The Dyad Leadership Model: Defining a New Physician/Nurse Relationship

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A Thesis Submitted to the Faculty of Social and Applied Sciences
in Partial Fulfilment of the Requirements for the Degree of

MASTER OF ARTS IN PROFESSIONAL COMMUNICATION

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Victoria, British Columbia, Canada

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August, 2019

COMMITTEE APPROVAL

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Abstract

Health care systems across Canada continue to be challenged to meet the growing health care demands of the population. These challenges are set against the backdrop of fiscal realities that demand strong leadership that strikes a balance between providing quality and safe care and obtaining financial sustainability in the taxpayer-funded system. A leadership model that is emerging in health organizations is the dyad model that often partners a physician and a nurse administrative leader as a leadership team to have accountability and responsibility for large, complex portfolios. In an effort to determine whether the physician-nurse dyad leadership model provides for a successful leadership partnership, this study examined whether the historical social relationship between male physicians and female nurses has an impact on that leadership partnership. A qualitative research approach was taken in this study using interpretative phenomenological analysis to frame the data collection and analysis. Semi-structured interviews were conducted with six key informants which included three male physician leaders and three female nurse leaders. The findings demonstrate that the physician and nurse leaders have the ability to develop relationships when there is respect for the skills and knowledge that each brings to the partnership and where each one acknowledges there are instances and circumstances where there is a need to have confidence and trust in the ability of the partner to take the lead. The support exists for the dyad relationship and that it is an effective model in health care as it allows administrators and clinicians to draw on the other's knowledge, skills and experience to form an interdependent leadership partnership.

Keywords: Leadership, health care, physician role, nurse role, dyad leadership model, gender

Acknowledgements

The completion of my Master's is an accomplishment that I share with many who have supported, encouraged, advised and cheered me on along the way. Despite the fact I have more than 30-plus years working in the field either in the media or in corporate communications, this academic pursuit, while exciting and exhilarating, was frightening and intimidating as I hadn't been inside the walls of academia for more than three decades. It is therefore very much appreciated when you have those around you who help you make that first step in your new endeavour, who keep you motivated along the way and who are there to urge you, push you in fact, to the finish line.

First, I would like to thank my thesis supervisor Dr. Virginia McKendry, a wonderful woman, exceptional mentor, and supportive adviser. I recall the comments she made on my first assignment for her course back in the fall of 2017 and how it provided the amount of encouragement I needed right at the start of this journey. That was just a small preview of the type of advisor Dr. McKendry would be in the completion of my thesis. While my constant cheerleader, she also provided the advice that allowed me to move beyond my "learning boundaries" to expand my knowledge and to take my work to higher levels. For that I will be forever grateful. It is also incumbent on me to acknowledge there is a whole community of supports for those pursuing post-secondary education at Royal Roads University including my thesis committee member, Dr. Julia Jahansoozi, the faculty and staff of the School of Communication and Cultural Studies, and those "research experts" at the library who were always so tremendously helpful.

To my friends, especially Vickie, Sharon, and Jacquelyn, who were always there to listen to me vent, offer words of encouragement and moments of levity, and of course, to share those much needed “socialables” along the way.

In everything I have done in my life, I have had the full support of my family and in this endeavour, it was no different and I am very grateful for them. I particularly want to recognize my sister Norma and her husband Murdoch for selflessly stepping up to provide the ever-increasing care that our parents have needed during this time. Knowing that mom and dad were receiving the best of care certainly put my mind at ease as I focused on my academic work and for that they have my love and gratitude.

Last, but certainly not least, I express my love and appreciation to my son, Dr. MacKenzie Turpin. As someone who has spent more years in academia than I could ever imagine, it was a no-brainer for him to say “go for it” when I first raised the idea of pursuing my Master’s. MacKenzie also provided encouragement along the way and took the time, as he was in the last days of completing his medical degree, to provide the advice and constructive criticism I needed to keep me on track and stay focused on completing this thesis. I am so very proud of you, MacKenzie.

Dedication

During the course of my studies for this Master’s, my home became the home away from home for several of my family members as my step-niece, Jennifer, put up the great fight against cancer. While I may have felt overwhelmed by the work I needed to do to attain this degree, nothing compared to the strength I saw demonstrated by Jennifer as she fought with everything she had to beat the dreaded disease. Unfortunately, Jennifer’s fight came to an end on August 8, 2018, at the age of 36. Her struggles confirmed for me that, if you have a life goal, get out there

and do what you can to achieve it as life can be way too short. For that lesson, Jennifer, I dedicate this to you. RIP.

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Introduction

The health care system in Canada faces many challenges that include rising costs, complex care, rapid change, and increased demands (Clausen et al., 2017). As noted in the study *How Canada Compares: Results from the Commonwealth Fund's 2016 International Health Policy Survey of Adults in 11 Countries*, there are areas where health systems in Canada fail to meet the needs and expectations of patients (Canadian Institute for Health Information, 2017). For example, the study noted that Canadians are waiting longer to see doctors and specialists, for elective surgeries and in emergency departments. These challenges within the health system come at a time when health care spending is increasing, as noted by the Canadian Medical Association in a news release on July 17, 2018, which stated that health care spending in Canada is expected to increase by $93 billion, or 20 per cent, over the next decade. The clinical issues—such as the increase in wait times for access to care and the organizational issue of rising costs—present an overwhelming challenge for those who are charged to lead and, as many aspire, transform health care organizations. Those challenges combined require strong leadership that must be able to "empower and motivate their workforce, define articulate a vision, build and foster trust and relationships, adhere to accepted values and standards, and inspire their followers to accept change and meet organizational goals on multiple levels" (McAlearney, 2006, p. 969).

The notion of the need for health care organizations to have strong leadership is supported by the Canadian Health Leadership Network (CHLNet), which defined health leadership in its Strategic Plan, 2017-2020, as the "collective capacity of an individual or group to influence people to work together to achieve a common, constructive purpose" (p. 2). CHLNet asserts that strong leadership has been identified as critical to making improvements to the health system; however, the traditional pyramid structure found in business organizations is not

necessarily appropriate for health organizations due to one key concern: physicians hold no formal leadership roles in such structures (Baldwin, Dimunation, & Alexander, 2011). While it has been traditional that nurses have been formal leaders in health care (Bolton, 2003), the situation is different for physicians, who resisted assuming formal leader roles due to the impact it could have on their sense of autonomy and professional identity (Spyridonidis, Hendy, & Barlow, 2015). Yet, research indicates that it is important to have physician leaders because of the unique knowledge they bring to be part of the solutions to improve health care (Snell, Dickson, Wirtzfeld, & Van Aerde, 2016). Additionally, according to MacPhee, Chang, Lee, and Spiri (2013), a shared leadership (rather than individual leaders) is necessary within health care as the lone leader "does not have the capacity to address the challenges" in health care (p. 22).

One of the leadership models that is emerging in health care organizations, and which looks to a shared leadership that includes physicians, is the dyad model, defined by Clausen et al. (2017) as a nurse and a physician forming a formal management team. Proponents of implementing dyad leadership in health settings argue that physicians and nurses represent a huge population of the health care professional teams and as such are in a good position to share leadership roles (Clausen et al., 2007). However, the two professions have a historical relationship wherein physicians have played a dominant role, holding power over the subordinate nurse (Casanova et al., 2007). A medical culture in which such dominant-subordinate roles are taken for granted could potentially have an impact on how a physician and nurse interact as co-leaders. As Hall (2005) pointed out, physicians are trained to "take charge" and "assume a role of leadership", which results in a situation where sharing leadership, such as in the dyad model, becomes a challenge for physicians (p. 190).

It is in this context where this current study was founded, posing the research question*: How is the historical characterization of physician-nurse communicative relations still evident and what impact does it have on the effectiveness of the dyad management model in the ever-challenging health care system in Canada?* I sought to determine, based on the experiences of the male physician and the female nurse, whether these two professions can be effectively partnered within the dyad model to provide the required leadership to improve the health system in the environment of increased demands and fiscal pressures. My study was to determine whether the individual physician leader and the individual nurse leader felt they were able to work collaboratively, considering their previous experiences. The study also sought to find out from clinicians themselves if there was an assumed imbalance of power evident in the decision-making capacity of the dyad, and whether and how the sex and professional role of the clinician shaped their perspectives on the likelihood of the dyad model being successful.

As this interpretivist research focused on the lived experiences of male physicians and female nurses, it took a qualitative, phenomenological methodology, which provided a greater understanding of an individual's subjective experience and their lifeworld (Mayoh & Onwuegbuzie, 2015; Maggs-Rapport, 2000; Finlay, 2009). Using purposive sampling, I conducted phenomenological interviews with a cohort of three male physicians and a cohort of three female nurses who are participants in a dyad leadership relationship. I collected the data through recorded telephone interviews, drawing on a sample of three informants from each cohort, and with the understanding that a small sampling size allowed for intensive analysis of each case (Robinson, 2014). To derive findings from the transcribed interviews of the informants, I employed interpretative phenomenological analysis (IPA), which Larkin and Thompson (2012) stated is an excellent form of analysis to determine how "people make sense

of their experience" (p. 101). Following Hycner (1985), the explicitation of the data was undertaken through a comprehensive review of the transcripts of the interviews to determine units of meaning implicit in the data, which potentially could be clustered in common themes. In consideration of the evolution of the relationship between physicians and nurses, a critical feminist theoretical lens was employed to illustrate whether the issues of power relations and the social construct of gendered roles influenced the functioning of the dyad.

I sought determine whether the historical relationship between physicians and nurses was still evident and how that impacted the functioning of the relationship within the physician-nurse dyad leadership. By better understanding the experiences of the dyad leaders who participated, my study gained new insight and information on how the participants developed their interpersonal relationships and communication to ensure the success of their dyad partnership to the benefit of their organizations. This research provided information that will assist those who look to implement the physician-nurse leadership dyad in their organizations and to those who become partners in such a dyad to understand the context in how this leadership model can develop and evolve as a viable model within the health care leadership structure at a time when strong, focused leadership is required to effect the changes necessary within the system of health care. What this research demonstrated is that, while the historical relationship between the physician and the nurse remains evident, the male physician and the female nurse can form an effective dyadic leadership partnership by incorporating strategies to define their relationship.

Literature Review

There are many facets to the study of the relationship between a physician and a nurse who assume co-leadership responsibilities for a specific area of authority. As such, this literature explores scholarship touching on the various complexities that have an influence on whether the male physician and female nurse can form a collaborative co-leadership relationship where communication is effective. First, I examined recent discussions of leadership specific to health care organizations, which is oft-described as challenging and complex, and a description of the physician-nurse leadership dyad. In particular, I looked at studies about the interprofessional collaborative relationship that existed between physicians and nurses and how professional identities and boundaries presented barriers to dyad leadership in the medical sector, with attention to the research on the historical construction of the dominant physician and the subordinate nurse. Finally, the variables of sex, gender, and gendered roles exists within the examination of all of the above noted topics, and, as such, the issue of gender and language and its impact in workplaces was explored.

The Uniqueness of Health Care Leadership

To understand the functioning of the dyad leadership model within health care organizations, this section of the literature review looks at theories of leadership, generally speaking, followed by studies on dyad leadership, which is a theory specific to leadership in health care organizations. It concludes with a brief synthesis of the research on barriers to nurse/physician dyad leadership, and particularly the gendering of the professions and the prevalence of women in the nursing profession.

Theories of leadership. As pointed out by Weberg (2012), theories on leadership were developed during the industrial era where the focus was on production. Traditional leadership

was described by "a role rather than a set of behaviours…places power in the position rather than in relationships" (Weberg, p. 269). In defining leadership, Weberg described it as a process that occurs where solutions have to be found to problems or situations that are unexpected. On the other hand, management is providing "known solutions to known problems" (Weberg, p. 269.). Dickson (2009) supported that difference between the term leadership and management when he described leaders are those "who go first" and set direction towards what is not known, while the managers follow to "build the paths" (Dickson, 2009, p. 295). In citing Bennis (2003), Dickson noted, "Leaders are the people who do the right thing; managers are the people who do things right" (p. 296).

Just as there is a difference between leadership and management, leadership itself comes in many styles and forms. For example, among the various styles of leadership discussed are transactional leadership and transformational leadership. In presenting the differences between transactional and transformational leadership, Sonnino (2016) said transactional leadership focus on "efficiency, control, stability and predictability", while transformational leadership speaks to motivating people for change. Further, as Rogers (2012) pointed out, transactional leaders work within the boundaries and standards that have already been established within organizations, while the transformational leaders encourage staff to be creative and innovative. While there are differences in the two types of leadership described, Rogers added these leadership styles are complementary and both may lead to attaining an organization's objectives.

While considering the definition of leadership and examples of leadership studies, research also informed that "leadership has substantial effects on people and organizational outcomes" (Vance & Larson, 2002). As such, leadership has become an important topic of

discussion and research as it relates to the contribution leadership can make to the health sector (Dickson, 2009).

Health care leadership—the case for co-leadership. Health care organizations are complex and their leaders face complex challenges that include the goal of delivering quality and safe care to patients in an environment where change is rapid and where cost-containment is important (Clausen et al., 2017). As Dickson (2009) pointed out, such circumstances resulted in the requirement for more and higher quality leadership. The call for better leadership has health care organizations such as the Canadian Health Leadership Network (CHLNet) bringing more attention on leadership in health care through its Strategic Plan, containing ten strategic priorities. Yet, while there is a recognition of the need for further development of health care leadership, the task is not that simple. As McAlearney (2006) pointed out, health care organizations have been known for "seemingly chaotic internal co-ordination" that is characterized by "hierarchies of professionals" within the administrative and clinical structures of the organization. For example, where health care differs from traditional organizations was that its core staff, including physicians, nurses and pharmacists, was comprised licensed professionals who were trained in practices and behaviours specific to those professions and therefore had professional identities that had an impact on their socialization within organizations (Ramanujam & Rousseau, 2006). Additionally, the leadership structure within the health care setting was distinct from those of other industries as "the impact of leaders extends to the lives and well-being of patients and their communities" (McAlearney, 2006, p. 969). It was not difficult to conclude that health care leadership was unique and challenging in consideration of the demands that exist on health care organizations and the varying internal structures that

exist from administrative and clinical perspectives. With that said, there are opportunities to strengthen leadership through various leadership models that exist within health care.

It was in that context that this research explored one of the leadership models specific to the needs of the health care sector—the dyad model of leadership. Zismer and Brueggemann (2010) described the dyadic, co-leader model as including a physician and non-physician leader. As pointed out by Saxens, Davies, and Philippon (2018), in such a complex environment as health care, the ability to manage and lead was "unlikely to reside in one individual alone" and there was a need to integrate the administrative work of the organization with its clinical work. (p. 239). In describing the dyad role, Saxens et al. (2018) pointed out that responsibility within the dyad was shared in the areas of vision, values, strategy, culture, and overall performance. The individual responsibilities for the physician leader included clinical quality, innovation, and standards while the non-physician leader held accountability for operations, budgets, and staffing (Saxens et al., 2018). As Buell (2017) described it, the dyad leadership breaks down traditional health care professional silos, allowing administrative and clinical professions to collaborate and to have a shared vision.

That non-physician leader identified in the dyad leadership model was very often a nurse (Baldwin et al., 2011), and Clausen et al. (2017) supported efforts to develop nurse/doctor co-leadership, stating that improvements can occur within the health system if physician and nurse leaders collaborate effectively. Clausen et al. stated that physicians and nurses are each uniquely positioned to establish co-leadership roles. The notion that nurses can function as leaders inside health care organizations was not new since they have long been involved in leadership functions, whether it was organizing other nurses' work or overseeing a ward or department (Bolton, 2003). More recent, physicians were recognized as potential leaders since physician

practices "directly affect the clinical and operating performance" of health care organizations (Zismer & Brueggemann, 2010, p. 15). This position was supported by St. Fleur and McKeever (2014), who suggested that hospitals must discover the means to "integrate and align" those who "drive their business" when referencing the role of physicians as leaders (p. 231). Through this model, physicians relinquished their autonomy and non-physicians acknowledged that physicians could be leaders (Zismer & Brueggemann). With that in mind, it appeared that there was more to the perfunctory roles of the physician and nurse in the dyad model that lead to an exploration, and indeed understanding, of the nature of the relationship between the two professions and their ability to collaborate.

Barriers to interprofessional collaboration in health leadership. There was shared opinion that it was through interprofessional collaboration that health care can be delivered safely, effectively and sustainably (Reeves, Nelson, & Zwarenstein, 2008). According to Green and Johnson (2015), among the key concepts of collaboration were sharing, partnership, interdependency, and power, and that collaboration is a "mutually beneficial", "well-defined relationship" to "achieve common goals" (p. 1). In health care, Clark and Greenawald (2013) noted that the effectiveness of interprofessional collaboration was described as "shared objectives, decision making, responsibility and power working together to solve patient problems" (p. 1). Considering the "status of medicine and sheer size of nursing", a collaborative approach between nurses and physicians was clearly warranted for the betterment of patients and the health system (Reeves et al., 2008, p. 1). Yet, when the relationship between nurses and physicians was considered, Blue and Fitzgerald (2002) argued that the relationship between the two professions had not reached a point where it was balanced and effective since mistrust and dominance of physicians over nurses continued. That raised the issues of whether barriers within

the professional relationship between physicians and nurses impacted the success of their interprofessional collaborative efforts as dyad partners.

The literature also raised several issues that created barriers between nurses and physicians in collaborative relationship. As Sirota (2007) claimed, there were barriers for meaningful collaboration between nurses and physicians that include physician dismissive attitudes about nurses, different approaches to care, power/gender issues, and education differences. Furthermore, Casanova et al. (2007) argued that the barriers to effective working relationships were found in the misalignment of role expectations. Physicians had expectations that nurses were an "extension of them" while nurses believed they have the knowledge to independently know what to do for the benefit of patients (Casanova et al., 2007, p. 68). These role expectations emerged from different professional cultures and identities. Hall (2005) stated that health professions have different values, beliefs, attitudes, customs, and behaviours that evolved as the professions developed in silos. The world views shared by professionals helped them exist within their own profession but did not necessarily help them connect to professionals in other professions and this created professional boundaries (Hall, 2005). The effort to define boundaries was what Hall referred to as "boundary work" and was used by professions to strengthen their world view, their ideology, and authority. Those boundaries and power relations were best understood as an effect of medical professionalization in the context of a larger set of patriarchal cultural attitudes about men, women, and the proper relationship between the sexes. To that end, I now turn to some of the relevant literature on how sexist stereotypes about male/female dynamics came to be mapped on to professional relationships in medical settings.

Gender and the Sexual Politics of Health Care Professional Identities and Interactions

To identify how sex/gender considerations also influenced the possibility of cross-professional boundary work, this section presents an overview of the literature on the history of nursing and its formation in relationship to the physician role in a male-dominated medical culture.

There was much literature on the relationship between nurses and physicians and how these positions were socially constituted from the historical context of medicine and nursing. Right from the beginning when the provision of health care was formalized, the relationship between physicians and nurses was patriarchal, reflecting the roles of men and women in society, and hierarchical, with physicians holding the position of power over nurses (Price, Doucet, & McGillis Hall, 2014). There is a scholarly consensus that the medical profession created its dominance in health care during the industrial revolution and the male physician reflected the gendered privileges of men in a patriarchal society (Hall, 2005). As Bell, Michalec, and Arenson (2014) explained, doctors used education to keep women out of medicine. They also used their power to deskill female midwives by taking over childbirth for rich women and in risky cases while the female midwives provided care for poor women. This further entrenched the physician as more competent and skilled and a figure of importance in the higher levels of society (Bell et al., 2014). It was no wonder then that Davies (2003) expressed the view that the nursing profession was created as subservient to doctoring. To whit, Hall (2005) described how the field of nursing arose as an appropriate profession for women to enter the workforce since it "embraced the virtues of true womanhood" at a time when women's roles mostly existed within the realm of their home, caring for children, and serving men (p. 189). The role of the nurse was

as a handmaiden for the physician, there to carry out his orders as subordinates (Price et al., 2014; Sirota, 2007).

In consideration of the view that physicians held a dominant position over nurses, it lead to the question of what impact that had on their relationship, particularly in terms of how these two professions communicated with each other. The communicative relationship between the physician and the nurse was often described in relation to the work of Leonard I. Stein (1967), who was credited with establishing the notion of the "doctor-nurse game", where the nurse must appear passive in making recommendations while the physician pretended he was not looking for one, such that the dominant physician was covertly guided in making decisions about a patient's care by the obliging nurse (Reeves et al., 2008). While being open to advice from the nurse may help the patient, the physician saw that as "highly threatening to his omnipotence" (Stein, 1967, 103). On the other hand, as Stein (1967) pointed out, the nurse resisted offering that advice since it would be insulting and would question his medical knowledge. As such, it was clear that both the physician and nurse, in this game, each played a role in reinforcing the dominant position of the physician in how they communicated with each other.

In light of the gendered dimensions of medical professionalization, and even regardless of the sex of the nurse or doctor, the nature of the historical relationship between physicians and nurses needed to be understood as a question of fields of practice that are themselves constituted as a hierarchy of roles and responsibilities—but this did not mean that the sex of the practitioner was irrelevant. Bell et al. (2014) have argued that, just as occupational hierarchies within health care influenced boundary work where professionals take ownership of areas of knowledge to achieve power, so did gender ideologies, insofar as the patriarchal regulation of sexed bodies in play at the formation of medicine as an institution shaped the structure of the medical hierarchy.

Another way to say this was that the gendered privilege of men in society was critical to the creation of the dominant position of the physician role in health care. Therefore, the subordination of nurses emerged as a result of the feminization of care work and as a "compromise occupation" that reflected the "sexual division of labour in the home" (Bell et al., 2014, p. 99). What this study demonstrated was that there was a level of connectivity between how physicians and nurses and men and women communicated with, between, and among each other, and how the cultural foundations of patriarchal gender ideology impacted on the relationship between physicians and nurses and their potential to serve as co-leaders within health care organizations.

In determining the potential for nurse/physician leadership dyads, I elicited from nurses and physicians their awareness (or lack of awareness) of how sex and gender colour their desire, ability, and readiness to enact co-leadership. Indeed, I selected an interpretative phenomenological analysis approach due to how gender ideology informed both the structures of health organization and personal experience of workplace interactions, making its structuring presence (nearly) invisible. In the next section, I provide a short overview of the gender and communication scholarship that provides the theoretical basis for the questions and analysis I brought to the research question.

Gender and Language: Influences of Leadership and the Workplace

To inform the study of the relationship between physicians and nurses, a review of the literature in this section focuses on the presence of gender in how it was reflected in the structures of organizations, in how communication was characterized and influenced by gender, and what it meant in how leaders were perceived.

To explain how gender was reflected in the relationship between physicians and nurses, Davies (2003) applied a critical feminist lens to the issue, theorizing that the occupation of a physician was tied to the ideals of hegemonic masculinity, notably as autonomous, rational, objective, decisive, authoritative, and competitive. Nursing, conversely, is described in relation to the purportedly "feminine" or more relational attributes of nurturing and providing comfort, and therefore as a role that was by nature dependent and subordinate to that of the physician. For Davies (2003), "doing dominance and doing deference" was how medicine and nursing were constructed from a historical perspective. That position was even more strongly presented by Zelek and Phillips (2003), who claimed that the power of the male physician was more attributable to gender than from the hierarchical position of the profession of medicine. That was evidenced by the fact that the traditional power imbalance was not as apparent when the nurse and physician were both female (Zelek & Phillips, 2003). Furthermore, as the occupations of nurse and physician were formed in the context of gender stereotypes, Hall (2005) pointed out the health care workplace reflected the ideology of the familial structure with men as the patriarchs and leaders and women as care takers. As such, there needed to be awareness of the relationship between women and men in order for there to be an understanding of the nurse-physician relationship since that relationship was essentially patriarchal (Sweet & Norman, 1985, as cited in Hall, 2005).

To that end, this study conceived of gender as an institution that colours the formation of personal and professional identities as well as more abstract social structures and organizational cultures. In the same way that concepts of "family" or "education" have been institutionalized, Martin (2004) described gender as a social institution since it was enduring and had social practices that "recur, recycle or are repeated" (p. 1256). By acknowledging that the construction

of an institution was enabled through the reproduction of action into patterns, the institution of gender was recognized as built into major social organizations of society since it "establishes expectations for people, orders social processes, and is willingly incorporated into identities or selves" (Martin, 2004, p. 1261). The institutional power of gender, Martin further explained, is demonstrated in how gender was used to "create and legitimate social relations" within other institutions (p. 1266). Bell et al. (2014) have noted that the representation of gender was quite evident in health care, for example in relation to the characterization of jobs, as the profession of nursing was feminized for its emotional and caring work while medicine took a masculine form due to its connection to leadership and science. Understanding gender as an institution that was constitutive of other institutions allowed me to look simultaneously at how gender was implicated at the level of health organization structures, as well as how male and female human agents used gender to understand themselves and interact with one another (Harris, 2015). In other words, using Martin's formulation allowed me to take a materialist-discursive approach that connected the macro level of culture and social structures and the micro level of individual identity formation and communication—thus fulfilling the purpose of feminist communication theory (Harris, 2015).

The work of Acker (1990) provided an understanding of the issues of gender and how it produced gendered jobs and an overarching patriarchal mindset within organizations. Along with ideologies of race and class, gender was defined as a discursive technology productive of inequality regimes in organizations (Acker, 2006). To say that an organization was gendered is to see how "advantage and disadvantage, exploitations and control, action and emotion, meaning and identity, are patterned through and in terms of distinction between male and female, masculine and feminine" (p. 146). Additionally, Nilsson (2005) pointed out that gender, as

understood as feminine and masculine, was formed through the influences of history, culture, and social relation. Acker (1992) stated that gender was a pervasive form of power and it existed "wherever one looks" (p. 567). That included, according to Acker (1992), within institutional structures and how these "gendered institutions" reflected gender through processes and practices and in how power was distributed. Within the health care environment, the notion of gendered institutions presents itself in how physicians, as representative of the masculine (Hall, 2005), viewed themselves as holding a dominant position over the nurse, as representative of the feminine (Davies, 2003).

One of the ways in which gender was demonstrated within institutions is through language, which, as Cameron (2003) described, is used to determine what counted as the gender-appropriate behaviour of men and women. Drawing on the historical context of the "silent woman ideal", Cameron (2003) was concerned with how communication between men and women served to position women as subordinate to men and as non-participants in the public sphere. While Cameron (2003) was thus able to explain how language and communication styles maintain gender distinctions and "naturalize gender hierarchies" (p. 452), she also provided insights on how the differences in the use of language between men and women pointed to a lack of skill in this area on the part of men. As she explained, due to their socialization in a sexist society that values male sovereignty above all, men were not socialized to interact relationally with others and may have difficulty creating rapport and intimacy, skills, or traits associated with femininity and, thus, with women.

Despite that negative view of male language skills, Holmes (2008) reminded us that interactions in the workplace have disadvantaged women, particularly as it related to the positioning of women and men as leaders. As people interact and talk with others at work,

individuals “enact gendered roles, adopt gendered stances, and construct their gender identities” (p. 278). According to Holmes (2008), leadership, power and authority were positioned in terms of so-called “masculine” traits of assertiveness and authoritative speech. That was in contrast to women, whose socialization in a sexist society made it more likely that they employed more facilitative styles and spoke in ways to “downplay their own authority” (Holmes, 2008, p. 482), and suffered the social consequences if they did not. As leadership was perceived as a masculine concept (Minnich, 2005), it impacted on how women are seen as leaders (Martin, 2015). According to Martin (2015), people looked more favourably on leaders who are confident, aggressive and self-directed (gendered as masculine behaviours), rather than on leaders who were empathetic, sensitive, open and co-operative, traits associated with femininity. As Baxter (2017) argued, with leadership as being reflective of the male and the masculine, women leaders did not fit that norm and therefore less competent in a leadership role. It was here the notion of the double-bind for women as leaders was evident in that, if a woman leader interacts with others as “indirect, co-operative, supportive”, she was not perceived to be a leader; yet, when women leaders interacted in ways which were “tough, no-nonsense, direct”—described as the masculine norm—they were seen as threatening and aggressive (Baxter, 2017, p. 142).

In consideration of the different, and competing, leadership styles and that masculine-style leadership was preferable to feminine-style leadership, there emerged the question of how males and females would be perceived in a co-leadership model. As such, an exploration of gender and language along with their impacts on leadership and the workplace needed to be explored in a study where its focus was on how physicians and nurses worked together as co-leaders. Looking at gender as a technology of socialization and professionalization and as constitutive of organizational cultures allowed me to address the complexity of the relationship

between the male physician and the female nurse and their potential as dyadic leadership partners.

Summary

Much of the literature covered the challenges of the relationship between physicians and nurses in non-co-leadership roles and there has not been significant study on understanding the experiences of the physicians and nurses leading up to and including their role as a dyad partner. As the literature demonstrated, there were significant complexities that could influence how the male physician and the female nurse formed a full, functioning, collaborative co-leadership team where communication was equal and effective. These complexities include the dominant/subservient historical context of the formation of the identities of a physician and a nurse, and of a leader and a helpmate: both gendered relationships. The physician/nurse relationship mirrored that patriarchal social construction of the place of men and women in society wherein gender, gendered roles, and organizations continued to define the interactions between the physician and the nurse, as it did for men and women. Armed with this knowledge, this study intimately explored with these male physician leaders and female nurse leaders their relevant experiences of how they worked with the other profession prior to and subsequent to assuming leadership roles.

Methods

In a study to determine whether the male physician and the female nurse can communicate and collaborate effectively in the dyad leadership model, it was essential to draw on their separate lived experiences where the informants provided rich, detailed descriptions of their experiences "in the way he or she experiences it" (Bevan, 2014), and "deep reflection upon subjective experience" (Cronin & Lowes, 2015). The exploration of an individual's lived experience was best accomplished within the interpretative paradigm (Mayoh & Onwuegbuzie, 2015). Understanding a person's lived experienced through the interpretative paradigm was supported by Wahyuni (2012) who stated that interpretivists recognize that individual's construct their reality through their own varied backgrounds, assumptions and experiences, which in turn impacts on their social interactions. As Mayoh and Onwuegbuzie (2015) described, it was through phenomenological-based research where a greater understanding of an individual's experience can be sought. Through phenomenological research, the "lifeworld" was studied, which Finlay (2009) defined as "an experienced world of meanings" reflecting an individual's sense of "space, time and relationships with the self and others" (p. 475). It was appropriate, therefore, that a qualitative research method was employed using a phenomenological approach as it attempted to collect experiences from the physicians and nurses who lived within the phenomena explored.

To that end, I elected to use interpretative phenomenological analysis methodology (IPA) to frame the data collection and analysis for this study**.** As Maggs-Rapport (2000) noted, interpretative phenomenological research focusd on the subjective experience of the world by the key informants, which allowed for deeper insights into human nature. As noted by Starks and Brown Trinidad (2007), phenomenology allows the researcher to see meaning and create

perception-thick descriptions of the experience. That deeper understanding of an individual's experience was found by shedding light on "taken-for-granted assumptions" (Starks & Brown Trinidad, 2007, p. 1373.) That contribution of phenomenology to research focused on the understanding of lived experiences was clear when Starks and Brown Trinidad quote Sokolowski (2000) in the value of phenomenological statements: "They tell us what we already know. They are not new information, but even if not new, they can still be important and illuminating, because we often are very confused about just such trivialities and necessities" (p. 1373). In relation to the current inquiry, Cronin and Lowes (2015) noted that phenomenological inquiry was useful in health research, particularly in the area of psychology since it can be both detailed and flexible in gathering information about how people made sense of their own world which was useful in dealing with "sensitive, complex or novel research questions", as would be the case in collecting from physicians and nurses intimate knowledge of their experiences in relation to the other.

Additional support for designing this research as a phenomenological-based inquiry came from the fact that it was concerned with how gender operated at both the levels of structure and individual agency in gendered workplace and professional roles. Currently missing from the literature was the kind of ideographic findings needed to understand how gender inflected the potential for effective physician/nurse leadership dyads. Gardiner (2018) has argued for taking a "feminist phenomenology" approach to creating knowledge about gendered experience and sexual difference, insofar as it allowed for the investigation of how "ideology, power and language affect lived experience", critical to the understanding of the lifeworld of the informants (p. 295). Therefore, using IPA, this study took an explicitly feminist phenomenological approach that engaged three male physicians and three female nurses in exploration of their professional

relationships, professional-specific leadership roles, and possible barriers or opportunities for enacting dyad leadership in their workplace. As Harris (2016) argued, feminist communication research was notable for holding those tensions of living as a gendered person in a gendered world with the goal always of transcending the systems of oppression that produce sex-based inequities and gendered institutions. It recognized that communication was at the heart of how those two poles of experience (structure and agency) that interact to produce gender, and hopefully, to produce more equitable relations between men and women, and between the people in organizations who enact gendered roles.

To capture these tensions and possible solutions productive of successful physician/nurse leader dyads, a phenomenological, feminist lens was carried through from the interview process to the analysis of the data collected. It was through the analysis that the research attempted to make sense of the experience of the informants through a line-by-line analysis of the data to identify patterns (Larkin & Thompson, 2012). As noted by Hycner (1985), the explication of the data (vs. analysis, an act of abstraction that removes a datum from its experiential context), was undertaken through a comprehensive review of the transcripts of the interviews to determine units of meaning which potentially could be clustered in common themes. This included an initial rigorous process of intense review of the transcripts to elicit the meanings to get at the essence of the individual informant's meaning without determining whether there was relevance to the research question (Hycner, 1985). From there, the method for making sense of the data followed Hycner's pathway to a critical phase of the explication of the data, which was to identify the units of meaning which were relevant to the research question, making explicit what is only implicit in the data. The physician-nurse relationship was explored using semi-structured

interviews of a cohort of six key informants that included three physician and three nurse leadership partners.

Data Collection

In this section, I first describe how I identified the informants on whom I based my study. Then, I present the type of interview protocol I employed in an effort to draw out the various experiences of the informants as they relate to the question of leadership and the potential for (male) doctors and (female) nurses to work as co-leaders in health care contexts.

Sampling. I employed purposive sampling to identify the key informants, as purposive sampling was "designed to enhance understanding of selected individual's or groups' experience(s)…" (Devers & Frankel, 2000, p. 264), and I sought to understand the experiences of an identified set of subjects—the physician and the nurse in a dyad partnership. To determine the study population, a set of inclusion and exclusion criteria was required (Robinson, 2014). In this study, the sample included physicians and nurses who were partners in a dyad management model in a health organization within Canada and who have at least one year of experience in that role. The criteria for inclusion also saw male physicians and female nurses identified as key informants. Consequently, female physicians and male nurses who were in a co-management partnership were under the exclusion criteria. The intent of this research was to determine whether there was an influence of how the professions of the physician and the nurse were historically constructed as reflected in the gendered roles of masculine and feminine on the physician and nurse dyad partnership. As such, this study focused on the experiences of the male physician and female nurse in such a partnership. A number of the key informants were identified based on the personal professional experience of the researcher while others were

identified based on the researcher's knowledge of and interest in the health organizations in Canada and their leadership models, confirmed by web-gathered information.

Robinson (2014) stated that for interpretative phenomenological analysis a sample size is usually small, about three to 16 participants, to allow for an intensive analysis of each case and allowing for the informants to have a defined identity. The number of research informants was also supported by Starks and Brown Trinidad (2007), who said getting detailed experiential stories from a few individuals who have experienced the phenomenon "can be suffice to uncover its core elements" (p. 1375). The sample size for this study included six participants, three of which were male physician leaders and three of which were female nurse leaders. In their case study of working relationships of registered nurses and general practitioners, Blue and Fitzgerald (2002) conducted in-depth interviews with 10 nurses and six general practitioners and were able to identity themes that provided an appreciation of the nature of the relationship between the nurses and physicians. It was therefore clear that my sample size of six informants was appropriate to finding an answer to my research question using IPA.

In terms of my sampling procedure, I used quota sampling and convenience sampling, allowing me to draw from my own network of nurse and physician leaders and to ensure each dyad consisted of a female nurse leader and a male physician leader. I had initially intended to contact participants directly in an effort to ensure the anonymity of the informants; however, due to the unavailability of contact information available online, I reached out to a number of the research participants through their assistants via email, requesting their voluntary participation in the study using a letter of invitation, included as Appendix A. As a result, confirmation of participation, including signing of the participant consent form (Appendix B), and scheduling of the interview time were transacted between the researcher and the assistant of the majority of the

key informants. However, the assistants of the key informants were not privy to the information provided during the data collection interviews.

Interview protocol. In qualitative research, interviews are one of the most commonly used methods of data collection as they are valuable to explore "the views, experiences, beliefs, and/or motivations of individuals on specific matters" (Gill, Stewart, Treasure, & Chadwick, 2008, p. 292). The interview allowed informants to express thoughts and feelings in their own voice and, as such, had been recognized as a useful data collection instrument in the field of social science research (Alshenqeeti, 2014). Alshenqeeti (2014) stated that the interview gathered information about the "life world" of the informant in a way that flowed freely and was rich in detail, which aligns quite well with the phenomenological approach (p. 40). As noted by Reid, Flowers, and Larkin (2005), one-on-one interviews provided the opportunity for the researcher and informant to develop a rapport which allowed for the informant to "think, speak and be heard" leading to an in-depth, personal discussion (p. 22). With that in mind, the researcher was able to gather detailed information of the informants' lived experiences to determine how that experience impacted on their dyad role.

There are three basic types of research interviews that are used for a qualitative research study: structured, semi-structured, and unstructured. Structured interviews are simply verbal questionnaires that will not allow for the personal reflection required to delve into the experiences of the informants whereas unstructured interviews have little organization, are time-consuming, difficult to manage, and have little guidance, which may impede an exploration of the topics the researcher wants to explore. The third type, and the one used for this project, is the semi-structured interview. Semi-structured interviewing allowed for the preparation of key questions to guide the interview, yet also allowed for the flexibility to probe and ask additional

questions based on the responses provided (Gill et al., 2008). With this method, the interview was more of a conversation, allowing the interviewee to feel comfortable and the interviewer to have the flexibility to probe for additional information in drawing on the experiences of the informant.

Support for using semi-structured interviews in this study came from Whiting (2008), in her guide for novice researchers noting that semi-structured interviews were frequently used by health professionals and possibly were a familiar format for the research subjects. Additionally, Whiting (2008) described these interviews as personal encounters in which "open, direct, verbal questions are used to elicit detailed narratives and stories" (p. 36). The ability to draw out narratives and stories was critical in this research as the objective of the research was to do an in-depth exploration of the experiences and perceptions of physicians and nurses in the co-leadership dyad model, those who have lived the phenomena. In taking the phenomenological approach, the researcher asked questions that focused on asking the participants to "describe specific situations and actions" (Bevan, 2014, p. 138). As an example, the research of Clark and Greenawald (2013) used semi-structured interviews to study the collaborative relationship between the physician-nurse dyad in rural hospital sites in Australia. The method employed by Clark and Greenawald allowed them to collect the in-depth data required to identify the issues and influences (including barriers) that had an impact on the quality of collaboration within the dyad.

For the semi-structured interviews used in this research, questions were prepared in advance in an interview guide, included in Appendix C, that allowed the researcher to focus on the issues or topic areas to be explored (Daymon & Halloway, 2002). Based on the knowledge gained in the literature review, the questions focused on how they would describe their

experience working as a physician/nurse, including: how they would describe the relationship between physicians and nurses; provide their views on leadership, communication and collaboration; and, how their individual experiences influence their role as a dyad partner. While the guide was useful to ensure similar data was collected to have validity in the findings, as Daymon and Halloway (2002) have pointed out, the questions were not asked in a consistent order when interviewing the key informants. Furthermore, in a phenomenological inquiry, interviews were focused on the "process of questioning" rather than being structured around what was actually asked (Bevan, 2014), thus this approach suited this study.

The interviews occurred based on the availability of the key informants in consideration of their time constraints. The first interview was held January 2019 and the final March 2019. The interviews were conducted via telephone due to the geographical location of the researcher and the key informants. The average duration of the interview was 42 minutes with the longest interview lasting approximately 67 minutes and the shortest was 30 minutes. The interviews were recorded and transcribed verbatim, including pauses and other nonverbal communications such as "ums" and "ahs" to allow for a thorough analysis of the data.

The data collected during the study has been stored securely on a password-protected laptop in a home office. The transcripts of the individual interviews have been coded to ensure there was no identifying information to protect the privacy of the informants. All data associated with the key informants will be destroyed once it is no longer required for the purposes of completing the thesis.

Data Analysis

As noted, the use of the interpretative phenomenological method flows through data collection to data analysis. Larkin and Thompson (2012) said that interpretative

phenomenological analysis (IPA) was a form of analysis excellent for determining how "people make sense of their experience" through "giving voice" and "making sense" (p. 101). In the interpretation of the data using IPA, the researcher identified "themes" or patterns of meaning that were developed through "codes" or detailed commentary of the data (Larkin & Thompson, 2012, p. 104). In determining the units of meaning, Hycner (1985) advised the need to get at the meaning of each part of the transcribed text including each word, sentence, paragraph, and non-verbal communication, which then was analyzed for its relevancy to the research question. Biggerstaff and Thompson (2008) advised the analysis includes the close reading and re-reading of the transcript during which the researcher made notes about her thoughts, observations and reflections and included highlighting recurring phrases, the researcher's emotion, and descriptions of the language used. Starks and Brown Trinidad (2007) further stated that the researcher "engages with the analysis as a faithful witness to the accounts of the data" (p. 1376). Additionally, the researcher paid heed to his/her own perspective, thoughts and beliefs of the phenomena which was accomplished through the self-reflective process of bracketing, but not voiding, their beliefs and assumptions (Starks & Brown Trinidad, 2007).

To conduct the explication of the data, I drew on Hycner's (1985) guidelines, which called for an in-depth review of the transcripts including every word, phrase, sentence, paragraph, and non-verbal communication to determine the informant's meaning and determine relevance to the research question. I formatted each of the transcript documents so that I had white space on both the left and right margins of the text, numbered the pages and printed one copy of each of the six transcripts. In the printed versions of the transcripts, each line of text was numbered for easier identification of the full context of a statement made by the informant. My initial review consisted of several readings of the transcripts and I used the left-side margin to

summarize what each of the informants had said. Subsequent readings of the transcripts allowed for the identification of topics and themes which were written in the right-side margin. According to Groenewald (2004), a critical phase of the explicitation process was delineating units of meaning during which the researcher identified the lists of units of relevant meaning, which were then reviewed to determine which were included or excluded in terms of significance. Once units of meaning were identified, these were then separated into themes, or clustered, where significant topics relevant to the research question were identified (Groenewald, 2004). Following the identification of the themes and topics on the printed transcripts, a summary of the topics/themes was noted on a separate document for each of the informants, supported by informants' quotes, noting the page number and in some cases text line for easier reference. The next step was to cluster themes/topics and subthemes from each of the informants from where findings were determined based on relevancy to the research question.

In sum, the researcher interviewed a cohort of six health care professionals—three of whom were male physicians, three of whom were female nurses—who were in a dyad leadership model within a health care organization in Canada. The objective of these semi-structured interviews was to have the key informants, in answering topical questions, provide a narrative of their experiences prior to and during their role within the dyad leadership. A detailed transcript of the interviews was analyzed in an effort to identity themes and reach conclusions about the individual experiences of the informants.

Ethics

As human subjects were involved in this research project, an application for ethical clearance was made to and approved by the Royal Roads University Research Ethics Board. There was some risk to the informants participating due to the potential of being identified by the

information they provided as part of the study. Therefore, it was critical that anonymity of the informants was maintained by ensuring non-identifiable information was presented in the final study. There was also benefit to the study in that participants of the dyad model were likely to gain furthering understanding of whether there were impediments to its effective functioning.

Consent and data protection were key considerations from an ethical perspective in this research project. All participants signed a consent form, attached as Appendix B, agreeing to participate in this research and confirming participation is entirely voluntary. An informant was notified that he/she could withdraw from the study at any time. Recordings and transcripts of the interviews are securely stored in a private home office and on a password protected laptop. There was no identifying information on the transcripts as identification of participants was coded and the code to decipher identities stored separately from other materials.

Findings

Using a qualitative research approach, the study used interpretative phenomenological analysis as its method wherein the informants of the research were asked questions in an effort to gather information about their lived experiences and how those experiences impacted their role as a leadership partner in the dyad model characterized by a male physician and a female nurse. Through an explicitation of the data collected through semi-structured interviews of three male physician leaders (identified as MP1, MP2, and MP3) and three female nurse leaders (identified as FN1, FN2, and FN3), a number of key themes emerged that are presented here as findings. These six overarching key themes include: pathways to leadership; leadership view; physician/nurse role in the health system and dyad; changing nature of the relationship; unanimous support for the dyadic leadership model; and, strategies for a successful dyad. When using direct quotes from the informants, these are presented in quotation marks, or if longer than 40 words, are presented in italics. Following the findings is a separate discussion section that provides interpretations of those findings in their relation to the literature.

The Path to Leadership

One of the areas where there was a noted distinction between the nurse leaders and their physician counterparts was their interest in and path to their current senior leadership positions at their health care organizations. The experiences of the nurse leaders pointed to the fact that they found themselves in progressive leadership roles and it was their varied experience that prepared them for their current senior level leadership positions. Conversely, what was heard from the physician leaders was mostly about the experiences they had in leadership positions associated with their respective medical association, not within health organizations. These experiences of the physician and nurse leaders are presented in more detail in the next sections.

The nurse leader pathways. From being the lead nurse at a long-term care facility supervising other staff just days after graduation, to becoming chief executive officers of health care organizations, the nurse leaders have decades of broad and varied experiences as leaders, supplemented by graduate level studies in either health administration or business administration. Since early on in her career, FN1 held leadership positions in clinical, policy development and education roles as she advanced her education from her practical nurse training to a Bachelor of Science degree in nursing and subsequently a Master of Health Administration. FN3 recalled that it was in nursing school that she recognized there would be "opportunities to be a leader" in health care and used "what I learned as a nurse to advance into leadership roles", leading her to build on her nursing diploma to attain her bachelor's degree. FN2 noted she always looked for opportunities for growth in the positions she held and specifically noting that she made a decision to want to "progress administratively", leading her to attain a Master of Business Administration degree. What was demonstrated by the nurse leaders was their journey to advance in leadership roles within their organization and to obtain high levels of education to support their transition from clinical nursing to administrative leadership.

The physician leader pathways. On the other hand, the physician leaders mostly had little experience in the running of the business of health care with most of their previous leadership roles related to their involvement in their professional medical associations, with little to no educational preparedness beyond their medical training to take on some of the most senior executive positions in large, complex health care organizations. With no operational experience, MP3 readily admitted his advancement into a formal leadership role was "not intentional" but founded in his desire to make improvements to the system: "I'd be happy enough working on the front line just as long as were changing things and making them better…I am more interested in

the system improving than I am as…being the big leader." MP2 described his foray into physician leadership as a "shouldering up", where physicians were encouraged to take on leadership roles by other physicians within their respective medical associations or speciality areas. MP2 described how when he first started to practice as a physician, he "almost immediately become involved in medical (association) leadership". MP1 is the only physician interviewed in the study who held various organizational leadership positions prior to his current position, even though he did not see himself as having leadership positions: "I did not really think of myself as being a health care administrator…always thought of myself first and foremost as a clinician." The types of leadership positions that were held by the physician leaders were not in health operations but rather came in the form of positions within their medical associations or disciplines and were not the result of the physicians defining for themselves a career path to administrative leadership.

Summary. The female nurse informants saw a progression in their careers as leaders moving up through the ranks of the health care system and gaining a tremendous amount of experience in health care operations while the male physician informants, with one exception, had little to no operational experience prior to assuming their current senior level leadership positions.

The Leadership View

For the majority of the leaders there is agreement on the importance of leadership being seen as engaging with others to build relationships and create an environment where members of the team work together. That leadership ideal was specifically noted by the nurse leaders who defined their leadership characteristics on their ability to focus on relationships and building coalitions as a means to achieve objectives and outcomes. Among the physician leaders, though,

the perspective existed that it is the purview of the leader to determine the vision and be innovative to tackle the obstacles encountered to achieve that vision, with the team working to implement that vision.

Leaders as facilitators of collaboration. The majority of the informants believed the key to providing good leadership was through collaboration. FN1 noted as leaders it was important to have relationships that are built on trust achieved through the engagement of others in the decision-making process and "the skills to build coalitions". Based on her experience, FN2 saw leadership as understanding there were various perspectives that a leader has to consider when taking on challenges: "There were usually six or seven different perspectives on a situation that happened and you needed to pull all that together to understand what was really going on." As FN3 explained good leaders had very good listening and observation skills and acknowledge that there was more than one way to achieve an identified outcome. FN3 summed it up this way: "If you are going to be a leader you have to be really good at being a team player." Aligning somewhat with the views of the nurses, MP1 noted the leadership in health care required collaboration "because this is certainly no question a team endeavour and health care is about partnerships". Based on the experiences of the three nursing leaders and one of the physician leaders the view existed that effective leadership required leaders to build relationships and coalitions, listen to different perspectives, engage others in decision making, all of which demonstrated the need to collaborate.

Leaders as vision holders. While one of the physician leaders shared similar views of the nurse leaders, his colleagues shared another perspective of leaders as one where the leader was in control of setting the direction and the vision. In MP2's description of a leader he noted: "(They) keep their eye on the prize…who knows where they need to get and who is not going to

let all the hurdles that you will inevitably encounter along the way of achieving what you know needs to happen." From MP3's point of view, the leader must clearly communicate "this is where we have to go" and push the team to be "forward thinking" to realize results.

Summary. In the area of leadership, based on the views shared by the physician and nurse leaders, it appeared that those who had more experience working in formal leadership positions within health care were more likely to acknowledge the value of being collaborative leaders, a characteristic learned through their years of experience. That contrasted slightly with the view of the two physician leaders who had little to no operational leadership experience and whose focus was quite clearly on setting the vision for others to execute.

Physician/Nurse Role in the Health System and the Dyad

In an effort to understand the leadership views of the key informants, it was helpful to understand how they perceived their own role as a nurse or physician and their view on the other's role in the health system and how that impacted their dyad role. As such, during the course of the interviews, each of the informants was asked to describe the role of the nurse and the role of the physician in the health system.

The role of the nurse. Overwhelmingly, the three nurse leaders presented a very broad view of the role of nursing as one where it enabled them to take on roles beyond that of a hands-on care provider, but remain grounded in the nature of that role. As FN1 noted, her experience as a front-line nurse "[spending] the most time with [patients]" and using that experience to bring "the patient voice to bear" provided the opportunity to influence policy and how health care was provided. The other nurse leaders reiterated that view describing how they used the essential nursing skills, which FN2 described as "assess, "decide", "take action", and "evaluate", and applied them to the various roles they held in the health system, such as leadership. FN3 clearly

represented that view, stating how the basic skills of nursing were applied to the challenges of working in the health system "whether you are planning at a large provincial level such as the role I'm doing now or whether you are planning…for a patient in front of you". Evidently, the nurse leaders believed the skills that stemmed directly from their nursing roles were quite useful in their career paths within the health system.

In their reflection of the role of their nurse colleagues, the physician informants clearly focused on the role of the nurse as providing direct care to patients. MP1 expressed that nurses provided "considerably more hands-on care to patient, direct patient care, than physicians do". His physician colleagues also saw that direct care for nursing but expanded on it by characterizing that role in relation to the role, indeed guidance, of the physician. For example, while MP2 indicated nurses "provide comfort…to the patient and their families", this was achieved by "[carrying] out the care plan that's developed by the physicians in consultation with other professionals". A similar view was expressed by MP3, who described the role of the nurse as providing the supportive care to the patient "in conjunction with the physician and the patient…to provide the direct care that…the nurse, physician and patient come up." The physician leaders clearly portrayed the role of the nurse as the providers of direct care to patients; however, it is also clear that the work of the nurse was under the direction of physicians.

Role of the physician. For the physicians, their view of their role, for the most part, spoke to varying roles of a physician in providing care to patients linked to the physician's area of practice. That was certainly found in the description by MP2, indicating that the type of physician determined the role of the physician. For example, he noted that a family physician was a case manager for the patient's medical needs, like a "quarterback" for their care, while a specialist physician was "much of a consultant" where there was a "periodic need for your

involvement and you offer your expertise to help solve a very specific problem." Another example he used was that of an emergency physician who had a one-off encounter with a patient to "to try to solve their most immediate emergent need, stabilize, treat and then pass on (to other provider)." For MP1, the role of the physician was even much broader, quite reflective of his own experience, as he referenced the role of the physician as a clinician, teacher, researcher, and administrator. In describing the role of the physician, MP3 noted that "it's our role to help patients with whatever problem they have," likening it to working "in the professional services industry," and giving the impression that the physician was not directly connected to the health organization.

That view of the separation of physicians from the health system was somewhat shared by the nurse leaders indicating their view of the physician role as actually functioning outside the health system. As FN1 noted: "They were there to care for patients (but) saw it as someone else's job to do the policy development, (to) look after the budget, and to make things happen." That view was also reflected in the thoughts of FN2: "Physicians are independent, private practitioners who function sort of beside the system through what I would call rules governed by their laws or by a privileging process that gives them access to the resources of the system." From her perspective, FN3 believed physicians, not unlike nurses, were advocates for patients and were part of the team of care providers since there was no one provider who did everything for a patient. She noted: "The team is big enough for all of the providers. Physicians bring a certain skill set to the table and it takes all of us to make the difference for patients, populations or communities."

Summary. Not surprisingly, there were shared opinions that the role of the physician was to provide care to patients; however, that care took various forms and there was a sense that physicians function independently from the operations of the health system.

Changing Nature of the Relationship

There was strong agreement among all informants that physicians and nurses each played significant roles to provide the required health care to patients. What was also evident from the data was how the nature of the relationship between physicians and nurses evolved over time from where there was a high degree of deference to physicians on the part of the nurse to where physicians demonstrate acceptance of the nurse's input.

From a nurse leader perspective on the nurse/doctor relationship, FN1 recalled that it was her training as a nurse that instilled in her the "great deference" to physicians, as reflected in her comment: "…if we were sitting and charting, we gave up our chair for the physician". Recalling her experience, FN2 stated: "I worked in hospital in an environment where to some degree the doctors were in control in terms of giving an order and you followed it and you didn't do much without getting an order." FN1 believed it was through "respecting that each one brings a kind of different contribution" that has brought about a change in how physicians and nurses worked together where there was more of an equal partnership.

From a physician-leader perspective, MP1 also acknowledges the "hierarchy has become flatter" where the physician was no longer considered the head of the team. For MP2, that was a result of nurses becoming more assertive and less deferential to physicians "and also acceptance that that is appropriate on the side of physicians…and that's fine for me". MP3 had also experienced a levelling of the hierarchy where "it's open that a nurse" can question an approach or offer an opinion on decisions around patient care.

While there was agreement among the informants that the relationship between physicians and nurses was becoming more of an equal partnership, there remained evidence to support the view that physicians had the final say when it came to making decisions on patient care. That position on physician authority was demonstrated in the comments of MP3: "Someone has to execute the decision making, someone has to pull the trigger on the decision and I think that's physicians." Even recognizing there was collaboration, MP2 noted "we're…discussing what I think needs to happen with the patient", indicating a reflection that, as a physician in a clinical setting, he was ultimately in charge when a key decision had to be made.

Nurses and physicians were in agreement that a hierarchy certainly existed in the nature of the relationship between the two health care providers; however, both physicians and nurses acknowledged the relationship was changing where there was more of an equal partnership. While there was evidence that physicians retained their privilege as the ultimate decision maker in the areas of patient care, there was the sense that nurses were becoming more assertive and less deferential; for their part, physicians were somewhat more welcoming of that transition.

Unanimous Support for the Dyadic Leadership Model

With the acknowledgement on the part of the informants that the relationship between physicians and nurses was moving towards one where there was more equity in the decision making around patient care, it came as no surprise therefore that there was strong, unanimous support for the dyad management relationship between physicians and nurse administrators. It was best described by MP3 as "the best of both worlds." He further noted:

> *My dyad partner…has such a wealth of knowledge of how administration works and how to get things done. You need someone with an administrative background whereas I think*

> *the value of having a clinician there is that it allows us to connect what is happening with the organization right at the time with the highest levels of leadership right at the time.*

That appreciation of complementary expertise was certainly reflected by FN1 as she described the dyad as an excellent way to pair clinicians and administrative leaders together to make "the best decisions…well-rounded, well-informed decisions." That sentiment was shared by MP1 who explained that health care requires leaders who have a vast scope of knowledge and skills which is not found in just one discipline of medicine and nursing:

> *The physician leader tends to have typically more knowledge and skills in the area of…clinical patient care, the clinical world of quality, safety, obviously physician engagement whereas the administrative partner typically has more knowledge of finance and managing the budget…more knowledge of nursing policy and other organizational policy.*

That pairing of the physician and nurse leader resulted in benefits to the health system, as FN1 noted that, from her experience, the dyad model lead to improved quality of care, higher degrees of satisfaction among physicians and operational staff, and cost reduction. Agreeing, FN3 indicated physicians and nurses were oft seen as health system leaders and through the dyad model the opportunity was provided to use "our differences to actually achieve those outcomes."

Another important aspect of the dyad model that was represented through this study was the benefit, almost a requirement, of having physicians involved in leadership roles. As FN1 noted, the objective of the move to integrate physicians into the leadership structure of her organization was to engage clinicians and to have the clinician voice at the table for decision making and strategy setting, rather just having the administrative voice making decisions. From her perspective, that benefitted her organization: "The opportunity for physician and clinical

feedback and their participation in engagement has influenced policy…has changed how we practice." FN3 also acknowledged the need for physicians as leaders: "So much of the work we need to do to recreate and rebuild involves physicians and if we don't have physicians as leaders it is hard for physicians to see their place in that." MP1 agreed noting that in order to improve and transform health care, physicians needed to be engaged. He added: "We also know physicians are…challenging to engage and typically much easier to engage by other physicians so having physician leaders as part of the management in health care makes sense from that perspective." MP2 added that his experience as a leader in the medical association allowed him to develop relationships with his physician peers and when people know and trust you it is a lot easier to lead them. He noted: "They have trust and confidence in you to have that physician voice in administration." Another advantage, MP2 stated, is the fact that the physician leaders still do clinical work: "If you are still not in the trenches…you lose credibility among the physician peers and that value of being in the dyad in the first place of bringing that physician voice is lost." The leaders acknowledged the importance of having physicians at the leadership table as a means to engage physicians in the effort to improve the health system.

The dyad model for health care has strong support from both the female nurse and male physician leaders since it merged the extensive administrative experience of the nurse leaders with the ongoing clinical experience of the physician leaders that lead to better outcomes for patients and the organization as well as presented the opportunity for the engagement of physicians in health operations.

Strategies for Successful Dyadic Leadership

While the physician leaders and nurse leaders overwhelmingly agreed that the dyad model was a good leadership approach for health organizations, the development of the

partnership did not just happen naturally. It required effort and commitment on the part of both partners to realize the benefits of the dyad model. In that context, the physician and nurse leaders provided insight into some strategies that are helpful for the partnership to be able to carry out their role effectively—these included the need to build a relationship, present a united front, and have the ability to change your role from being a mentor or a learner, depending on the situation.

Need to build a relationship. The nurse and physician leaders agreed on the importance of building the dyad relationship and determining its functionality. As FN3 pointed out: "We're different. We have different backgrounds. We have different education and experience. We have to become very comfortable with each other's knowledge, skills and ability because it has to be in step." For FN1, that meant having purposeful conversations with her dyad partner to discuss how decisions are made, how to effectively communicate, and how to manage conflict: "You need to be deliberate in the discussion…sort of build a confidence and trust in each other that you can talk through some of the issues that are in front of us." FN1 also added it was about having clarity of the roles the partnership members have collectively and individually. Further to that, MP1 described the relationship as a Venn diagram, where some responsibilities, skills and knowledge overlapped while others were unique to each member of the dyad. To reach the point where both dyad members understood the value of what each brought to the partnership, MP2 recalled how he and his partner went from "trying to be a bit too prescriptive", to finding common ground in how the relationship functioned:

> *We did recognize either of us could take the lead on anything but at times it is obvious. If it's a physician issue why would I not…take the lead versus whether it was a labour relations issue with staff…my partner who knows more about that so why wouldn't she*

> *take the lead on that…It just became what was just obvious…I guess maximizing our expertise.*

The dyad partners recognized that each of them brought different knowledge and skills to the relationship and that the best way to make the dyad work was to have focused discussions on how to capitalize on the individual strengths in an effort to make the dyad partnership an effective leadership model.

The united front. What was also demonstrated by the key informants as instrumental to making the dyad function effectively was the need for the partnership to be seen as united—as MP2 stated: "We have been very intentional to assert that we are equal partners." That came from ensuring the message that comes from the dyad was consistent and their expectations were aligned, noted FN1, adding, "We stand together because the (physicians) need to get the message…(as well as) the operational leaders." As stated by FN2: "If one answers a question, that's the answer." In order to present that united front, it means "(hashing) it out beforehand" according to MP2, with FN3 adding "leave the disagreements between the two of us" in order to be positioned to deliver the same message. In fact, FN3 likened it to parenting saying:

> *We have the ability to have the same message and if we disagree…something like why did you make that decision or what are your thoughts on going down that direction we leave that between the two of us…so that we still have that ability to be united.*

It was evident that this team decision making process of working together as a single unit was somewhat of a departure from how physicians saw how they function, a dynamic aptly described by MP3: "It's an equal team decision making process where clinically it is more of a hierarchy where I have to make the decision ultimately with information provided by the nurses but I'm the one who has to make the decision." That traditional hierarchy relationship would make working

with a nurse as a dyad partner difficult, noted MP1, adding that he had seen situations where the dyad relationship did not function effectively "if the (physician) wants to be the boss". That sentiment was shared by FN2, who commented that "if there is a power disparity or perceived power disparity then there are significant challenges", recalling that in her working relationships with physicians, she experienced the most difficulty when "a physician takes a medical model approach to the relationship". In explaining that medical model approach, FN2 described it as the situation where the physician believes he was the "writer of the orders and administrator is the secretary who carries out what they are told to do". The levelling of the power distribution in the physician-nurse dyad structure was best described by MP2:

> *In the clinical situation the male physician is more dominant than the female nurse because of the role and the hierarchy in the system. But now we are paired with administrators who have been administrators for over 20 years…so you know you are not going to be the dominant one. At the same time being a male physician makes you dominant enough to hold your own at least.*

It was important for the dyad leaders to present a united front when decisions were made, directives were provided, and when setting strategic priorities. That often means physicians had to set aside their tendency to be a sole decision maker and recognize the significant administrative experience of their dyad partner.

Be the mentor…be the learner. Another important strategy for the leaders as they assumed their roles within dyadic leadership was to acknowledge there were times when they would be the mentor and, in contrast, there were instances where they would be the learner. As pointed out by FN1, she understood there were situations when her dyad partner had more

knowledge and there were situations when she was the content expert. She described the relationship this way:

> *There is a fluidity around respecting skills, knowledge and experience of the other partner, knowing that in some circumstances they take the lead and in others (they) are the subordinate. It is not that one is better or worse. It is building on the skills that the other person has and being respectful of that and being willing to sit back and enable that person to take the lead but knowing you're with them.*

FN3 agreed that the nature of the relationship had to be fluid considering the pairing of clinical and administrative leaders brought different backgrounds, education and experience to the table which resulted in a "continual mentoring/learning piece." However, she also recognized the significant role of the nurse leaders in the development of the dyad partnership: "The nursing leaders really have a big role in mentoring and growing the physician leaders, not because we are better at it but because we have been socialized and have more experience at it." FN2 supported this position by stating it was important for her to be a mentor to her partner while not devaluing his perspective. As she pointed out, "I have to be mindful that I'm not piping up all the time. It's letting it play out. If I keep piping up all the time then he doesn't have the opportunity for learning." MP3 agreed that the experience of his nurse leadership partner was valuable to him in his role as a leader but also noted she gained from his clinical work: "I learn a lot from her from the historical perspective of what's been done and why but I think she learns from me about what is being said at the point of care." MP1 also commented that his partner relied on his clinical knowledge as he continued to practice medicine while he, in turn, "certainly depends on her…to have more knowledge and details on the operating budgets." It was a benefit to the dyad if the

partners acknowledged there were certain circumstances when they had to rely on the fact their partner had more knowledge and experience and were willing to mentor and learn from the other.

The key informants had consensus there needed to be a fluidity within their dyad relationship as to when one of the partners assumed the leadership role depending on the nature of the issue that defined the most appropriate lead.

Summary

By conducting semi-structured interviews with three male physician leaders and three female nurse leaders, I collected data related to the lived experiences of the key informants to understand what impact those experiences had on how these leaders function within a dyad leadership model in health care. Thematically, my key findings from the data explication process included: pathways to leadership; leadership view; physician/nurse role in the health system and dyad; changing nature of the relationship; unanimous support for the dyadic leadership model; and, strategies for a successful dyad. These findings will be discussed in the next section in relation to the research question and the learnings from the literature review.

Discussion

In this section, the findings of the research are discussed in relation to the research question, research objectives, and the literature. The study was grounded by the research question: *How is the historical characterization of physician-nurse communicative relations still evident and what impact does it have on the effectiveness of the dyad management model in the ever-challenging health care system in Canada?* The objectives of the study are to determine whether:

- The male physician and the female nurse can be effectively partnered within the dyad model to provide the leadership required to improve the health system;
- The individual physician leader and the individual female nurse leader feel they are able to work collaboratively, considering their previous experiences;
- There is an assumed imbalance of power evident in the decision-making capacity of the dyad; and,
- The sex and professional role of the clinician shapes their perspectives on the likelihood of the dyad model being successful.

Keeping in mind the research question and objectives, this section discusses the relation between the literature review and my findings based on the following topics: health leadership and the dyad model; the relationship between physicians and nurses; and, the impact of gender on the relationship between the physician leader and the nurse leader in a dyadic leadership model.

Leadership, Health Leadership, and the Dyad Model

As has been presented in the literature, there were various styles and forms of leadership that included, as Rogers (2012) described, transactional leaders who work within boundaries and standards set by the organization, and the transformational leaders who drive creativity and

innovation among staff. From the key informants, it was found that the nurse leaders could be described as transactional leaders from the perspective of their knowledge of and compliance with the budget, governing policies, and procedures of the organizations for which they worked. On the other hand, the majority of the male physician informants self-described themselves as leaders more aligned with the transformational style, as they wanted to set the vision for what has to be accomplished and encouraged their staff to be innovative in achieving that vision. As Rogers (2012) also noted, though, the styles of transactional and transformational leadership, while different, are complementary and may lead to attaining the objectives of the organization. With that consideration, there was evidence to support pairing a physician leader and a nurse leader to form a strong, balanced leadership team where differing leadership styles could work together in an effort to accomplish the outcomes required to provide quality, transformative, and sustainable health care.

The research supported the view that leadership in health care presented unique challenges, as health care organizations were characterized by hierarchies of professionals within administrative and clinical structures and the fact health leadership carried the burden of the health and wellbeing of the people and communities served (McAlearney, 2006). Furthermore, as noted by Saxens et al. (2018), no one health leader had the capability to lead alone and therefore it was necessary to integrate administrative and clinical leadership. This research found unanimous support to pair the administrative leader, most often a nurse (Baldwin et al., 2011), with a clinical leader, the physician, in a joint leadership model. The key informants recognized the broad-based, extensive experience the nurse leaders bring to the partnership from an administrative perspective and acknowledged the ongoing clinical work of the physician leaders as a means to ensure the continual close connection with the clinical care being provided with the

decision makers at the administrative level. The informants also referenced the importance of having physicians in leadership positions as a means to engage physicians and lend credibility to senior level decision making. As one informant stated, the pairing of physicians and administrators in a dyad leadership model brings together the "best of both worlds".

Through both the literature and the current research, it has been demonstrated that the partnering of the clinical (physician) leader and the administrative (nurse) leader in the dyad model was a leadership model that was accepted by both nurses and physicians and one that was necessary for health organizations to effectively manage challenging environments to ensure the delivery of quality health services and programs.

Defined Relationships and Shared Power Lead to Collaboration

A common theme that had been noted through the literature and the current research indicated there was a need for collaboration between professionals who worked with health care organizations. That notion of collaboration was described by Green and Johnson (2015) through the concepts of sharing, partnership, interdependency, and power in a well-defined relationship. In support, Clark and Greenawald (2013) stated that was through sharing decision making, responsibility and power that effective interprofessional collaboration was realized. Key informants for this study acknowledged that, in order for them to work effectively as dyad partners, effort was required to build a trusting relationship between the two partners. That effort included discussions on the functionality of the relationship and the recognition of the experience and skills that each brings to the partnership that led to circumstances where the power dynamic of the relationship shifted to one or the other depending on the nature of the circumstance or the task to be completed.

Conversely, there was existing literature that spoke to the challenges of the relationship between physicians and nurses that included the dominance of physicians over nurses (Blue & Fitzgerald, 2002) and the issue of professional boundaries that lead to professions strengthening their world view, ideology, and authority (Hall, 2005) in an effort to exert power. There was acknowledgement among the key informants that, oft times, there was deference on the part of nurses in the relationship with physicians and that physicians did exert authority. That was best described by one female nurse informant who indicated that nurses did not provide patient care in the absence of a direction from the physician. However, while there remained the notion of the physician being a final decision maker in care provision, the informants spoke to the changing nature of the relationship. That changing relationship was where the experience of collegiality and collaboration were existent as both professions consulted on and discussed the needs of a presenting patient which lead to better health care outcomes. Additionally, both professions could function as equals in senior level leadership positions which lead to better outcomes for quality of care and cost effectiveness for the health care organization.

What has been learned from the experiences of the key informants was that, because of the historical nature of the physician-nurse relationship, there was the necessity of making a concerted effort to work together to define their dyadic relationship, recognizing that each one brought a set of skills and knowledge that were beneficial to the responsibilities they shared and enabled them to work together collaboratively as leaders in the health system.

The Undertones of Gender

From the literature, it had been shown that the formation of the relationship between the nurse and the physician was both patriarchal and hierarchical, clearly depicted in the role of the nurse as the handmaiden for the physician there to carry out his orders (Price et al., 2014). In

fact, as noted by Bell et al. (2014), the dominant position of the physician role in health care was a reflection of the gendered privilege of men in society and the subordinate position of nurses emerged from the feminization of care work. Furthermore, in the work of Acker (1990, 1992) there was a presentation of gendered jobs, the overarching patriarchal mindset within organizations, and that gender was a pervasive form of power that existed within and even structured organizations and institutions. As such, it was reasonable to identify health care institutions as reflecting the gender mindset. Interestingly, when asked specifically about gender and its impact on their dyadic partnership, each of the key informants indicated they did not think the gender or sex of their partner influenced the nature of their relationship. However, several of the key informants, both physicians and nurses, through answering that question and as a reflection of their experiences as expressed to the researcher, did reference the hierarchical nature of the relationship between physicians and nurses and the high level of esteem that physicians were held within institutions and society in general. Even while acknowledging the fact that their nurse dyad partners had tremendously more administrative experience than they did, physicians saw the fact that they were physicians and that they continued to practice medicine, albeit part-time, put them on equal footing with their nurse partner. In that context, the work of Martin (2004) remained relevant as her study spoke to the institution of gender being built into society's social organizations with connection to the masculinity of medicine as described by Bell et al. (2014) and Hall (2015). The presence of gender was also clear in how the informants characterized leadership. For the most part, the nurse leaders spoke of building relations and coalitions while physician leaders spoke of the visionaries and this reflected the research of Holmes (2008), who described leadership as positions in the masculine traits of assertiveness while women employed more facilitative styles.

The gendered nature of positions of physicians and nurses and the gendered nature of health care organizations was reflected in the findings of the research, although not expressed overtly by the informants in describing their relationships with their dyad partners but noticed in the undertones of the understanding of that relationship.

Summary

In summary, examination of the experiences of physicians and nurses in a dyadic leadership relationship has revealed the importance of establishing such a relationship between physicians and administrators by incorporating physicians into the formal leadership structures of organizations. However, the partners in such a relationship need to engage in communication with the other to define that relationship and be willing to accept there are instances where, while there is equity in the partnership, there will be circumstances where it is appropriate for one to lead over the other. Furthermore, while not explicitly expressed by the informants, the issue of gender and gendered jobs was present, confirming the continued existence of the historical and social context of the position of physician and nurse. Therefore, there was evidence to support that while the relationship between physicians and nurses was changing, that historical relationship of where the physician holds the power in relation to the nurse continued. As a result, when physicians and nurses became partners in a dyad leadership model, they had to work at building their relationships through recognizing the competencies and contribution the other brings to the relationship and knowing when to cede power to the other.

Conclusion and Limitations

The delivery of health care in Canada will continue to be one of the most significant public policy challenges faced by federal, territorial, and provincial governments, by health care leadership, and by the many professional health care providers that work within health care systems. Increased demand, increased complexity of care, and increased costs are among the leading issues politicians, administrators, bureaucrats, physicians, nurses, and other health care providers are struggling to address. In fact, throughout my research, I clearly heard from the six key informants who are senior leaders in large health care organizations of the immensity of their roles and responsibilities, and while not stated, a sense of the tremendous amount of pressure and responsibility that has for each of them. Having said that, each informant is clearly committed and dedicated to the task at hand and have taken on their leadership positions with the view of ensuring that quality, safe health care is delivered to the people they serve in a sustainable manner. What was also evident was how their dyadic leadership partnership provides the means through which they can meet their mandate. It is through having a partner to share the decision making, accountabilities, and responsibilities that there is confidence in achieving positive outcomes. Through the effort required to develop the trusting relationship, the acknowledgement and recognition of the others' skills and knowledge, and knowing when to lead and when to follow, these senior leaders are demonstrating the benefits of the dyad leadership model.

It has been established, through this study and other research, that leadership within health care is a critical element to the success of the delivery of health care. Furthermore, while it has been members of the nursing profession who have been primarily taking on the administrative burden to ensure safe and sustainable health care operations that meet the needs, and oft times expectations, of the people served, it is important that physicians are also involved

as administrative leaders due the role and influence they have in the provision of health care. This study has provided insight and, in some respect, guidance, as to how physicians and nurses can effectively develop a dyad leadership relationship in an effort to bring together the skills, experience, and knowledge of both for the betterment of health care delivery.

Limitations

There are several limitations that should be noted. Most obvious, the mix of participants as interviewees consisted only of male physician dyad participants and female nurse dyad participants. This excluded exploring other dyad leadership partnerships that exist including male physician/male nurse, female physician/female nurse, and female physician/male nurse. Further studies in those areas could more intimately explore the issue of gender, gendered jobs, and the relationships that exist. There were not any inclusion/exclusion criteria based on whether the physicians/nurses are experts in certain disciplines/specialties, which potentially could have an impact on their work experiences and professional identity. For instance, in certain specialty areas of medicine, a physician is clearly the leader/expert in a patient-care event, leaving little room for consultation with other team members such as nurses. A study exploring how physicians from certain specialties would provide insight into how these physicians can function inside a leadership partnership where co-decision making is required. The study was also limited by the approach to a purposeful selection process of participants based on the researcher's intimate knowledge of various health care organizations and contacts within certain organizations that could present a bias. Interviewees could have felt reluctant and self-conscious on providing detailed information on their experiences; as such, it was important for the interviewer to make the informants feel comfortable about the interview and provide reassurance of the confidentiality of the information they provided. A multi-method approach that would use

various forms of data collection including surveys and focus groups to expand the number of people informing the research could provide a broader view of the opinions that exist of the physician-nurse dyadic leadership.

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Appendix A
Letter of Invitation

Dear (Key Informant)

I am conducting a research project as part of my thesis for the completion of a Master of Arts in Professional Communication degree offered by the School of Communication and Culture at Royal Roads University. At this time, I am inviting you to be a participant as a key informant for my research.

The focus of my research is on the physician-nurse dyad leadership model using an interpretative phenomenological inquiry. I believe that as a physician/nurse and as a leader within the health care system your experience as a member of a leadership dyad will be valuable in the examination of this relationship.

Your agreement will consist of participation in an interview that will be conducted via telephone and will last approximately 60 minutes during which time I will ask you questions about your career experiences as a nurse and as a partner in the dyad leadership model.

Your interview will be recorded digitally and will be stored securely on a password protected flash drive. The interview will be transcribed for analysis and the transcripts will contain no personal identifying information in an effort to protect your confidentiality and privacy. The flash drive and the printed transcripts will be secured separately in a home office in a locked drawer. The final report of the study will not contain any information that will identify you as a participant. A copy of the final research paper will be housed at Royal Roads University but will not be publicly accessible. Should I pursue publication with a journal, I will request further consent from you.

My credentials with Royal Roads University can be established by telephoning Dr. Virginia McKendry, at xxx-xxx-xxxx, my thesis supervisor. Alternatively, she can be contacted by email. For additional queries about the research, you may also contact Dr. Julia Jahansoozi, Director, School of Communication and Culture by email or xxx-xxx-xxxx.

This research project has received clearance from the Royal Roads University Research Ethics Board. If you have any questions regarding your rights as a research participant, please contact the ethics office at ethicalreview@royalroads.ca; 1-250-391-2600 ext. 4206.

While your participation will be greatly appreciated for the advancement of study in the area of the dyad leadership model, you are not compelled to participate in this research project. If you do choose to participate, you are free to withdraw at any time without prejudice. Similarly, if you choose not to participate in this research project, this information will also be maintained in confidence.

Should you require further information or wish to discuss your participation further, please feel free to contact me via email or by phone xxx-xxx-xxxx. I thank you for your consideration of my request.

Sincerely,
Carmel Turpin

Appendix B
Participant Consent Form

My name is Carmel Turpin and I am conducting a research project as part of my thesis for the completion of a Master of Arts in Professional Communication degree offered by the School of Communication and Culture at Royal Roads University.

My credentials with Royal Roads University can be established by telephoning Dr. Virginia McKendry, at xxx-xxx-xxxx, my thesis supervisor. Alternatively, she can be contacted via email. For additional queries about the research, you may also contact Dr. Julia Jahansoozi, Director, School of Communication and Culture by email or xxx-xxx-xxxx.

This research project has received clearance from the Royal Roads University Research Ethics Board. If you have any questions regarding your rights as a research participant, please contact the ethics office at ethicalreview@royalroads.ca; 1-250-391-2600 ext. 4206.

This document constitutes an agreement to participate in my research project, the objective of which is to conduct an examination of the physician-nurse dyad leadership relationship using an interpretative phenomenological inquiry approach that is concerned with nurse and physician leaders *lived experience,* particularly as concerns their dyadic leadership role.

The data to be collected in this qualitative research study will consist of a series of semi-structured one-on-one interviews focusing on the personal narratives that will include information about and references to you. The interviews will be recorded and transcribed for analysis. The transcripts of the interviews will contain no personal identifying information in an effort to protect the confidentiality and privacy of the participants.

This consent form seeks your consent to be included in the study.

A copy of the final research paper will be housed at Royal Roads University but will not be publicly accessible. If and before the author chooses to pursue publication with a journal, further consent will be sought from you.

You are not compelled to participate in this research project. If you do choose to participate, you are free to withdraw at any time without prejudice. Similarly, if you choose not to participate in this research project, this information will also be maintained in confidence.

By signing this letter, you give free and informed consent to be included in this project.

Name: (Please Print): _____

Signed: _____

Date: _____

Appendix C

List of Questions for Key Informants

Introduction

Thank you for agreeing to participate in my research study. Our interview will be recorded to ensure the information you share is collected accurately and in detail.
I again assure you the information you provide to me will be kept confidential.

Career and Personal Experience
1. Let's start with you providing your name, your current position at (insert name of organization), how long you have been in that role and how long you have worked as a (nurse/physician)?

2. Can you please provide me with information about how you decided to become a (nurse/physician)? Probe as necessary – what drew you to the profession?

3. How do you describe your role as a (nurse/physician)?

4. How do you describe the role of a (nurse/physician)?

The Nurse-Physician Relationship
5. Can you reflect, generally, on your experience as a (nurse/physician) and, particularly, in terms of how you would describe the professional working relationship with (nurses/physicians)?

6. As a follow up, can you describe for me your thoughts on the collaboration between physicians and nurses from your experience?

7. How about your thoughts on how nurses and physicians communicate?

Personal Leadership and Leadership in Health Care
8. At what point in your career did you develop an interest in assuming a formal leadership role?

9. What areas of your experience do you think prepared you for your current role as a leader?

10. What characteristics do you believe define a good leader? Probe – Based on that, do you believe you are a good leader?

The Dyad Leadership Model
11. What are your thoughts on the dyad model that often pairs a physician and a nurse as a leadership team?

12. Do you believe your role in the dyad model is clearly defined?

13. Does your past experience working with (nurse/physician) influence your relationship with your dyad partner? If so, how?

14. How would you describe your leadership style within the dyad? How about your partner's style?

15. Do you believe the dyad model results in a shared and equal leadership partnership? If so, how? If not, why not?

16. Can you describe how your direct reports respond to the leadership of the dyad partners? Probe – is one partner more influential than the other?

17. Can you share with me your thoughts on whether you believe the gender of the leader matters when it comes to ensuring a strong leadership dyad

Conclusion

17. Is there anything you wish to add about your experience and your role that you believe is relevant to my study?

18. Should I need some clarification on the information provided, can I contact you via email for follow up?