.*
> *The patient takes ownership for their health…Unless the patient*
> *understands, participates and builds (the plan of care) he/she may feel*
> *that it is being done to them…rather than with them. That repeats itself*
> *time and time again. How do we foster that kind of ownership?*
> *Secondly…there are areas where we have things such as unmet*
> *expectations…where people are throwing up their hands and saying,*
> *"Well it's out of my control" or "It's not what I do." They put up barriers*
> *and don't take ownership for their actions instead of asking, "What*
> *happened because I did this or didn't?" I don't know how we foster that in*
> *the culture but I believe that we have the strength.* (MLL focus group, CI #*
> 6)

Unexpected Occurrence

After the focus group, five interested individuals spontaneously stayed and continued with discussion and feedback. This impromptu occurrence was also audio-recorded, with their permission, and provided additional data for transcription and review. The conversation focused on the ways and means of continuing the patient and family-centered care education, which had been recently interrupted. This information further demonstrated the motivation and interest that many held in advancing the organizational culture towards strong patient and family-centered relationships. If this small group had demonstrated views vastly different from the larger group of participants, it might have had significant impact on the findings. However, this was not the case and it was an extension of and in consensus with the prior focus group conversation.

Discussion

Phase 2 revealed one component of the organization's culture, that of a motivated group of mid-level leaders, eager to volunteer their time and thoughts toward exploring ways to seek greater engagement of healthcare customers for improved care relationships. This motivation was evident both at the individual level, by the high survey response rate and focus group participation for individuals and the group, respectively, and by the in-depth participant contributions. The mid-level leaders clearly stated that customer service was very important in their own day to day work and believed that this contributed to positive outcomes, citing improved partnership with patients and staff, service satisfaction and transitions between health services.

In their award-winning article, Crossan, Lane, and White (1999) described a framework for organizational learning, first mediated at individual and group levels by intuiting and interpreting the phenomenon of interest, which later becomes embedded at group and organizational levels by integrating and developing shared understandings, coordinated actions and institutionalizing routines in systems and strategies. This was a dynamic process which moved forward and backward as changes were adopted and interactions occurred between all levels. This research exemplified the Crossan et al. (1999) framework of organizational learning by first engaging individuals and then a group of mid-level leaders in discussion and development of shared knowledge and meanings about healthcare relationships. Real members of the organization generated possible actions for organizational change by sharing creativity and enthusiasm towards these opportunities and envisioning applications for further growth.

Mid-level leaders play a unique role in the organization as they work with and transfer information between multiple groups. Great leadership is built on effective relationships and collaboration which inspires others to be effective (Goleman & Boyatzis, 2008). In the current study, managers reported that their focus on customers and service, including staff as well as patients and families in their definitions of customers, was important in their work. This underlying motivation to build relationships and attend to those around them leads to the development of socially intelligent leaders who can act as role models to others in the organization (Goleman & Boyatzis, 2008).

Another important motivation is the willingness of leaders to share information broadly with others in the organization (Goh, 2002). This contributes to an open culture that is ready for innovation, the creation of new ideas and a win-win mindset to improve the work (Ball, 2009; Youngblood, 1997). In reflecting and contributing to the change ideas generated by the healthcare providers within the organization, mid-level managers were able to reflect on this knowledge and add additional practical ideas. A future plan would be to hold conversations together with a great variety of individuals from all levels of the organization to spread ideas and generate greater innovation.

A limitation in the first author acting as participant/observer/researcher was that her emic knowledge of the organization may have influenced analysis. Every effort was made to represent the participant voices by using key informants for consultation and participant observation, and presentations as a form of member-checking within the organization and outside to peer-audiences. The co-authors independently analyzed transcripts and consensus coding was built to decrease bias in analysis. Including additional mid-level leaders with non-clinical portfolios from other organizational sites

would have allowed for deeper cultural representation, but resources and time precluded this as part of the study.

As the ethnography described the culture of a non-acute hospital organization, these findings are very specific to the identified local community and may not be generalizable to other settings (LeCompte & Schensul, 1999). The cultural themes and change ideas derived from the mid-level leader participants may well be useful in other hospitals; however, settings would need to be compared before applying the results to other contexts.

A critical ethnographic approach was used to explore the meaning of customer service and relationships for care for mid-level leaders working together in a mid-sized hospital organization. Important cultural themes enabled further discussions and debate, which were directed towards identifying concrete strategies for change. These strategies will be used in the next phase of the research, involving senior leaders and key informants within the organization, with anticipation that future integration and adoption will advance customer service relationships for all within the organization.

References

Accessibility for Ontarians with Disabilities Act (2005) Government of Ontario Statistics.

Atkins, C. G. K. (2010). *My imaginary illness: A journey into uncertainty and prejudice in medical diagnosis*. Ithaca, NY: Cornell University Press.

Baird, K. (2000). *Customer service in health care: A grassroots approach to creating a culture of service excellence*. San Francisco, CA: Jossey-Bass.

Ball, T. (2009). Designing integrated healthcare service delivery systems. *Managing Change, Winter*, 1-17.

Barrere, C. C. (2007). Discourse analysis of nurse-patient communication in a hospital setting: Implications for staff development. *Journal for Nurses in Staff Development, 23*(3), 114-122; 123-114.

Beach, M. C., Insui, T., & The Relationship-Centered Care Research Network. (2006). Relationship-centred care: A constructive reframing. *Journal of General Internal Medicine 21*, S3-8.

Bissell, P., May, C. R., & Noyce, P. R. (2004). From compliance to concordance: Barriers to accomplishing a re-framed model of health care interactions. *Social Science and Medicine, 58*(4), 851-862.

Blickem, C., & Priyadharshini, E. (2007). Patient narratives: The potential for "patient-centred" interprofessional learning? *Journal Interprofessional Care, 21*(6), 619-632.

Brander, R. A., Paterson, M., & Chan, Y. E. (2012a). *Customer service to partners-in-care: Healthcare providers' perspectives of care relationships*. Manuscript submitted for publication.

Brander, R. A., Paterson, M., & Chan, Y. E. (2012b). *Using a common vision of 'partners-in-care' to enhance hospital relationships*. Manuscript submitted for publication.

Cahill, J. (1996). Patient participation: A concept analysis. *Journal of Advanced Nursing, 24*(3), 561-571.

Cahill, J. (1998). Patient participation - A review of the literature. *Journal of Clinical Nursing, 7*(2), 119-128.

Canadian Medical Association. (2008). *Achieving patient-centred collaborative care*. Available from CMA Online. Retrieved from http://policybase.cma.ca/dbtw-wpd/Policypdf/PD08-02.pdf

Casey, M. (2008). Partnership - Success factors of interorganizational relationships. *Journal of Nursing Management, 16*(1), 72-83.

Conlon, P. (2007, June). *Family and patient centred care.* Paper presented at the Ontario Hospital Association Conference, Canada.

Coulter, A. (1999). Paternalism or partnership? Patients have grown up-and there's no going back. *British Medical Journal, 319*, 719-720.

Creswell, J. W. (1998). Data Analysis and Respresentation. In C. D. Laughton (Ed.), *Qualitative inquiry and research deisgn* (pp. 140-165). Thousand Oaks, CA: Sage.

Crossan, M. M., Lane, H. W., & White, R. E. (1999). An organizational learning framework: From intuition to institution. *The Academy of Management Review, 24*(3), 522-537.

Curran, V. (2007). *Collaborative care*. Ottawa, Canada: Health Canada. Retrieved from http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/prim/2006-synth-collabor-eng.pdf

Customer. (2004). In Canadian Oxford Dictionary (2nd ed.). Don Mills, Canada: Oxford University Press.

D'Amour, D., Ferrada-Videla, M., San Martin Rodriguez, L., & Beaulieu, M. D. (2005). The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks. *Journal of Interprofessional Care, 19*(Suppl. 1), 116-131.

Dalton, J. M. (2003). Development and testing of the theory of collaborative decision-making in nursing practice for triads. *Journal of Advanced Nursing, 41*(1), 22-33.

Denis, J. L., Davies, H. T. O., Ferlie, E., & Fitzgerald, L. (2011). Assessing initiatives to transform healthcare systems: Lessons for the Canadian healthcare system. *Canadian Health Services Research Foundation Series on Healthcare Transformation*, 1-35.

Dewing, J. (2004). Concerns relating to the application of frameworks to promote person-centredness in nursing with older people. *International Journal of Older People Nursing 13*(3a), 39-44.

Eldh, A. C., Ekman, I., & Ehnfors, M. (2006). Conditions for patient participation and non-participation in health care. *Nursing Ethics, 13*(5), 503-514.

Epstein, R. M., & Street, R. L. (2011). The values and value of patient-centred care. *Annals of Family Medicine, 9*(2), 100-103.

Epstein, R. M., & Street, R. L., Jr. (2007). Patient-centered communication in cancer care: Promoting healing and reduced suffering. *National Cancer Institute* (No. 07-6225).

Excellent Care for All Act. (2010). Ontario Regulation 444/10 Stat.

Gerteis, M., Edgman-Levitan, S., Daley, J., & Delbanco, T. L. (Eds.). (1993). *Through the patient's eyes.* San Francisco, CA: Jossey-Bass.

Goh, S. C. (2002). Managing effective knowledge transfer: An integrative framework and some practice implications. *Journal of Knowledge Management, 6*(1), 23-30.

Goleman, D., & Boyatzis, R. (2008). Social intelligence and the biology of leadership. *Harvard Business Review September*, 74-81.

Gravel, K., Légaré, F., & Graham, I. (2006). Barriers and facilitators to implementing shared decision-making in clinical practice: A systematic review of health professionals' perceptions. *Implementation Science, 1*, 16.

Higgs, J., Titchen, A., Horsfall, D., & Armstrong, H. B. (Eds.). (2007). *Being critical and creative in qualitative research*. Sydney, Australia: Hampden.

Hinojosa, J., Sproat, C. T., Mankhetwit, S., & Anderson, J. (2002). Shifts in parent-therapist partnerships: Twelve years of change. *American Journal of Occupational Therapy, 56*(5), 556-563.

Hirschman, E. C. (1987). People as products: Analysis of a complex marketing exchange. *Journal of Marketing, 51*, 98-108.

Hobbs, J. L. (2009). A dimensional analysis of patient-centred care. *Nursing Research, 58*(1), 52-62.

Kerfoot, K. M., & LeClair, C. (1991). Building a patient-focused unit: the nurse manager's challenge. *Nursing Economics, 9*(6), 441-443.

Kotter, J. P., & Schlesinger, L. A. (2008). Choosing Strategies for Change. *Harvard Business Review, July-August*, 130-138.

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *The American Journal of Occupational Therapy, 45*(3), 214-222.

LeCompte, M. D., & Schensul, J. J. (1999). *Analyzing and interpreting ethnographic data* (Vol. 5). Walnut Creek, CA: AltaMira.

Lee, F. (2004). *If Disney ran your hospital: 9 1/2 things you would do differently*. Bozeman, MT: Second River Healthcare.

Leebov, W. (2008). Beyond customer service. *American Nurse Today, 3*(1), 21-23.

Légaré, F., Stacey, D., & Forest, P. (2007). Shared decision-making in Canada: Update, challenges and where next! *ScienceDirect, 101*, 213-221.

Légaré, F., Stacey, D., Graham, I., Elwyn, G., Pluye, P., Gagnon, M.-P., . . . Desroches, S. (2008). Advancing theories, models and measurement for an interprofessional approach to shared decision making in primary care: A study protocol. *BMC Health Services Research, 8*(1), 2.

Légaré, F., Stacey, D., Pouliot, S., Gauvin, F.-P., Desroches, S., Kryworuchko, J., . . . Graham, I. (2011). Interprofessionalism and shared decision-making in primary care: A stepwise approach towards a new model. *Journal of Interprofessional Care, 25*, 18-25.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry* (1st ed.). Newbury Park, CA: Sage.

Makoul, G., & Clayman, M. L. (2006). An integrative model of shared decision making in medical encounters. *Patient Education and Counseling 60*(3), 301-312.

Martin, G. P. (2008). 'Ordinary people only': Knowledge, representativeness, and the publics of public participation in healthcare. *Sociology of Health & Illness, 30*(1), 35-54.

Minore, B., Boone, M., Katt, M., Kinch, P., & Cromarty, H. (2003). How clients choices influence caner care in nothern Aboriginal communities. *Circmpolar Health, 62*(2), 129-132.

Niedz, B. A. (1998). Correlates of hospitalized patients' perceptions of service quality. *Research in Nursing & Health, 21*, 339-349.

Nolan, M., Davies, S., Brown, J., Keady, J., & Nolan, J. (2004). Beyond person-centred care: A new vision for gerontological nursing. *Journal of Clinical Nursing, 13*(3a), 45-53.

Nolan, M., Davies, S., Ryan, T., & Keady, J. (2008). Relationship-centred care and the 'Senses' framework. *Journal of Dementia Care, 16*(1), 26-28.

OConnor, A. M., Drake, E. R., Wells, G. A., Tugwell, P., Laupacis, A., & Elmslie, T. (2003). A survey of the decision-making needs of Canadians faced with complex health decisions. *Health Expectations, 6*(2), 97-109.

Pelzang, R. (2010). Time to learn: Understanding patient-centred care. *British Journal of Nursing, 19*(14), 912-914.

Picard, A. (2011, Aug. 21). Canadians want health charter to guarantee quality and timeliness. *The Globe and Mail*. Retreived from http://www.theglobeandmail.com/life/health/new-health/health-news/canadians-want-health-charter-to-guarantee-quality-and-timeliness/article2136635/

Portney, L. G., & Watkins, M. P. (2009). *Foundations of clinical research: Applications to practice* (3rd ed.). Saddle River, NJ: Pearson/Prentice Hall.

Preskill, H., & Catsambas, T. T. (2006). *Reframing evaluation through appreciative inquiry*. Thousand Oaks, CA: Sage.

Rao, J. K., Anderson, L. A., Inui, T. S., & Frankel, R. M. (2007). Communication interventions make a difference in conversations between physicians and patients: A systematic review of the evidence. *Med Care, 45*(4), 340-349.

Registered Nurses' Association of Onatario. (2006a). *Nursing best practice guideline, client centred care supplement.* Toronto, Canada: Registered Nurses' Association of Ontario.

Registered Nurses' Association of Ontario (2006b). *Client Centred Care* (rev. suppl.). Toronto, Canada: Registered Nurses' Association of Ontario. Retrieved from http://www.rnao.org/Storage/15/933_BPG_CCCare_Supplement.pdf

Robinson, J. H., Callister, L. C., Berry, J. A., & Dearing, K. A. (2008). Patient-centred care and adherence: Definitions and applications to improve outcomes. *Journal of the American Academy of Nurse Practitioners, 20*(12), 600-607.

Romanow, R. J. (2002). *The Commission on the Future of Health Care in Canada*. Ottawa, Canada: Health Canada. Retrieved from www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/romanow-eng.php

Sahlsten, M. J. M., Larsson, I. E., Sjostrom, B., Lindencrona, C. S. C., & Plos, K. A. E. (2007). Patient participation in nursing care: Towards a concept clarification from a nurse perspective. *Journal of Clinical Nursing, 16*(4), 630-637.

Schensul, S. L., LeCompte, M. D., Nastasi, B. K., & Borgatti, S. P. (1999). *Enhanced ethnographic methods: Audiovisual techniques, focused group interviews, and elicitation techniques* (Vol. 3). Walnut Creek, CA: AltaMira.

Schensul, S. L., Schensul, J. J., & LeCompte, M. D. (1999). *Essential ethnographic methods: Observations, interviews, and questionnaires* (Vol. 2). Walnut Creek, CA: AltaMira.

Shenton, A. K. (2004). Operationalising the concept of "information" for research into information behaviour. *Aslib Proceedings: New Information Perspectives 56*(6), 367-372.

Sherman, D., & Canadian Press. (2011). Baby Joseph can go home to die: Hospital. Retrieved from http://www.cbc.ca/news/canada/windsor/story/2011/02/28/wdr-maraachli-release.html

Streubert, H. J., & Carpenter, D. R. (1999). *Qualitative research in nursing: Advancing the humanistic imperative* (2nd ed.). Philadelphia, PA: Lippincott.

Wente, M. (2011, February 26). Three days in a hospital. *Globe and Mail.* Retrieved from www.theglobeandmail.com/news/opinions/opinion/three-days-in-a-hospital/article1921336/

Williams, A. M., & Irurita, V. F. (2004). Therapeutic and non-therapeutic interpersonal interactions: The patient's perspective. *Journal of Clinical Nursing, 13*(7), 806-815.

Youngblood, M. D. (1997). Leadership at the edge of CHAOS: From control to creativity. *Strategy and Leadership, 25*(5), 8-14.

Appendix A

Survey for Mid-level Leaders

Thank you for your time and consideration of the following questions. Your responses will help to inform recommendations regarding customer service for the organization and research study. There is no right or wrong answer. Responses are anonymous and will be aggregated for analysis. **Please circle, write or choose the most appropriate response where appropriate:**

1. Customer service is a concept that belongs with the delivery of healthcare.

Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Agree

2. Please describe why or why not:

3. Is there a phrase(s) or term(s) that better represents customer relations in healthcare and if so, what would it be?

4. Providing good customer service is linked with partnering in care, in healthcare.

Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Agree

5. Please describe why or why not:

6. Who do you identify as your customers at work? (E.g., patients, etc.)

7. How many times during your workday do you provide customer service?

0	1-5	5-10	10-15	greater than 15

8. Please provide 2-3 examples of when you were able to provide good customer service at work:

9. a) The hospital's culture would support organizational change related to customer service.

Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Agree

b) Please briefly describe why or why not?

10. List 3 (or more) suggestions to enhance partnership in care at the hospital:

11. Are there suggestions that might be more difficult to implement but which would still be important to consider?

Thank you for your help!

Appendix B

Focus Group Strategy and Interview Guide: Mid-level Leaders

Opening Script:
- Welcome. Please help yourself to lunch.
- Please place your completed forms on the table in the labeled boxes.
- Is everyone here? Is everyone comfortable?
- Does everyone know each other? Introduce participant-observers taking 'field notes'.
- Is it OK to start the recorders? (Started recorders)
- Thank you for bringing your expertise and creativity to our second focus group.
- Next 1.5 hours are booked for our discussion. We will wind up at 1:25 pm, if not before.
- Be comfortable, move around, and ask questions as needed.
- Please bring your imaginations and forthrightness to the discussion

Just to review some group norms:
- Please feel free to openly contribute to our discussion, listen respectfully and allow one to finish talking before joining in, giving time for all to speak.
- It's great if you share different opinions or are controversial, so please bring any and all of your ideas forward. You hold unique positions within the organization to speak to customer service and relationships for care, so I'm very fortunate to have your time.
- Participation is voluntary, details of our conversations are confidential and everyone has indicated that they will respect confidentiality. I will remove any and all identifying features from the transcripts and no one sees them but me. Results are all rolled up together for analysis and presentation purposes.

Are there any questions so far? Let's get started chatting about customer service in healthcare.

Presentation

- First author presents an overview of the study, the progress to date and Phase 1 findings, including cultural themes and organizational change ideas. These were presented on a large screen throughout the focus group for reference and to stimulate discussion.

Guiding Focus Group Questions

1. Which of the internal organizational change ideas stood out?
2. Which could be applied easily and provide positive impact on care relationships?
3. Are there other change ideas that are important to consider?
4. Which of these are priorities?
5. In what new ways could the learning be introduced and sustained?
6. How could we move forward?

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