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**Doctor of Education in Organizational Leadership**

*Nannette W. Glenn, Ph.D.*

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Abilene Christian University  
School of Educational Leadership

An Interpretative Phenomenological Analysis of Leadership and Interprofessional Conflict in a  
Chronic Joint Venture Setting

A dissertation submitted in partial satisfaction  
of the requirements for the degree of  
Doctor of Education in Organizational Leadership

by

Jeffrey Thomas Stevey

February 2021

### **Dedication**

I would like to dedicate this work to my wife Amy. Without your patience, understanding, and words of encouragement throughout this journey, this dissertation would not be possible. No words can express my heartfelt thanks for your sacrifices and support. Thank you for being my counselor, social worker, and supporter throughout this journey. I can never repay you for the many hours you spent reading and commenting on my work and the personal sacrifices we made to get to this point.

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## **Abstract**

The logics of medical professionalism and managerialism often result in differences in perspectives and conflicting prioritization of healthcare delivery, resulting in interprofessional conflict that stymies healthcare reform initiatives. In the context of dialysis joint ventures in the chronic healthcare setting, interprofessional conflict threatens the collaborative processes needed to deliver the desired clinical and financial performance outcomes. This study sought to explore the influence of leadership behaviors on the manifestation of collaboration and conflict in dialysis joint ventures to provide leaders with recommendations on how to modify behaviors to achieve desired outcomes. Six dyads of physicians and managers, three dyads from high- and three from low-performing joint ventures, participated in semistructured interviews. The purposeful selection of high- and low-performing ventures facilitated a differentiation in experiences and perspectives. Analysis of participant data relied upon the interpretative phenomenological analysis methodology, moving beyond descriptive phenomenology to explore how the participants made sense of their experiences. The data analysis revealed four superordinate themes that suggest leadership and communication behaviors that support inclusion, open-mindedness, and concern for the patient lessen professional identity salience and create the space to enjoy a team identity founded in trust and the desire for collaboration and compromise. Conversely, information withholding, controlling behaviors, and an overemphasis on financials created barriers to success by overemphasizing individual identity salience. These leadership differences differentiated high- versus low-performing ventures. The results of this study support prior literature in the acute setting suggesting the importance of leader attentiveness to team building through the creation of shared norms, common values and a team identity that values inclusion, debate, and compromise. Similarly, effective leaders engage

frequently with transparent communication, fostering trusting relationships that allow the emergence of collaborative relationships. As a word of caution, overemphasizing financial performance and engaging in efforts to create alignment to organizational goals stimulated average or subaverage performance of the ventures.

*Keywords:* alignment, collaboration, communication, engagement, healthcare reform, inclusion, inclusive leadership, interprofessional conflict, joint venture, leadership, medical professionalism, managerialism, open-mindedness, and social identity theory



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## **Chapter 1: Introduction**

Consider the challenge of working with someone on a complex institutionalized problem. Now, assume the other party has different educational and experiential backgrounds that created perspectives and priorities that are quite different from your own. Finally, assume the other party speaks a different language. Finding a solution in this context would be challenging and fraught with opportunities for frustration, tension, and conflict. This scenario represents a simplification of the current challenges associated with healthcare reform in the United States and many other countries around the world.

### **General Introduction**

Healthcare reform is a global challenge driven by complex health care systems (Glouberman & Mintzberg, 2001; Snell et al., 2011). Glouberman and Mintzberg argued that health care is “one of the most complex systems known to contemporary society” (p. 56). The complexity of health care contributed to significant reform efforts with largely unsuccessful results (Herzer & Pronovost, 2015). While managers typically implement reform initiatives, physicians control direct patient care and resource utilization: physician engagement is central to the success of reform initiatives (Lindgren et al., 2013; Skillman et al., 2017). Physicians and managers experience differences in education, training, proximity to healthcare systems, and sources of power that cause unique perspectives and priorities and ultimately lead to communication challenges: physicians and managers speak different languages (Glouberman & Mintzberg, 2001). As a result, interprofessional conflict (IPC), represented by a range of responses from annoyance to passive resistance to affective conflict and power struggles are common (Andersson, 2015; Kim et al., 2017; Skirbekk et al., 2018). In the presence of IPC, physician engagement withers, dooming the success of reform efforts (Skillman et al., 2017).

Increased costs and calls to improve quality resulted in increasingly complex reform initiatives in the dialysis industry in the United States (Jones & Hostetter, 2015; Nissenson, 2014). As the dialysis industry implements initiatives to respond to reform pressures, the role of IPC confounds the success of these efforts.

## **Background**

Recent healthcare reform initiatives that shifted from cost control to value-based medicine altered the nature of the relationship between physicians and managers in the healthcare industry, inclusive of the dialysis sector. Reform initiatives before 2011 emphasized cost control rather than quality, leading to the rise of managerialism in the healthcare industry (Janus & Brown, 2014). The managerial focus on cost control resulted in initiatives designed to lessen professional autonomy and align physician behavior with organizational goals, creating tensions between physicians and managers (Janus & Brown, 2014; Martin et al., 2015). As the cost of dialysis care continued to escalate and the sector encountered increased pressures to improve quality, the Centers for Medicare and Medicaid Services (CMS) and other regulatory bodies began to implement policies to shift towards value-based care (Nissenson & Maddux, 2017). In 2011, the Prospective Payment System bundled dialysis reimbursement to control costs and addressed safety concerns resulting from medication overuse (Jones & Hostetter, 2015; Weiner & Watnick, 2017). The Quality Incentive Program (QIP) followed in 2012, creating the first pay-for-performance model in an outpatient setting, tying dialysis reimbursement to quality outcomes. The passage of the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) in 2015 enhanced the importance of quality outcomes by mandating participation of physicians and healthcare providers in programs and partnerships that tied reimbursement to quality and cost outcomes, shifting financial risk to physicians and

healthcare providers and signaling a transition to collaboration rather than control (Lin et al., 2017; Nissenson, 2014; Nissenson & Maddux, 2017; Weiner & Watnick, 2017). The MACRA led to advanced payment models such as the End-Stage Renal Disease Seamless Care Organizations in 2015 and Comprehensive Kidney Care Contracting models in 2019, designed to create at-risk partnerships between dialysis providers and nephrologists that improve clinical and financial outcomes in the dialysis and chronic kidney disease patient populations (Centers for Medicare & Medicaid Services, 2019b; Lin et al., 2017; Weiner & Watnick, 2017). Over time, dialysis reform initiatives became increasingly complex and reliant upon the formation of collaborative relationships between dialysis providers and nephrology partners, amid the already strained relationships associated with previous cost-control reform efforts. The shift from cost control to value fundamentally altered the approach to dialysis delivery and reimbursement, requiring an evolution in the relationship between the nephrologists and dialysis providers.

The new models of healthcare reform necessitated changes in the relationship between physicians and managers to improve collaborative processes. Because physicians directly manage patient care, the physician controls healthcare delivery and therefore controls the rate and extent of acceptance of healthcare reform initiatives (Ham, 2003; Lindgren et al., 2013; Skillman et al., 2017). As the dialysis sector pursues the mandated quality measures, the sector must evolve to engage the physicians in collaborative processes between the dialysis organization, physicians, and other healthcare providers affecting dialysis outcomes (Jones & Hostetter, 2015; Lin et al., 2017; Nissenson & Maddux, 2017). In the author's context of a large dialysis provider organization, several ongoing initiatives target the improvement of collaborative processes with the nephrology community. One such initiative is the formation of



dialysis joint venture (JV) partnerships: the JV forms a financial relationship intended to engage the physician in collaboration with dialysis managers to improve desired outcomes.

The conflict between physicians and managers threaten physician engagement in reform initiatives. Physician ethos and training prepare physicians for the central role of problem-solving, delivering results, and desire to improve patient outcomes (Glouberman & Mintzberg, 2001; Lindgren et al., 2013). The physician focus on quality outcomes and problem-solving situates physicians as central to the change processes necessary for the success of current health care reform (Phipps-Taylor & Shortell, 2016; Swensen et al., 2016). Unfortunately, physician engagement has been challenging to achieve. Ninety percent of physicians believe they are necessary to improve quality (Teleki et al., 2006). However, physicians often choose not to become engaged because of conflict with or distrust in healthcare managers (Bååthe & Norbäck, 2013; Spaulding et al., 2014). The mistrust and conflict stem from the rise of managerialism in previous reform efforts that focused on cost and led to structures in healthcare systems where non-clinical managers sought to exercise power over physicians to achieve organizational goals, threatening the physician autonomy and eroding physician power in healthcare (Kirkpatrick et al., 2016; Martin et al., 2015). The power struggle and identity threats resulting from the focus on cost stymied physician engagement and led to lasting conflict and mistrust.

The differences between physician and managerial identities play a central role in the interprofessional conflict (IPC). IPC occurs when dissimilarities resulting from education and socialization processes lead to conflict between professions (Caricati et al., 2015; Foronda et al., 2016; MacArthur et al., 2016). The physician logic of medical professionalism focuses on autonomous individual patient care, while the logic of managerialism centers on efficiency, financial performance, and population health management: these differing logics often stimulate

IPC (Andersson, 2015; Glouberman & Mintzberg, 2001; Skirbekk et al., 2018). Similarly, identity plays a role in power structures resulting in physician use of expertise, knowledge, and training and manager use of policy and organizational structure to justify their respective positions (Fincham & Forbes, 2015). In multidisciplinary teams in the acute setting, identification with one's profession increased conflict, negatively influencing knowledge sharing, innovation, and performance (McNeil et al., 2013; Mitchell, Parker, et al., 2014; Molleman & Rink, 2015). Because IPC has a deleterious effect on multidisciplinary team outcomes, it is essential to understand the effect of IPC in the dialysis JV setting and how leadership behaviors might overcome IPC in this setting.

Forcing together the often conflicting logics of professionalism and managerialism requires effective leadership to overcome IPC. Skillman et al. (2017) identified strong leadership as a differentiator in the quality outcomes of high- and low-performing hospitals: good leadership had a direct influence on patient quality. However, managers often impose or dictate programs and initiatives on physicians, creating IPC and physician resistance (Herzer & Pronovost, 2015; Martin et al., 2015; Numerato et al., 2012). The formation of JVs with nephrologists results in an expectation of leader emergence from either the physicians, the operational managers, or both. However, there is no formalized training program to educate physicians on the requisite leadership skills needed to engage in collaborative work with nonphysician managers. While operational managers often have some leadership training, this training may not include skills necessary to lead physicians effectively. As a result, joint ventures may experience a gap in leadership required to stimulate physician engagement. This research study explored how leadership processes influence the manifestation of IPC in high- versus low-performing dialysis JVs.

## Statement of the Problem

Dialysis JVs often experience IPC that threatens collaborative processes needed to deliver desired clinical and financial performance outcomes. Nondialysis joint ventured facilities demonstrated comparable outcomes relative to wholly-owned facilities (Trybou et al., 2015), suggesting an underlying deficiency in leadership behaviors to engage physicians in collaborative processes (Shanafelt et al., 2015). The composition of JV management boards typically consists of managers, employed by the dialysis provider, and the physician investors, where the managers typically assume leadership roles. Managers who engage in ineffective leadership behaviors can stimulate IPC, compromising the desired outcomes (Mitchell, Parker, et al., 2014; Numerato et al., 2012; West, 2017). Leadership behaviors in dialysis JV influence a spectrum of responses from conflict to collaboration between physicians and managers on JV management boards.

Leadership behaviors influence the role of professional identity in IPC (Martin et al., 2015; Mitchell, Parker, et al., 2014; Mitchell et al., 2015). The dialysis managers' primary role is the management of employees engaged in the operations of dialysis facilities. However, many of these managers lack experience leading physicians, resulting in the use of leadership behaviors that increase professional identity salience, stimulate resistance, and decrease trust, hindering team performance (Folkman et al., 2019; Sfantou et al., 2017).

More information is needed to understand the influence of leadership behaviors on IPC in chronic settings, such as dialysis JVs. While much is known about the antecedents and mediators of IPC, little is known about how leadership behaviors influence the characteristics that form multidisciplinary team cultures (Keller et al., 2019; Kim et al., 2017; Salvatore et al., 2018). This study provides guidance to leaders of dialysis JVs to help understand what behaviors influence

IPC and collaboration. By understanding how to minimize IPC, the parties in the JV may engage in collaborative practices to improve desired performance outcomes.

### **Purpose Statement**

The purpose of this phenomenological qualitative research study was to understand the influence of leadership behaviors on the manifestation of IPC and collaboration in dialysis JVs. The population selected for this study included physician and manager board member dyads of high- and low-performing JVs operating in one operations group in the southern United States. The choice of board managers was applicable because these members are typically the most engaged in the JV, interact frequently, and represent each party's interests. The rich detail of the lived experiences of these board members provided insight into how JV leaders can modify leadership behaviors to reduce IPC and stimulate collaboration to achieve desired outcomes and maintain positive social relationships amongst JV board managers.

### **Research Questions**

**Q1.** How do joint venture board members think about the influence of leadership behaviors on the social identities of themselves and other board members?

**Q2.** How do joint venture board members think about the influence of communication processes on the social identities of themselves and other board members?

**Q3.** How do joint venture board members think about the role of individual and team identity in the context of a mature joint venture relationship?

### **Definition of Key Terms**

**Acute care setting.** The acute care setting, generally referred to as the acute setting, refers to settings of care where patients receive the most time-sensitive care for emergent

healthcare issues that could lead to death or disability: hospitals represent the prototypical example of an acute care setting (Hirshon et al., 2013).

**Alignment.** Alignment refers to organizational initiatives that create financial incentives or other structures to stimulate physician behaviors that are consistent with organizational goals (Hilligoss et al., 2017; Spaulding et al., 2014).

**Burnout.** Burnout is a work-related syndrome characterized by mental, physical, and emotional exhaustion that creates a sense of cynicism, isolation, strained relationships, and feelings of a lack of personal achievement (Kaissi, 2014; Roberts, 2018; West et al., 2016).

**Chronic care setting.** Chronic care settings seek to treat chronic health conditions by controlling disease progression, prolonging survival, and improving quality of life: dialysis clinics are considered chronic care settings (Kammerer et al., 2007).

**Chronic health conditions.** Chronic health conditions are permanent conditions with a nonreversible course of disease progression that requires ongoing long-term support to sustain patient lifespan, quality of life, and functioning (Kammerer et al., 2007).

**Dialysis.** Dialysis is a life-sustaining treatment for patients who experience chronic kidney failure and develop end-stage renal disease: dialysis removes toxins and excess fluids through ongoing treatments in chronic settings, such as in dialysis clinics or home therapy programs (Fresenius Medical Care, n.d.).

**End-stage renal disease.** End-Stage Renal Disease is a chronic medical condition that results from kidney failure, preventing the removal of fluid and wastes from the body and requiring long-term dialysis care to survive (Centers for Medicare and Medicaid Services, 2019a).

**Engagement.** Engagement refers to a reciprocal process between physicians and organizations where physicians experience an energetic sense of partnership and motivation to expend personal effort and commitment to meet and exceed organizational goals and improve quality outcomes, while organizations recognize, support, and encourage the physician contributions (Kaissi, 2014; Suelflow, 2016).

**Extrinsic motivation.** Extrinsic motivation exists when one is rewarded for the completion of a task or behavior with a separate consequence, such as pay (Deci et al., 2017).

**Identity salience.** Identity salience represents the activation of social identity in a specific situational context, activating in-group and out-group stereotypes, normative pressures, and accentuation of positive comparisons for in-groups and negative comparisons for out-groups (Hogg et al., 1995; Mitchell & Boyle, 2015).

**Inpatient setting.** The inpatient setting has the same meaning as an acute care setting.

**Interprofessional conflict.** Interprofessional conflict represents a range of responses from annoyance and tension to passive and overt resistance to affective conflict and burnout that results from differing priorities and perspectives associated with professional differences in education, training, socialization, sources of power, and proximity to healthcare organizations (Andersson, 2015; Martin et al., 2015; Skirbekk et al., 2018).

**Interprofessional practice.** Interprofessional practice is an emerging trend in healthcare delivery using teams of diverse healthcare providers from a broad range of specialties and disciplines to collaborate on healthcare delivery and problem-solving activities (McNeil et al., 2013; Mitchell et al., 2011).

**Intrinsic motivation.** Intrinsic motivation occurs when the reward for behaviors or task accomplishment results from the experience itself, satisfying the psychological needs for autonomy, competence, and relatedness (Deci et al., 2017).

**Joint venture.** A joint venture is a business partnership between two or more individuals or entities that creates a shared responsibility for the operations of a specific business venture where the parties seek to create synergies through collaborative relationships that exceed those of any individual partner (Bradshaw & Hinson, 2020; Content Team, 2014).

**Open-mindedness.** Open-mindedness represents a willingness to consider divergent perspectives and beliefs of others and an openness to modifying one's perspective and beliefs through the process of engaging in constructive dialogue and debate (Mitchell et al., 2012; Mitchell & Boyle, 2015).

## **Summary**

Healthcare delivery is a complex system that is often confounded by differences in education, experiences, and perspectives of different professions responsible for different functions within the system. In effect, each profession speaks a unique language and prioritizes different aspects of healthcare delivery, stimulating IPC that runs a gambit of annoyance and tension to conflict and power struggles. Historic healthcare reform initiatives resulted in efforts by managers to control physician behavior, often creating an environment of conflict and mistrust. Because physicians control the rate and extent of acceptance of reform initiatives, these prior reform initiatives were largely unsuccessful. Current healthcare reform initiatives emphasize a change from cost control to value-based medicine, shifting efforts to control physician behavior to collaborative practices that seek to engage physicians in problem-solving to improve care delivery. In the dialysis industry, one such effort is the formation of dialysis JVs.

However, IPC is pervasive in the dialysis JV setting, potentially compromising the desired clinical and financial performance outcomes. The purpose of this study was to understand how leader behaviors manifest IPC or collaboration. The research questions focused on how the participants think about the role of leadership behaviors and communication processes on the social identities of themselves and others, as well as how the participants think about the role of individual versus team identity in the JV setting.



## Chapter 2: Literature Review

Ideological differences resulting from membership in distinct social groups influence and contribute to conflict and tension in dialysis joint ventures, potentially mitigating the desired clinical and financial outcomes. This phenomenological qualitative research study sought to understand how leader behaviors influence the manifestation of IPC, collaboration, and physician engagement amongst physician and manager JV board members. This research explored the confluence of physician engagement, the ideological conflict between professionalism and managerialism, and managerial leadership behaviors in the context of a chronic healthcare business relationship. This review was informed by literature identified using the following key search terms: *engagement, burnout, alignment, medical professionalism, managerialism, social identity theory, identity, value-based care, healthcare, healthcare reform, joint venture, interprofessional practice, interprofessional conflict, inclusive leadership, transformational leadership, and leadership*. The literature search emphasized publications starting in 2012 to present and published in English. Some older seminal articles or references from more recent publications were included. The search identified a wealth of literature, with more than 50 articles each, on physician engagement and burnout, and the interactions between the ideologies of professionalism and managerialism. The search produced a moderate amount of research, more than 35 articles, on leadership in the healthcare context. The overwhelming majority of research occurred in the acute context, with modest availability of research in chronic settings. The search produced scant evidence of literature in the context of chronic joint venture relationships, with only one explicit article on physician ownership and a few articles with general references to joint venture structures. Articles were selected for review and inclusion in this literature review based on the article's contribution to the literature review.

## **Intersection of Engagement, Conflict, and Leadership**

A qualitative study on physician engagement conducted by Keller et al. (2019) illustrated the relationship between engagement, interprofessional conflict, and leader behaviors. Keller et al. (2019) recruited 20 physicians and 20 administrators working in a large urban hospital and sought to identify how cultural differences between physicians and managers influenced physician engagement. The researchers stated that physician engagement is critical to accomplishing organizational change but that cultural differences confound efforts to stimulate the needed engagement (Keller et al., 2019). Ninety percent of the participants noted difficulty in working with the other profession, despite shared beliefs about desired outcomes and potential solutions (Keller et al., 2019). Physicians expressed frustration with managerial emphasis on financial outcomes and the lack of consultation with physicians before implementing procedural changes that resulted in disruptions to the physician workflow, increasing threats to the physician prioritization of patient quality (Keller et al., 2019). Conversely, managers commented on the lack of business skills and leadership training amongst physicians, making physicians ineffective at organizational change (Keller et al., 2019). The physician and manager identities reflected different priorities in organizational commitment, decision-making processes, communication preferences, and leadership style (Keller et al., 2019). While physicians expected managers to collaborate on initiatives, managers likened physicians to children and engaged in efforts to control physician behavior by creating processes and structures to stimulate alignment to organizational goals (Keller et al., 2019). The differences in identity and the use of ineffective leadership behaviors decreased physician engagement, increased interprofessional conflict, and resulted in an emphasis on individual rather than team identity salience (Keller et al., 2019). The use of leadership behaviors that seek to control rather than collaborate and inattention to the

ideological differences that exist between physicians and managers created barriers to physician engagement, compromising change initiatives in this hospital. Personal experience with dialysis JVs demonstrated frequent efforts by managerial leaders to control physician behavior, stimulating disengagement, information withholding, and inattention to initiatives. This literature review will discuss each of these topics individually.

### **Physician Engagement**

Physician engagement is the foundation for the successful implementation of healthcare reform initiatives. Engagement occurs when the physician “self-identifies as part of the organization and is personally motivated to help the organization succeed” (Suelflow, 2016, p. 3). While it is necessary to engage physicians in quality and improvement work (Herzer & Pronovost, 2015; Phipps-Taylor & Shortell, 2016; Skillman et al., 2017), often organizations implement change without gaining physician input, leaving the physician to focus on direct patient care with little concern for organizational objectives (Studer et al., 2014; Swensen et al., 2016). While most physicians acknowledge their role in improving quality of care and patient outcomes (Teleki et al., 2006), many choose not to become engaged because of burnout (Swensen et al., 2016; West et al., 2014), lack of intrinsic motivations (Skillman et al., 2017), conflict or mistrust in executive leadership (Bååthe & Norbäck, 2013; Spaulding et al., 2014), or because the initiatives fail to align with the professional ethos (Snell et al., 2011; Storkholm et al., 2017). By addressing these barriers, healthcare organizations, executive leadership, and front-line managers can improve physician engagement.

Several large healthcare organizations provide useful insights into strategies to stimulate engagement. In the Mayo Clinic, the oldest and one of the most respected healthcare organizations in the United States, the executive leadership team reduced burnout and improved

physician engagement by involving physicians in decision-making processes and stimulating physician critical thinking to problem-solve organizational issues: educating the employed physicians about organizational needs and processes proved central to the problem-solving process (Shanafelt et al., 2015; West et al., 2018). The Mayo Clinic leadership also emphasized the importance of front-line leadership by enhancing leadership education and evaluation, improving communication concerning the organization's vision and values, and emphasizing physician intrinsic motivations by focusing reform efforts on the quality of patient care (Shanafelt et al., 2015; Shanafelt & Noseworthy, 2017; West et al., 2018). The Mayo Clinic experience focused on the creation of constructive physician-manager relationships framed in respect, trust, and camaraderie that acknowledged the mutual dependence of physician and managers to collaborate on the design of initiatives to improve care delivery, creating a shift from the perspective of the physician as an employee to the physician as a partner (Swensen et al., 2016). The Mayo Clinic experience demonstrates the importance of executive leadership and managers working with physicians as partners to create collaborative pathways to resolve organizational problems and improve patient care delivery.

Similar results are found in other systems. Thirty-eight management leaders in a large health system emphasized the importance of developing relationships that encouraged open dialogue, transparency, and physician involvement in decision-making processes (Spaulding et al., 2014). The managers noted the importance of understanding how engagement and alignment look from the perspective of both physicians and managers to facilitate effective partnerships (Spaulding et al., 2014). Seventeen physicians in high- and low-performing hospitals indicated the leadership in high performing hospitals emphasized patients and quality and created shared vision and values that considered physician needs (Hockey & Bates, 2010). The high performing

hospital leadership teams also demonstrated open communication, emphasized education opportunities for physicians on business and leadership, and created close relationships with the physicians (Hockey & Bates, 2010). Other studies of healthcare systems reinforced the importance of effective leadership, open communication, and the importance of focusing on the physician-manager relationship as a partnership (Milliken, 2014; Strömberg et al., 2016; Studer et al., 2014; Suelflow, 2016). Much like the Mayo Clinic experience, studies of engagement in hospital systems emphasized the importance of effective leadership and an orientation towards a partnership to affect the quality of care delivery.

Evaluation of physician engagement in reform initiatives casts doubt on the value of extrinsic motivations to stimulate physician engagement. Some experts suggest that financial motivations are sufficient to stimulate physician engagement in reform initiatives (Jones & Hostetter, 2015; Lin et al., 2017). In a study evaluating physician motivation in nine high-performing accountable care organizations, financial motivations were found to be necessary but insufficient to stimulate physician engagement (Phipps-Taylor & Shortell, 2016). Focusing on intrinsic motivations such as the medical professional drive to problem-solve and improve patient care, emphasizing professional development, and creating opportunities for collaboration proved more effective in this setting (Phipps-Taylor & Shortell, 2016). Similarly, focusing on the intrinsic motivations of mastery, pride, and patient care through collaborative processes improved physician engagement in two large scale quality improvement initiatives (Herzer & Pronovost, 2015). In a study of 21 new healthcare delivery models, educating physicians on business models, goal structures, and leadership processes enhanced physician engagement (Skillman et al., 2017). Aligning the delivery model to physician values, gaining physician input early in the initiative, and focusing on outcomes physicians could control further improved

engagement and desired organizational outcomes (Skillman et al., 2017). These early results in large-scale reform initiatives demonstrated the importance of intrinsic motivations rather than financial incentives to stimulate physician engagement.

Reform initiatives that utilize strategies and structures to control physician behavior and force alignment to organizational goals negatively influenced physician engagement. In a contrasting case study analysis of engagement in large health systems in Canada, a country using a national health insurance program similar to that in the United States, and the Netherlands, a country with a social insurance system, Denis and van Gestel (2016) found that efforts to engage physicians were common but typically insufficient. Regulatory constraints using financial incentives failed to stimulate long-term physician engagement (Denis & van Gestel, 2016). Rather, when systems sought to balance financial motivations with processes to remove barriers, improve physician education, and establish collaborative working environments, physicians experienced alignment to organizational goals and engagement with reform initiatives (Denis & van Gestel, 2016). This study reinforces the notion that financial motivations prove insufficient to stimulate broad and sustained physician engagement. Overcoming professional differences to build collaborative working relationships proved more effective at stimulating the desired physician engagement.

Much of the research in physician engagement occurred in either the inpatient setting or in large health systems using pay-for-performance strategies, necessitating further research in chronic settings and in structures using alternative motivational strategies (Herzer & Pronovost, 2015; Phipps-Taylor & Shortell, 2016; Spaulding et al., 2014). Dialysis JVs establish a financial relationship intended to stimulate physician engagement and collaboration on financial and quality outcomes. It is unclear if the JV strategy stimulated physician engagement and delivered

the desired engagement outcomes, necessitating research in this setting to understand how leadership behaviors and IPC influence the barriers to physician engagement. By understanding the positive or negative influences of leadership behaviors, leaders of joint ventures can modify their approach to achieve the desired engagement and collaboration.

### **Professionalism and Managerialism**

While physicians and managers often agree on goals, the conflicting priorities of the differing mental models introduce conflict. In a report on two qualitative studies conducted in two inpatient wards, Skirbekk et al. (2018) identified divergent views between physicians and managers: managers emphasized cost control, scheduling, and flow of patients while physicians expressed primary concern for patient outcomes. The managerial orientation annoyed physicians and created a sense of lost autonomy, the pressure to conform, and decreased organizational alignment as physician ideals, norms, and ethics came into direct conflict with managerial influences (Skirbekk et al., 2018). While the managers expressed agreement with physician values, meetings focused on finances and budgetary concerns that drowned out the physicians' voices within the organization, causing the physicians to feel a lack of respect and support from the managers (Skirbekk et al., 2018). In managerial led quality initiatives, physicians reported feeling forced to comply with managerial logic, increasing tensions, and undermining physician engagement (Martin et al., 2015). Similarly, a study of 156 conflict narratives in three hospital systems in the Pacific Northwest found that conflicts in interprofessional teams are frequent, complex, long-lasting, and harmful to care delivery (Kim et al., 2016). Managerial threats to professional autonomy and disrespect towards the medical professionalism identity stimulated conflict and power struggles that resulted in physician resistance and workarounds that jeopardized patient outcomes (Kim et al., 2016).

The differences in medical professionalism and managerialism may stimulate identity threats and power struggles between physicians and managers in healthcare delivery systems. The results of four longitudinal qualitative studies comprised of physicians and managers engaged in quality improvement initiatives demonstrated the physician identity acted as an “elite identity” with greater importance than organizational membership (Andersson, 2015, p. 88). Physician education, norms, and values formed professional camaraderie that resisted managerial influences, leading to conflict and power struggles between physicians and managers (Andersson, 2015). Physician leadership in the initiatives reduced conflict and power struggles but strained the physician identity, confirming the necessity of physician engagement in reform processes but emphasizing the importance of physician and manager collaboration to facilitate managerial leadership that preserves the physician identity (Andersson, 2015). Similar identity influences were found in the results of a survey of 219 physicians in Italian hospitals: the researchers found the medical professionalism identity confounded alignment and engagement in organizational initiatives when managerial behaviors threatened professional autonomy (Salvatore et al., 2018). The maintenance of professional autonomy created space for the expression of both professionalism and organizational identities, increasing physician engagement (Salvatore et al., 2018). The results of a qualitative study of 14 physicians with administrative responsibilities in chronic homecare facilities found similar resistance towards physician assumption of managerial responsibilities (Olakivi & Niska, 2017). The physicians proved reluctant to focus on financial outcomes but felt more comfortable viewing their role as a coach or mentor seeking to maximize the patient quality outcomes within the constraints of reform initiatives, suggesting a willingness to assume some managerial duties but not all (Olakivi & Niska, 2017). The results of these studies support the assertion that medical professionalism



and managerialism prioritize different aspects of healthcare delivery that can result in a divide between the professions that often creates a barrier to successful collaboration. Managerial threats to physician identity constructs often resulted in conflict and power struggles that lead to resistance of managerial influences, compromising the desired engagement necessary to achieve reform outcomes. Physician involvement in dialysis JVs expands the prototypical role of physicians by recruiting the physician to engage with managers in the management of the business. This research will contribute to an understanding of how physicians experience the partnership with the managers and how financial discussions influence the medical professionalism ideology.

Leadership behaviors can mitigate the power struggles between physicians and managers. Numerato et al. (2012) cautioned that research placed too much emphasis on the role of conflict and identified the need to find ways for physicians and managers to coexist, cooperate, and merge roles to address the evolving healthcare reform challenges. In a longitudinal analysis of a newly formed interprofessional team, identity processes stimulated conflict between physicians and non-clinical members of the team (Cain et al., 2019). Initial efforts to control the physician members threatened perceived boundary conditions causing setbacks in the team performance (Cain et al., 2019). Managerial efforts to create open-mindedness norms and a shared vision allowed the team to band together, accept differences, and capitalize on the strengths and knowledge of the team members to overcome the identity challenges (Cain et al., 2019; Molleman & Rink, 2015). In a study of quality improvement initiatives in a medium-sized Swedish hospital, managers who directed organizational change increased tensions with physicians and created dysfunctional collaboration processes (Gadolin & Andersson, 2017). However, when managers aligned change initiatives to clinical outcomes and sought to establish

relationships, trust, and cooperation with physicians, constructive relationships emerged, and physician engagement improved (Gadolin & Andersson, 2017). In quality improvement initiatives, managers who emphasized organizational strategies that conform to the physician norms and values associated with quality patient care appealed to the physician identity and improved physician engagement and outcomes (Herzer & Pronovost, 2015; Storkholm et al., 2017). Physicians in the acute setting noted that increased communication, trust formation, and the ability to control and organize their work are necessary to improve physician and manager relationships (Skirbekk et al., 2018). By establishing a vision oriented towards quality outcomes rather than cost and embracing open-mindedness norms that respect the physician identity and encourage physician problem-solving, managers can avoid the direct threat to physician autonomy that stimulates conflict and power struggles. In the absence of conflict, the physicians and managers enjoy more robust communication and trust that leads to a collaborative rather than a competitive environment. More information is needed to understand how leader behaviors influence the creation of shared norms and values that respect interprofessional differences and avoid identity threats in the dialysis JV context.

### **Interprofessional Conflict**

In a broader context, professional identification plays a role in the effectiveness of interprofessional practice (IPP) healthcare teams. Collaboration in the form of IPP teams, inclusive of physicians, managers, and other healthcare specialties, is common in current healthcare reform initiatives: while IPP teams are thought to stimulate innovation and improved effectiveness through access to diverse perspectives and expertise, identity threats often lead to interprofessional conflict (McNeil et al., 2013; Mitchell et al., 2018). Strong identification with one's profession increased affective conflict in IPP teams, stifling innovation and effectiveness

(Mitchell, Parker, et al., 2014; Mitchell et al., 2015). The affective conflict in IPP teams decreased trust, respect, teamwork, and collaboration, leading to dissatisfaction, decreased organizational commitment, and impaired quality outcomes (Kim et al., 2017). In a study of IPP teams in the acute setting, team meetings rarely focused on improving team performance, leading the investigators to call for strategies to improve communication and teamwork processes in teams (Bergman et al., 2016). The results of a literature review in leadership in interprofessional teams resulted in similar calls for team building activities to encourage the creation of cohesion, respect, and trust amongst interprofessional team members (Smith et al., 2018). Teamwork and collaboration are central to ongoing reform initiatives. However, teams often fail to attend to communication and teamwork processes, allowing the healthcare professional identity constructs to introduce conflict that stifles desired performance outcomes. The barriers associated with identity differences amongst healthcare professionals necessitate a change in leader behaviors and team processes.

Creating a team identity with shared norms and values mitigates the role of professional identity in team performance. Leaders who stimulated team-building behaviors that formed a salient team identity decreased professional identification while increasing engagement and organizational commitment that improved team outcomes (Almost et al., 2016; Miller et al., 2018; Nembhard & Edmondson, 2006). To create a shared identity, leaders demonstrated inclusive behaviors and stimulated the creation of shared values and norms that enhanced team identity and improved collaborative and innovative behaviors (Mitchell et al., 2015; Mitchell, Parker, Giles, et al., 2012). In teams composed of physicians and nurses, concomitant salience of both team and professional identity constructs optimized interprofessional collaboration (Caricati et al., 2015). Teams with open-mindedness norms that valued professional differences, open

communication, and debate of diverse or divergent views mitigated the deleterious impact of professional identification by reducing tension and improving team identity (Mitchell et al., 2018; Mitchell & Boyle, 2015). Mindfulness norms that considered contextual factors improved team member relationships by separating task and relationship conflict, shifting the focus of the conflict from relational differences to task accomplishment (Yu & Zellmer-Bruhn, 2018). Norms that establish respect for team member differences enhanced feelings of inclusion, value, and team identification (Ellemers et al., 2013). IPP teams benefited from team-building behaviors that emphasized shared norms and values that respected professional differences, building a team identity. The team identity mitigated interpersonal conflict by focusing on task behaviors while stimulating open communication and debate to create innovative solutions that improved team performance. This study explored physician and manager experiences with team-building and organizational identification and the influence of these behaviors on interprofessional conflict, collaboration, and performance in dialysis JVs.

### **Interprofessional Leadership**

Effective leadership is central to overcoming the gap between professionalism and managerialism. In a study investigating the National Center for Healthcare Leadership's core leadership competencies, mid to upper-level managers identified the importance of leader competency development in team leadership, change leadership, and talent development (Herd et al., 2016). Herd et al. recommended front-line leaders demonstrate engagement, vision, caring, and understanding of individual characteristics and the needs of team members to improve team performance and innovation. To increase understanding of individual needs and characteristics, leaders of interprofessional teams who dedicated time to team-building early in team development improved team identity and communication process through shared vision, values,

and goals that improved trans-professional knowledge and reduced IPC (Sims et al., 2015; Supper et al., 2015). These results were reinforced in studies of front-line managers in acute settings who identified the need for effective leadership to overcome barriers between physicians and managers through the promotion of each profession's strengths while encouraging distributed leadership amongst team members, information sharing, and collaboration: managers viewed reliance upon hierarchical structures negatively (Folkman et al., 2019; Günzel-Jensen et al., 2018). Pursuing distributive leadership exposed physicians to leadership opportunities, enhancing collaboration and mitigating conflict (Andersson, 2015). Echoing the results of the studies on IPC, leader behaviors that emphasize a team identity, common vision, and shared norms and values bridge the gap between professionalism and managerialism. Capitalizing on distributive leadership opportunities served as an additional mechanism to improve physician and manager interactions.

More information is needed to understand the role of team versus professional identity and shared values and norms on performance and innovation in the chronic healthcare setting in the United States. While the evidence suggests an important role in team-building in the acute setting, limited information is available in the chronic setting (Miller et al., 2018). Researchers in the field called for additional research on effective leadership behaviors (McNeil et al., 2013; Mitchell et al., 2015), shared norms (Mitchell & Boyle, 2015; Yu & Zellmer-Bruhn, 2018), shared values (Mitchell, Parker, Giles, et al., 2012), and teamwork (Miller et al., 2018) in nonacute settings. This research expands on the current body of literature by investigating the role of leadership in establishing shared norms, values, and teamwork in a chronic healthcare setting.

## **Leadership Styles in Interprofessional Contexts**

Physicians respond poorly to traditional transactive or directive leadership styles. Business leadership models focused on incentives and rewards are a poor fit with physician leadership (Xirasagar et al., 2005, p. 721). While the satisfaction of financial interests is an important factor in physician leadership, an overreliance on these types of transactional relationships stimulated physician self-interest, average performance, low organizational commitment, and conflict with manager-driven initiatives (Almost et al., 2016; Sfantou et al., 2017; Xirasagar et al., 2005). Similarly, managers using dominant or directive approaches threatened physician autonomy, leading to conflict and disengagement (Almost et al., 2016). Managers who assumed a laissez-faire leadership approach, characterized by lack of direction and engagement from the leader (Northouse, 2016), led physicians to feel devalued, resulting in negative impacts on the culture of quality and conflict with the manager (Almost et al., 2016; Sfantou et al., 2017). These traditional leadership models are ineffective at stimulating the required physician engagement necessary to keep pace with the rapidly evolving healthcare environment.

Conversely, more inclusive leadership styles demonstrated promise in the dynamic healthcare setting. While both servant leadership and authentic leadership demonstrated improvements in quality outcomes in the acute setting, transformational leadership improved engagement in teams facing challenging and dynamic situations (Jiang & Chen, 2018; Ribeiro et al., 2018), such as the implementation of healthcare reform initiatives. Transformational leadership consistently proved more effective than transactional and laissez-faire leadership styles in the healthcare setting (Günzel-Jensen et al., 2018; Sfantou et al., 2017; Smith, 2015). Healthcare managers' contentment with transaction leadership may be ascribed to the simplicity

of the contingent-reward nature of this leadership style (Smith, 2015). Moreover, in a qualitative study investigating the perspectives of 13 senior healthcare executives on the success of leadership development programs for front-line managers, Whaley and Gillis (2018) determined that selection criteria for front-line managers reflected preferences for technical expertise rather than leadership ability. Further, the leadership training programs typically emphasized the importance of communicating policies, procedures, and initiatives rather than leadership development, resulting in improved efficacy as a manager but ineffective leadership skills (Whaley & Gillis, 2018). Conversely, transformational leadership appeals to the cognitive functions associated with healthcare delivery by appealing to the intrinsic motivations of healthcare providers (Smith, 2015). Transformational leadership represents an inclusive leadership style with proven efficacy in healthcare teams experiencing dynamic change. The following sections will explore how inclusive and transformational leadership overcome the conflict inherent in the healthcare setting.

### **Inclusive Leadership**

Inclusive leadership strategies are effective in diverse groups. Inclusive leadership behaviors value individual differences of group members and create team cohesion through shared purpose, mutual decision-making processes, information sharing, and group participation (Mor-Barak, 2017). Study results outside of healthcare demonstrated inclusive leadership improved team commitment, communication processes and reduced conflict and stress in diverse groups (Mor-Barak, 2017). Similar results in the healthcare setting found inclusive leadership strategies in interprofessional teams demonstrated improvements in team identity and reductions in status differences, improving team performance (Mitchell et al., 2015). In interprofessional teams in a neonatal intensive care ward, inclusive leadership behaviors created a safe

environment that recognized individual differences and encouraged debate that improved engagement in quality improvement work (Nembhard & Edmondson, 2006). Inclusive leadership mitigates individual differences and creates a safe space for debate and collaboration to achieve desired quality outcomes in the acute setting.

### **Transformational Leadership**

The criticality of physician engagement in healthcare reform necessitates the use of a leadership style that can respond to the rapid changes in healthcare and improves the physician-manager relationship. In a literature review of 28 journal articles on leadership in interprofessional teams, Smith et al. (2018) asserted that transformational leadership is an important leadership style in the healthcare context: the creation of shared values, inspiration, motivation, and the flexibility and capability to act as a change catalyst proved important in the healthcare context. Transformational leaders communicated a vision and common mission that instilled feelings of team identity, pride, trust, and respect that stimulated cooperation and innovative behaviors amongst team members (Mitchell, Boyle, et al., 2014; Smith, 2015). By creating a shared vision and expectations that transcended the financial exchange of employment contracts, managers improved work meaning and engagement in organizational goals (Li et al., 2016; Ribeiro et al., 2018). Through the group-level transformative processes, leaders stimulated a motivation to work across professional boundaries to communicate and collaborate on innovative strategies to achieve organizational goals, causing researchers to claim that openness to the diversity of other professions is critical to the exploitation of diverse knowledge and essential to the stimulation of engagement of interprofessional team members (Mitchell, Boyle, et al., 2014). The inclusive features of transformational leadership transcend transactional relationships by establishing a shared vision and norms that facilitate the formation of team



identity and alignment to organizational goals. The vision and norms create a collaborative environment that respects and appreciates the differences between team members, allowing team members to collaborate on innovative strategies to achieve team and organizational needs.

However, more information is needed to understand the role of transformational leadership in chronic settings, such as dialysis joint ventures. While transformational leadership has more supporting research than any other contemporary leadership theory, more information is needed in specific healthcare contexts (Ribeiro et al., 2018; Xirasagar et al., 2005).

Researchers also called for additional research on how transformation leadership mediates the performance of interprofessional teams (Ribeiro et al., 2018) and in how to help leaders access and implement transformational leadership behaviors in interprofessional contexts (Smith, 2015). This research study explored these calls for additional research by investigating how leaders implemented transformational leadership behaviors in chronic dialysis joint venture contexts and what impact these behaviors had on joint venture performance.

### **Theoretical Framework Discussion**

The social identity theory (SIT), published by Henri Tajfel and Robert Turner in 1979, serves as a theoretical framework to understand intergroup relationships in this study (Tajfel & Turner, 2004). SIT is a psychological theory that explains the formation of the social self, intragroup processes, and intergroup relationships (Hogg et al., 1995). The foundation of SIT is the process of self-categorization, a process of categorizing and classifying the self as a member of social groups that shapes one's identity in relation to other groups (Hogg et al., 1995; Stets & Burke, 2000). SIT postulates that social categories exist prior to one's birth and that individuals derive identity through social categorization and achievement of membership in social groups (Stets & Burke, 2000). The individual's membership in multiple social groups combines to form

one's self-concept (Stets & Burke, 2000). Through self-categorization processes, individuals categorize themselves into social groups, shaping the formation of the self-concept. Therefore, group membership is essential to the formation of one's self-concept.

Categorization results in the formation of in-groups and out-groups. The foundations of SIT explain perceptions of belonging to social groups, creating a socialization categorization of in-groups and out-groups that facilitates stereotyping, differentiation, and a bias favoring in-group members (Hogg, 2016; Tajfel & Turner, 2004). SIT predicts the formation of group-level norms and values that stimulate normative behaviors and conformity: group members who violate normative qualities of the group experience distrust, dislike, and marginalization (Hogg, 2016). The categorization of in-groups creates the formation of a prototypical ideal of a group member that influences normative processes and conformity, creating homogeneous group members (Hogg et al., 1995). Individual desires for self-enhancement stimulates positive assessments of the group, resulting in increased group commitment, even in low-status groups (Hogg et al., 1995). This commitment and normative pressures to conform discourage deviant behaviors, resulting in groupthink, information withholding, and minimal debate (Hogg et al., 1995). SIT explains how group membership results in pressures that dictate how group members should behave, believe, think, and feel. These normative pressures explain the resistance to deviate from expectations and result in self-correcting behaviors to sustain group membership.

Depersonalization processes further explore the influence of prototypical features of group members. John Turner expanded upon SIT with the formation of self-categorization theory (SCT): the features of SCT are largely consistent with SIT, leading many to view SCT as part of SIT (Hogg et al., 1995). SCT adds to SIT by explaining that the categorization of individuals into social groups results in the depersonalization of the individual: depersonalization results in

perceptions that the individual embodies the features of the prototypical group member (Hogg et al., 1995). Under SCT, the prototypical ideal can evolve as comparisons to out-groups change: group comparisons to different out groups or evolution of the out-group stereotype results in changes in the prototypical ideal of the in-group (Hogg et al., 1995). The evolution of the prototypical ideal accounts for the flexibility and change of one's social identity (Hogg, 2016). The depersonalization process introduces barriers to the perceptions of individual differences based on group membership, despite the existence of the unique identities that result from multiple group memberships. The depersonalization further exacerbates stereotypical perceptions of group members. However, through depersonalization and comparisons to out groups, the SCT contributes to the idea of changing social identities based on the evolution of the prototypical member. As the prototypical member changes, conformity processes change the entire group.

The categorization into groups explains intergroup relationships. The creation of in-groups accentuates the similarities ascribed to group members while accentuating the stereotypes and dissimilarities of the out-group (Hogg et al., 1995; Stets & Burke, 2000). Through self-enhancement processes, individuals desire to perceive the self positively and therefore make comparisons between groups that favor the in-group and judge the out-group negatively, promoting and protecting the group's perceived superior status and prestige (Hogg, 2016; Hogg et al., 1995). These categorization and self-enhancement processes stimulate the formation of ideological constructs that enhance group stability and legitimacy and govern relationships with out-groups (Hogg et al., 1995; Stets & Burke, 2000). These ideological constructs influence intergroup mobility and conflict. Low-status group members who desire to gain membership within dominant groups may conform to the stereotypes and norms of the high-status group (Hogg et al., 1995; Stets & Burke, 2000). When access to the high-status group is not possible,

the low-status group may increase the solidarity of the group and engage in direct intergroup competition (Hogg et al., 1995; Stets & Burke, 2000). The evaluation of in-groups and out-groups reinforces the positive attributes of the in-group while negatively assessing the attributes of the out-group, creating stereotypes and bias that lead to discriminatory behaviors. When barriers exist that prohibit efforts by low-status groups to penetrate high-status groups, intergroup conflict increases.

Situational contexts influence the activation of social identities. Individuals are members of multiple social categories with differing levels of importance (Hogg et al., 1995; Stets & Burke, 2000). Situational context influences the salience, or activation, of a social category (Hogg et al., 1995). The salient identity influences the perceptions of the self and others, governing intragroup and intergroup behaviors (Hogg et al., 1995). Therefore, context affects social behavior (Hogg et al., 1995). Individuals activate different social identities based on contextual influences. For example, one might activate a social identity as an employee in one context and as a student in another, each with different social comparisons and normative processes. Identity salience helps to explain the differences in behavior based on the situation and the social category that is activated in that context.

### **Conceptual Framework Discussion**

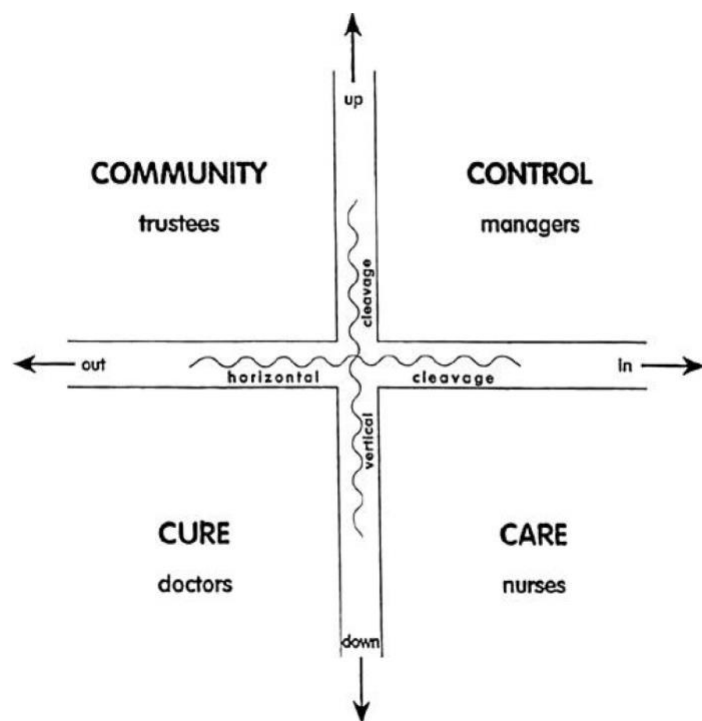
The four worlds of the general hospital model explains the formation of the ideological constructs of medical professionalism and managerialism that influence the intergroup relationships between physicians and managers. Sholom Glouberman and Henry Mintzberg described the four worlds of the general hospital in the care-cure-control-community model in 2001 (Glouberman & Mintzberg, 2001; Lindgren et al., 2013). This model, illustrated in Figure 1, describes the four worlds of the general hospital based on professional roles and the cleavages

of proximity to healthcare systems and patients that affect the identity of each world (Glouberman & Mintzberg, 2001). The horizontal cleavage represents the proximity to direct patient care, while the vertical cleavage differentiates proximity to healthcare systems and associated hierarchical structures, policies, and procedures (Glouberman & Mintzberg, 2001). The community quadrant in the upper left represents roles such as legislators, trustees, and other bodies that govern healthcare delivery: the community is separated from both the organization and the patient (Glouberman & Mintzberg, 2001). The control quadrant in the upper right quadrant is occupied by managers in health systems who are responsible for implementing governance coming from the community world (Glouberman & Mintzberg, 2001). This quadrant represents the managerial ideology that emphasizes hierarchical structures that express control over systems and processes with the intent to manage the cost of healthcare delivery to populations of patients (Glouberman & Mintzberg, 2001). The lower right quadrant represents the world of care that is occupied by nurses and other nonphysician professionals: those in this quadrant work within the hierarchical organizations under the control of managers and in concert with physicians to provide direct patient care (Glouberman & Mintzberg, 2001). Finally, physicians occupy the lower left quadrant and are responsible for the cure of the patient: the cleavage separating the physician from the healthcare organization represents the autonomy afforded physicians related to caring for the patient (Andersson, 2015; Glouberman & Mintzberg, 2001). This quadrant represents the medical professionalism ideology and is founded in common education, training, and socialization processes that emphasize medical expertise, direct control of patient care through the fulfillment of the social contract with patients, and the satisfaction of medical-legal responsibilities for healthcare delivery (Glouberman & Mintzberg, 2001). The cleavages represented in the four worlds of the general hospital model emphasize the

division of healthcare professions into unique social categories that are influenced, in part, by proximity to the healthcare organization and direct patient care. In this model, physicians and managers are separated by two cleavages that explain the interprofessional tension between the two worlds of control and cure.

**Figure 1**

*Four Worlds of the General Hospital Model*



*Note.* Visual representation of the four worlds of the general hospital model. The four quadrants represent the roles of trustees, managers, nurses, and doctors. The horizontal cleavage distinguishes proximity to the patient, while the vertical cleavage represents proximity to the system. From “Managing the Care of Health and the Cure of Disease-Part 1: Differentiation,” by S. Glouberman and H. Mintzberg, 2001, *Health Care Management Review*, 26(1), p. 58.

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SIT explains how the ideological differences of medical professionalism and managerialism affect the intergroup relationships of the cure and control worlds. SIT is a useful theoretical framework to understand the differing ideologies associated with managerialism and medical professionalism (Edmonstone, 2017). Managers come from diverse backgrounds in education and socialization processes, resulting in the prioritization of organizational outcomes, specifically financial performance and operational efficiency (Edmonstone, 2017; Glouberman & Mintzberg, 2001). Managerial beliefs occupy a dominant role in healthcare delivery, emphasizing perceptions that managerial governance is essential to controlling healthcare delivery: managers assume control of healthcare delivery through hierarchical structures (Edmonstone, 2017; Salvatore et al., 2018). Conversely, the commonality of education, training, and socialization of physicians results in an elite identity construct that prioritizes the physician specialty and other physicians over the healthcare organization (Andersson, 2015; Keller et al., 2019). The elite status of physicians grants power in healthcare delivery through the control of physician prescribing and ordering of procedures (Denis & van Gestel, 2016; Kirkpatrick et al., 2016). The educational requirements and prescriptive authorities of physicians create barriers to entry, prohibiting managers from adopting the medical professional ideology. Physicians who assume managerial roles often experience stress associated with a strong identification with the medical professional ideology. The differences in ideological constructs shape the social identities of physicians and managers that stimulate tension, conflict, and power struggles in intergroup relationships.

## **Summary**

Common themes emerged from the literature on engagement, interprofessional conflict, and leadership styles in the healthcare context. While physician engagement proved critical to

the success of change initiatives, the differences in physician and manager social identities, along with the application of ineffective leadership behaviors, created barriers to engagement, collaboration, innovation, and organizational performance. Ineffective communication, overreliance on financial incentives, inattention to team and organizational identity, and leadership behaviors that sought to control physician behavior stimulated identity threat, interprofessional conflict, and decreased physician engagement. Conversely, when managerial leaders utilized effective communication processes, such as educating physicians on organizational needs, involving physicians in the decision process, encouraging information sharing and debate, and ensuring transparency in decision processes, the parties developed trust and enhanced collaborative efforts. When managers emphasized inclusive leadership behaviors, as seen in transformational leadership, team identification improved, creating the space to reduce the medical professional and managerial identity salience in favor of the team or organizational identity. The creation of a team identity established a shared vision, values, and open-mindedness norms that emphasized the value of relationships and differences in perspectives, leading to improved communication, team building, and collaboration. Through effective team building, collaborative efforts enhanced innovation and improved clinical and financial outcomes. The creation of an inclusive environment minimized the influence of social identity differences between physicians and managers.

While the literature identified common themes, more information is needed in nonacute settings. The preponderance of the identified research occurred in the acute setting or within large healthcare systems. More information is needed in chronic settings. The purpose of this phenomenological qualitative research study is to understand the influence of leadership



behaviors on the manifestation of IPC and collaboration in chronic dialysis JVs, satisfying the call for additional research in chronic settings.

### **Chapter 3: Research Method**

This chapter outlines the rationale for the use of qualitative methods and IPA in this study, followed by a description of the sample population and data collection, processing, and analysis. The chapter addresses study trustworthiness, researcher reflexivity, and ethical considerations. The chapter concludes with key assumptions, limitations, and delimitations of the study.

The purpose of this study was to understand how leader behaviors manifest IPC or collaboration. The research questions focused on how the participants think about the role of leadership behaviors and communication processes on the social identities of themselves and others, as well as how the participants think about the role of individual versus team identity in the JV setting. The study participants included physician and manager board member dyads from high- and low-performing joint ventures located in one operations group in the southern United States. JV performance was determined based on clinical and financial outcomes in the joint ventured dialysis facilities. Data collection utilized semistructured interviews and field notes using videoconference mediums. The semistructured interviews explored how the participants think about the influence of leadership and communication on the social identities of themselves and other board members and how the participants consider the role of individual and team identity constructs in the JV setting.

This study utilized the interpretative phenomenological analysis (IPA) methodology (Smith et al., 2009) to explore how the participants make sense of the role leadership behaviors have on IPC and collaboration. By exploring how leader behaviors interact with the participant's social identities and ideological constructs of professionalism and managerialism, the analysis

conceptualized how the participants considered decisions to engage and collaborate or respond with tension and conflict. The research questions in this study were:

**Q1.** How do joint venture board members think about the influence of leadership behaviors on the social identities of themselves and other board members?

**Q2.** How do joint venture board members think about the influence of communication processes on the social identities of themselves and other board members?

**Q3.** How do joint venture board members think about the role of individual and team identity in the context of a mature joint venture relationship?

### **Research Design and Methodology**

This study utilized the IPA qualitative research methodology to explore the resultant manifestation of IPC and collaboration associated with leader behaviors in the dialysis JV context. Because the social identities of physicians and managers are socially constructed and subject to contextualized influences of individual joint ventures, the participants have different experiences and perspectives that shaped their realities. These characteristics necessarily inform a relativistic ontology and subjective epistemology consistent with the interpretative paradigm and phenomenological qualitative methodology (Leavy, 2017; Singh, 2019), making the choice of a phenomenological study appropriate in this context. The use of a phenomenological methodology will enable a deep exploration of the lived experiences of physicians and managers in joint venture settings, providing insight into how leader behaviors contribute to the manifestation of IPC or collaboration.

This phenomenological study utilized the IPA methodology. IPA is an interpretative phenomenological methodology that incorporates the three elements of phenomenology, hermeneutics, and idiography (Noon, 2018; Smith et al., 2009). Through the phenomenological

underpinnings of IPA, the researcher observes and explores the contextualized experiences and perspectives of the participants, assigning meaning based upon the researcher's perspective at the time (Peat et al., 2019; Smith et al., 2009). The researcher's role in assigning meaning is central to the hermeneutic element of IPA (Noon, 2018). IPA incorporates a double hermeneutic circle where the participant is trying to make sense of their world while the researcher is trying to make sense of participants making sense in their world (Smith et al., 2009). According to Noon (2018), "Interpretations are therefore bounded by both the respondent's capacity to articulate their experience, and the investigator's ability to dissect them" (p. 75). Therefore, the researcher's role in interpreting meaning is complicated by the researcher's preconceived perceptions (Noon, 2018). The hermeneutic element emphasizes the researcher's role in engaging in iterative cycles of analysis that consider the data from multiple points of view, resulting in an evolution of the researcher's interpretation with each iteration (Larkin et al., 2006; Smith et al., 2009). The flexibility of IPA allows researchers to engage with extant literature and theoretical frameworks in the cycles of analysis and meaning-making processes (Larkin et al., 2006; Peat et al., 2019). The idiographic element of IPA emphasizes the use of small and purposefully selected samples, allowing researchers to deeply explore the participant's experiences: IPA researchers treat cases individually and then generalize findings across cases (Smith et al., 2009). IPA research engages with small purposeful samples to explore the lived experiences of the participants. The interpretative nature of IPA moves beyond descriptive analysis by allowing the researcher to explore the phenomenon from multiple perspectives and to engage with extant literature to interpret how the participants perceive their experiences.

IPA was an appropriate methodology in this study. IPA is an increasingly popular methodology in healthcare and organizational research (Gill, 2014; Smith, 2017), consistent with

the dialysis JV setting. This may be attributed to the flexibility in the structure of cases for analysis, including the ability to investigate couples or dyads (Smith et al., 2009). This research study investigates the complexities of the physician-manager relationship in the context of a dialysis JV. Given the physician and manager interactions occur within individual ventures, the idiographic elements emphasizing within-case analysis before exploring cross-case analysis is appropriate. Finally, the ability to interact with social identity theory and the four worlds of the general hospital conceptual model proved useful in the interpretation of participant feedback. Differences in education, socialization, and role responsibilities result in the formation of distinct social identities for physicians and managers. These social identities stimulate the formation of medical professionalism and managerialism ideological constructs that influence physician and manager perceptions and behavior, often outside of the individual's awareness. Using the flexibility of the IPA methodology supported the ability to frame questions and interpret participant responses using the foundational aspects of these theoretical and conceptual frameworks. Because the research sought to understand the lived experiences of physicians and managers and how the participants made sense of the influence of leadership behaviors on IPC and collaborative behaviors, the idiographic and hermeneutic elements and the use of existing frameworks made IPA an appropriate methodology for this research.

### **Population**

The population of this study included physician and manager dyads who serve as board members in dialysis joint ventures. Recruitment utilized purposeful selection of dyads from JVs in one operations group in the South. The selection of this operations group resulted from the stability and tenure of the regional and senior leadership teams and the geographical similarities of the group. The selection criteria excluded JVs with less than one year of operations to

minimize confounding factors associated with the start-up of the venture: including JVs with greater than one year of experience provided adequate opportunities for the physicians and managers to develop relationships and experience how leadership behaviors influenced social identities and IPC. The governing documents of JV boards result in structures that are similar across ventures, contributing to the homogeneity of the sample population. Using dyads from mature joint ventures in one stable operations group contributed to the homogeneity of the sample.

Purposive sampling procedures created cases for analysis with differing perspectives. The study included three dyads from high- and three dyads from low-performing JVs, creating six cases for analysis. Ranking of the joint ventures in the operations group utilized financial performance using earnings before income and taxes (EBIT) and the dialysis organization's proprietary quality rating, the clinical quality score (CQS). The Joint Venture Finance Team provided the EBIT data, and the Corporate Medical Office provided the CQS data. The EBIT and CQS scores held equal weighting, creating a forced-ranked performance list of the JVs in the operations group. Selection began with the highest and lowest performing ventures, respectively, and proceeded until three high- and three low-performing dyads agreed to participate in the study. This population enabled the exploration of differing perspectives arising from the differing ideologies of physicians and managers, as well as the different experiences of high- versus low-performing ventures.

Exclusion of dyads occurred under the following conditions. Inability to secure agreement for both members of the dyad, a physician and a manager, to agree to participate in the study. Physicians or managers who had less than one year of service on the JV board:

validation of board member tenure utilized an internal JV database. Finally, exclusion occurred if participants refused to, at a minimum, have the audio of the interview recorded.

## **Participants**

The operations group included a total of 26 eligible JVs. Typical manager board representation included a local director of operations (DO), the regional vice president (RVP) of operations, and the group vice-president (GVP) of operations, representing three tiers of the managerial hierarchy. Because of this structure, managers at the RVP level frequently participated in multiple joint venture boards, some with high and low performance. For example, one RVP served on the board of eight JVs, including JV2 and JV5, in this study. The GVP occupied a board position in all but seven of the JVs. The DOs participated in one to two JVs. Similar confounding factors occurred with the physician participants, where the physicians had multiple joint ventures, though the JV performance typically demonstrated similar high or low performance when viewed based upon physician participation. For example, the 24<sup>th</sup> and 26<sup>th</sup> ranked JVs had the same physician board membership. Consequently, 62 board members met the eligibility requirements to participate in the study. I contacted 20 board members before completing the enrollment of 12 participants in the study. Details regarding the six cases of analysis and the 12 participants can be found in Appendix H. The eight participants not enrolled chose to be excluded for a variety of reasons; one due to health issues, one received legal advice not to participate, and six failed to respond to the email and phone requests.

## **Materials**

The administration of semistructured interviews with each study participant represented the primary data source for this study. IPA researchers typically utilize semistructured interviews to stimulate open and extensive dialogue on the research phenomenon (Noon, 2018; Smith et al.,

2009). Semistructured interviews provide structure and consistency of interviews across the sample while allowing the participant to “tell their story” in a way that allows reflection and the ability to explore responses and idea development (Saldaña & Omasta, 2017; Smith et al., 2009). The purpose of this study is to explore how leadership behaviors influence the manifestation of IPC and collaboration in chronic dialysis JVs. The interviews in this study utilized semistructured interviews using open-ended and probing questions designed to stimulate dialogue around the research questions. The first and second research questions explored how joint venture board members think about the influence of leadership behaviors and communication processes on the social identities of themselves and other board members. The third research question explored how joint venture board members think about the role of individual and team identity in the context of a mature joint venture relationship. The interview questions should seek to explore the major elements of the research problem identified in the research questions (Rubin & Rubin, 2005). Four domains are central to the research problem: managerialism ideology, medical professionalism ideology, leadership behaviors, and team identity. The design of the interview questions focused on encouraging the participants to speak about these domains without directly addressing the desired domain: mapping of the interview questions to the research questions and domains can be found in Appendix A. The ordering of the research questions starts with broad, easy to answer questions that encourage the participants to share their experiences (Rubin & Rubin, 2005; Smith et al., 2009). These questions explore ideological beliefs through the discussion of career decisions, experiences, and the purpose of the joint venture. As the participants became more comfortable and trusting, the interview questions cycled through descriptive, analytical, and evaluative structures (Rubin & Rubin, 2005; Smith et al., 2009). As interview questions begin to address leadership, communication, and team identity,



the questions explored specific examples of interactions, perceptions of change over time, and evaluations of what could be done differently. The following questions are from the interview guide found in Appendix B:

1. Could you tell me what influenced you to become a nephrologist/dialysis operations manager?
2. To what extent has this career choice been what you expected?
3. How would you describe the purpose of the joint venture?
4. To what extent has your membership as a JV board member been what you expected?
5. Could you describe a typical interaction between yourself and your physician/manager partners in the joint venture?
6. How, if at all, has your relationship with your partner evolved over time?
7. What experience(s) have been the most rewarding or challenging since you joined the joint venture?
8. Could you tell me about how an important decision was made or not made in the joint venture?
9. If you could change anything about decision-making processes with your partners, what would it be?
10. Could you describe a time when your partner was open to or ignored one of your ideas?
11. How are the communication practices with your partner now compared to when you first started working together?
12. If you could change anything about how communication occurs with your partners, what would it be?
13. If there was one thing your joint venture partner could change about you, what do you

think it would be?

14. If there was one thing you could change about your joint venture partner, what do you think it would be?

Additional documents included the field notes and a reflective journal. The field notes provided a contemporaneous account of the interview, eliminating the need to rely upon memory and recall of the interview. Field notes captured notable participant feedback and observations, such as visual cues that were not observable on audio recordings. The reflective journal provided a space to create transitional writings that condensed exploratory comments into emergent themes, bridging the data collection to the final report (Saldaña & Omasta, 2017; Smith et al., 2009). Additionally, the reflective journal is an essential tool in IPA research, allowing the exploration of personal biases present during the data collection and analysis, a central component of reflexivity (Hadi & Closs, 2016; Smith et al., 2009). The reflective journal captured reflections on the interactions with the participants, emergent themes in the data, thoughts on how the participants are making sense of their experiences, and how I was making sense of the participants making sense of their experiences. The reflective journal played a central role in the interpretative element of the analysis, allowing for exploration of emergent themes and researcher bias, while creating transitional writings that bridge the participant data to the final report.

Pilot interviews tested the interview guide. Pilot studies represent a proven process to test the interview guide and to explore interviewer bias in the instrumentation and data collection procedures: Pilot studies test the interview guide on a small sample with similar inclusion criteria to the study, allowing the researcher to adjust the interview guide to ensure the instrument achieves the desired outcomes (Chenail, 2011; Tong et al., 2007). Pilot testing occurred using

two physician and manager dyads. At the completion of the interviews, each participant had the opportunity to comment on the interview questions and process. The pilot test investigated the wording and order of the questions to ensure a logical flow of the questions and that the questions do not confuse the participants. Analysis of the pilot test interviews used the same data analysis procedure as the research participants to validate that the interview questions result in the desired feedback from the participants. Finally, participant feedback and the data analysis processes enabled the exploration of bias in the interview questions. Based on the experience of the pilot testing, no changes were made to the interview guide.

### **Data Collection Methods**

Collection of participant email addresses and phone numbers used the company's email system for managers and through the JV database or from the JV manager for the physician participants. The initial contact with all participants occurred through email (see Appendix C). Follow-up via a telephone call occurred two days after the initial email: a transcript of the call can be found in Appendix D. The second round of email communications occurred two days after the telephone call. Nonresponse by one or both members of the dyad resulted in their exclusion from the study. Each participant received a consent form found in Appendix E that explained the purpose of the study, the type of engagement, information regarding Institutional Review Board (IRB) approval, and risks and benefits of the research. Participants were informed of the confidential and voluntary nature of the research, the option to withdraw consent for their participation, and that both members, physician and manager, needed to agree to participate in the study.

After both members of the dyad signed consent forms, the scheduling of individual interviews occurred. The interviews between the participant and the investigator utilized the

Microsoft Teams videoconference platform. Interviews lasted between 46 and 67 minutes and were recorded using the recording function of the Microsoft Teams platform to facilitate transcription to a permanent record of the interview. Transcription of the interviews used NVivo 11 transcription. Field notes, along with an initial contemporaneous memo, were entered into the reflective journal to capture any initial thoughts and observations about the interaction with the participant.

The interview included three phases, starting with rapport building before moving into the interview questions and ending with a conclusion. The beginning of the interview focused on making the participant comfortable and establishing rapport. To encourage a deep dialogue with honest responses, researchers need to create trust and establish rapport with the participants (Smith et al., 2009). The investigator reminded the participants of the voluntary and confidential nature of the research and asked the participants to share honest feedback about their experiences and perspectives, indicating there were no right or wrong answers. The interview questions located in Appendix B began with general questions that explored the participants' background and what factors influenced their respective career decisions and interest in forming a JV. The questions then narrowed to explorative questions around leadership, experiences interacting with one another, and the evolution of the relationship between the parties. Finally, questions narrowed further to emphasize decision-making processes and communication patterns at the JV board level. Throughout the interview, participants received ample time to respond to questions: follow-up and probing questions encouraged the participants to elaborate on their responses and share examples to encourage deeper exploration of their experiences and perspectives.

## **Data Processing Methods**

Transcription of the recorded interviews utilized NVivo 11 transcription services.

Transcription using NVivo 11 utilizes cloud-based transcription technology: participants proved consent to utilize NVivo 11 transcription. Reviewing transcriptions facilitates the accuracy of the transcription and familiarization with the data (O'Brien et al., 2014; Smith et al., 2009).

Validation of the transcription utilized two passes through the transcription to confirm accuracy.

The assignment of the speaker and the editing of the text occurred during the first review.

Verification of the edits and accuracy of the transcription occurred during the second review.

## **Data Analysis Methods**

The data analysis used iterative and inductive cycles of analysis. The data analysis in IPA is a fluid process that “involves flexible thinking, processes of reduction, expansion, revision, creativity, and innovation” (Smith et al., 2009, p. 81). Immersion within the participant feedback started with listening to the interviews while reviewing the transcript. Immersion in the data identified shifts in narrative patterns that indicated evolving trust, confidence in responses, and sources of passion, frustration, and engagement from the participants. The immersion also identified areas of contradictions, particularly as the participants described how relationships developed in the JVs. Once immersed in the data, the analysis shifted to an exploratory analysis of emergent themes.

The data analysis or coding process in IPA utilized an exploratory analysis of the interview transcript using descriptive, linguistic, and conceptual comments. See Appendix F for samples of the exploratory analysis of one physician and manager dyad. Initial passes identified descriptive comments about objects, events, and experiences that matter and the meaning that these things imply to the participant (Smith et al., 2009). Subsequent noting passes explored

linguistic comments, emphasizing the way participants presented content and meaning by looking at mood, tone, specificity, and fluency in their responses (Smith et al., 2009). The last pass explored conceptual comments: conceptual comments shift focus to the participant's understanding of the phenomenon and begin the introduction of the interpretative elements of the researcher's experiences and professional knowledge (Smith et al., 2009). The conceptual comments explored personal reflections, discussion of observations, and identify emerging ideas or understanding (Smith, 2017). The investigator utilized field notes and analytic memos to support the conceptual comments. Iterations of analysis utilized the existing theoretical framework of social identity theory and the conceptual framework of the cure-care-control-community model to inform the generation of exploratory comments. The exploratory analysis expanded the data for analysis by generating transitional writings for the thematic analysis.

Exploratory comments facilitated the thematic analysis. The thematic analysis shifted from interactions with the participant feedback to distilling the exploratory comments into meaningful relationships, connections, and patterns (Smith, 2017). See Appendix G for samples of the thematic analysis of one physician and manager dyad. Deconstruction of the individual parts of the interview while considering the interview as a whole, generated concise statements that expressed the emergent themes. These themes were then charted and mapped to subordinate themes (see Appendix G) to show how the themes interacted with one another. With the thematic analysis completed for an individual case, the process continued with subsequent cases using bracketing of individual cases to allow new themes to emerge in new cases. After the completion of the analysis of individual cases, the analysis continued with a cross-case analysis to identify what commonality existed in the cases. The cross-case analysis resulted in multiple revisions of

the themes, distilling them to a final table of themes that incorporated quotes from the participants to support the themes.

### **Researcher Characteristics and Reflexivity**

My professional role and relationships with study participants created the opportunity to influence participant feedback and my biases. In qualitative research, the researcher is the primary analytical tool responsible for the interpretation of participant feedback, making researcher bias inevitable (Chenail, 2011; Tong et al., 2007). A central element of the IPA methodology is the exploration of the researcher's position, perspective, and bias in the interpretation of data (Smith et al., 2009). I am a non-clinical healthcare professional with over 21 years of experience in healthcare sales, consulting, and business development, including 10 years of experience working for the dialysis provider, shaping perspectives on managerialism and medical professionalism. In the past 6 years, I held a senior role in the corporate development team, responsible for negotiating the formation of JV relationships. These occupational responsibilities, past and present, inform perceptions of the criticality of physician engagement to implement successful change initiatives in the healthcare context. Prior education and socialization experiences created a closer alignment with the managerialism ideology than medical professionalism. However, work responsibilities negotiating JVs is a boundary spanning role that facilitated an appreciation of the medical professionalism ideology, attenuating some personal bias. Bracketing managerial preferences during the interactions with the physician participants and during the data analysis facilitated monitoring the influence of the my managerial orientation on the interpretation of the participant data. Exploration of bias occurred in the reflective journal.

Position and tenure bestow benefits and risks associated with the conduct of this research. Familiarity with the participants and the organization under study enhanced trust, contributed to an understanding of the situational context, and improved access to research participants but ran the risk of influencing the researcher's bias and perceptions of the problem under study (Shenton, 2004). With physician participants, positional status conferred a degree of credibility and trust, but the direct access to operational and business development leadership at the highest levels of the organization may have influenced participants to withhold information perceived as negative: during two physician interviews it wasn't until late into the interview that the physicians felt comfortable sharing negative experiences with senior leaders, suggesting some hesitancy to share negative information until after the participant felt comfortable and trusted the anonymity of the conversation. A long tenure in the organization lead to established relationships with four of the six managers and three of the six physicians, though some limited interaction occurred with all six physicians prior to this research study; see Appendix H for more information on the relationships with participants. While the personal relationships largely facilitated more robust dialogue, concerns regarding sharing negative information did influence some participant feedback. Recruitment processes exercised caution to ensure the participants did not fear reprisal should they elect to not participate. Previous experiences, relationships, position, and title influenced bias and the interactions between the study participants and me.

Self-reflection during the data collection and analysis process is necessary to address researcher bias. Field notes and a reflective journal facilitated the exploration of researcher bias during the data analysis and interpretation. Entries into the reflective journal identified examples of the emergence of researcher bias, requiring bracketing and reflection on the participant data.



### **Trustworthiness Techniques**

The quality of an IPA research study may be weighed against the four principles of quality in qualitative research presented by Lucy Yardley (Smith et al., 2009; Yardley, 2000). The first principle emphasized the importance of sensitivity to context, represented by a grounding in the extant literature and theoretical frameworks, sensitivity to the socio-cultural setting of the research, and an immersion in the participant data (Smith et al., 2009; Yardley, 2000). IPA researchers demonstrate sensitivity to context by supporting the interpretation of participant data with the use of references to the extant literature and direct quotes from the participant transcripts: using participant quotes to support the investigator's argument "gives the participant a voice and allows the reader to check the interpretations being made" (Smith et al., 2009). The interpretation of the participant data in this study engaged with the extant literature on social identity theory, professionalism and managerialism, leadership, and physician engagement. The use of verbatim quotes from across the participant interviews demonstrated support for the interpretations made.

Yardley's (2000) second principle addressed commitment and rigor. Commitment in the context of IPA requires researchers to create a comfortable environment for the participant and to demonstrate attentiveness during the interview and data analysis process, much like in the sensitivity to context principle (Smith et al., 2009; Yardley, 2000). Yardley explained that rigor stems from the care in the choice of sample, the use of triangulation, the level of depth and breadth seen in the interview, and the ability of the researcher to demonstrate the capacity to move beyond the description of the data to an interpretation of the data's meaning, seen in the use of quotes from across the samples showing consistency in the thematic analysis (Smith et al., 2009; Yardley, 2000). The purposeful selection of physician and manager dyads in three high-

and three low-performing ventures in the one operations group demonstrates a rigorous selection process that allowed for the triangulation of participant feedback. Initial interactions with the participants focused on putting them at ease by explaining the purpose of the study, the voluntary and confidential nature of the research, and through initial interview questions designed to establish trust and rapport. Interview and probing questions allowed for the exploration of a breadth and depth of discussion. The reporting of my interpretation of the results relied upon quotes to demonstrate consistency of themes across cases.

In the third principle of transparency and coherence, the researcher must stay true to the foundational underpinnings of IPA research (Smith et al., 2009; Yardley, 2000). The thematic analysis should demonstrate a consistency of themes across cases that demonstrate fit between the research and the underlying theoretical frameworks: contradictions and ambiguity in the participant data should be explored (Smith et al., 2009). Implicit in the principle of coherence is the requirement for an interpretative analysis that demonstrates the researcher is making sense of the participants making sense of the phenomenon (Smith et al., 2009). The interpretation of participant responses in this study relied upon the theoretical framework of social identity theory and the conceptual frameworks of professionalism and managerialism. The thematic analysis emphasized how I made sense of how the participants made sense of how leader behaviors influence elements of each profession's identity construct, resulting in the manifestation of IPC or collaboration. The presentation of the results identified consistency across cases as well as outliers.

Finally, Yardley (2020) suggested that qualitative research should demonstrate impact and importance. The IPA research study should tell the reader something interesting or important (Smith et al., 2009). By understanding how leader behaviors manifest IPC or collaboration,

leaders in the JV context can begin to understand how and why their actions stimulate desired or undesirable outcomes. By changing behaviors, leaders may begin to see increased collaboration and engagement that could facilitate desired outcomes in chronic dialysis JVs.

### **Ethical Considerations**

Institutional Review Board (IRB) approval was received for this study. Completion of two online ethics training classes, including the Abilene Christian University ethics training and the six-model ethics training program offered by the Online Research Ethics Course, helped ensure compliance with ethical standards for human research. The Abilene Christian University IRB approved the research design and interview questions prior to initiating the research project (see Appendix I). Moreover, my parent organization's Medical Office reviewed and approved the research proposal, consent forms, and IRB approval prior to initiating the research.

Consistent with the ethical standards for human research, participants were informed of the voluntary and confidential nature of the study, the ability to withdraw, and the potential benefits and harm of the research. All participants completed a consent form that described the nature of the study, what information I sought to obtain, how the information would be obtained, and the participants' right to withdraw consent at any time. While steps to blind participant information were taken, participants were informed that the dyadic nature of the interview participants precluded the ability to ensure absolute anonymity. The participants understood my role in the organization and that participation in the research was not a work or partnership requirement and that no reprisal would occur if individuals elected to not participate or withdrew from the study. Participants were provided the opportunity to ask any questions and withdraw consent at any time.

Data security utilized multiple techniques. Participant deidentification used a master key, locked in a secure file, to record participant information and corresponding naming conventions. The NVivo 11 software and any electronic records were secured on my personal computer using a secure password to access. All paper copies of field notes, jottings, or analytic memos were secured in a locked file cabinet. All relevant files and participant information will be deleted or destroyed on October 14, 2023.

### **Assumptions**

Several assumptions guided the population selection and sample size of the study. Recruitment of the participants came from one operations group in the south. Using one group minimized the geographic idiosyncrasies in healthcare delivery in the United States. Additionally, the leadership team in this group demonstrated long-term stability. The choice of this group contributed to the homogeneity of the sample and included leaders with tenure I believed would add to the rich detail of the experiences of the participants. Exclusion of joint ventures with less than one year of operations minimized any confounding factors associated with the start-up of the business. Operations of greater than one year allowed the physicians and managers ample opportunity to interact, adding to the rich detail of the experiences. Finally, the decision to include three cases from high- and three cases from low-performing ventures met the criteria for doctoral-level IPA research (Smith et al., 2009) and provided an adequate sample to explore the participant experiences without overloading me. The assumptions on the sample population contributed to the collection of enough rich detail of participant experiences to conduct an IPA study.

The criteria for stratification of JVs into high- and low-performing ventures necessitated using a ranking structure. The assignment of a 50% weighting for the financial and clinical

rankings of earnings before interest and taxes (EBIT) as the financial metric, and the clinic quality score (CQS), a proprietary quality metric that incorporates key performance indicators that align with CMS guidelines for value-based medicine created a forced ranking structure for all JVs in the group. These weightings represent the primary concerns of the managerial and medical professionalism ideologies, respectively.

Participant honesty in responses is a major assumption in this research. My experience with operations managers and physician JV partners created an expectation of honest and forthright feedback. The participant consent form addressed concerns with confidentiality and anonymity with the intent to instill participant confidence in sharing honest feedback, good or bad. Further, in the consent form and before beginning an interview, I informed the participants that there is no right or wrong answer, only their experiences. While in two physician interviews, some initial trepidation occurred, both interviews eventually led to a candid discussion concerning some difficult interactions with senior leaders in the company. I encouraged the participants to engage in open and honest feedback regarding their experiences, and the participants demonstrated a high degree of candor and comfort throughout the participant interviews.

### **Limitations**

Several limitations influence the interpretation of this study. I am an employee of the dialysis organization with responsibility for the formation of dialysis JVs. With a non-clinical background, I am unable to enter the medical professional social group and therefore occupy an ideology most comparable to managerialism. This status as an employee and member of the managerial social group introduces a potential bias in the interpretation of the data and could

lead to information withholding by both physicians and managers who feared sharing negative perceptions of leadership and IPC.

The ranking assumptions represent an additional limitation. While EBIT represents a standard measure of the financial success of an organization, other financial and accounting measures could be applied. Similarly, the CQS captures a broad picture of dialysis quality. Other measures, such as the QIP, exist. I selected the EBIT and CQS because these are standard performance indicators utilized by the dialysis provider. I chose to weigh these measures equally because they align with the ideological constructs of managerialism and medical professionalism. An additional limitation of using both EBIT and CQS is that quality often contributes to the financial performance of the business, suggesting an equal weighting could over count the influence of quality on financial performance.

While the decision to focus on only one dialysis operations group contributed to the homogeneity of the sample, this choice may limit the transferability of results. Other operations groups may experience different leadership tenure, poor experiences resulting from leader turnover, and market factors that influence profitability and competition. Homogeneity in this context emphasized geographic and leadership structure only. Identification of board participation revealed many of the managerial board members sat on multiple boards, necessitating recruitment of managerial participants at three different hierarchical levels of the organization. The perspectives and experiences varied based on the positional hierarchy in the organization, confounding the homogeneity and generalizability of the results. Physician and manager interactions outside the dialysis context may vary. Additional research will be necessary to expand the findings to a broader population.

The selection of one operations group intended to secure a homogenous sample. However, even within the one operations group, some differences existed in the socioeconomic status of the JVs included in this study. Lower socioeconomic status could negatively influence both clinical and financial performance metrics for a JV. JV4 (see Appendix H) serves as a good example of the negative influence of lower socioeconomic status on JV performance.

The small sample size limits the generalizability of the results. While this study is considered large for an IPA study, the sample population relative to the total population of the board membership is small. Dialysis operations within the company are standardized across the country and JV structures and governing documents are markedly similar. However, variations could exist that affect the generalizability of the results across a broader population of dialysis JVs. I have provided background information on the participant selection, the participants' background, and the data analysis to support the readers' interpretation and generalization of the results in this sample population.

### **Delimitations**

This study explored the influence of leadership behaviors on the ideological constructs of professionalism and managerialism and how these leadership behaviors influence the manifestation of IPC and collaboration amongst dialysis JV board members in one operation's group in the south. Because it's up to the reader to determine the transferability of the results to their context (Shenton, 2004), certain delimitations should be considered. While this study explored leader behaviors, a specific leadership construct was not investigated. Board members have the most frequent contact, but interprofessional interactions occur outside board participation. The inclusion of only JV board members excluded some front-line managers and senior leadership of the dialysis organization who are not board members. Similarly, physician

owners in the venture who are not board members were excluded. Additionally, this study investigates an operations group with mature leadership: intergroup differences based on regional dynamics and leadership tenure exist. The inclusion of mature leaders may limit the transferability of the results to newer leaders. This selection criterion excluded JVs in the formation phases of the venture, a period when team identity formation may be important. Finally, this study did not investigate the phenomenon outside of the dialysis JV context. Further study is warranted in other operations groups, within other physician and manager interactions, with developing leaders, and in the formation phase of the JV.

### **Summary**

Healthcare reform in the United States is amid a fundamental shift in reimbursement methodologies, changing from efforts to control costs to strategies to increase value. In the new era of value-based medicine, collaboration with physicians is essential but is often confounded by the ideological differences of physicians and managers. Chapter 2 demonstrated that inclusive leadership behaviors in the acute setting proved superior to controlling behaviors at stimulating physician engagement and collaboration. Chapter 2 also established a need for additional research into the manifestation of IPC and collaboration in chronic settings. This IPA study answers that call by seeking to identify how leadership behaviors manifested IPC or collaboration in a chronic dialysis JV setting.

The choice of IPA as the research methodology was appropriate in the context of chronic dialysis JVs. The IPA methodology is concerned with how participants make sense of their life experiences (Smith, 2017; Smith et al., 2009). The use of the IPA methodology allowed an exploration that moves beyond the mere description of the existence of conflict or collaboration by interpreting how the participants considered the manifestation of conflict or collaboration.



The idiographic element of IPA supported engaging with purposefully selected physician-manager dyads in high- and low-performing JVs, allowing for within-case analysis before generalizing the thematic analysis across cases, an important element in the context of the distinct JV relationships. The hermeneutic element of IPA allowed for the application of features of social identity theory, professionalism, and managerialism in the interpretation of the participants' meaning-making processes. These central tenants of phenomenology, hermeneutics, and idiography supported the use of IPA in this research study.

This chapter provided a detailed account of the research methods, including participant recruitment, materials utilized, data collection, processing, and analysis, consistent with the IPA methodology proposed by Smith et al. (2009). While the methods are consistent with the guidelines for IPA research, Smith et al. cautioned against reliance upon a prescriptive process and encouraged researchers to focus on creating an environment where study participants feel comfortable telling their stories and conducting an analysis that stays true to the “interpretative nuance in the study findings” (p. 182). Through the use of the IPA methods and flexibility in exploring the participant responses, the research methods focused on stimulating a rich dialogue around experiences and meaning-making processes with the participants that led to an interpretation of how leader behaviors manifested IPC and collaboration.

## Chapter 4: Results

This research study sought to understand the influence of leadership behaviors on the manifestation of IPC and collaboration in the context of a chronic dialysis JV setting. The study participants included three high- and three low-performing physician and manager dyads. JV1, JV2, and JV3 represent the high-performing dyads composed of physician and manager participants using corresponding naming conventions, MD1 and MGR1 in the JV1 dyad, for example. JV4, JV5, and JV6 represent the lower-performing dyads. This chapter utilizes the participants' narratives to explore the phenomenological and interpretative elements of the participants' lived experiences to answer the research questions. The chapter begins with an analysis of each of the four superordinate themes and corresponding subordinate themes. The analysis utilizes direct quotations from the participant transcripts to present the phenomenological experiences and perspectives of the participants that formed the interpretations of the participant data. The inclusion of participant quotations gives roughly equal voice to the participants in this analysis. Given the existence of differing perspectives of physicians and managers and the diverse experiences of high- and low-performing JVS, the analysis necessarily explores the convergence and divergence of participant experiences, identifying outliers as appropriate. The chapter will conclude with answers to the research questions.

The analysis of the descriptive comments revealed emergent themes that were consolidated into superordinate and subordinate themes, as identified in Table 1. Given the inclusion of the differing perspectives of physicians and managers along with the experiences of high- and low-performing JVs, the emergence of themes resulted in a positive and negative directionality (see Table 2) dependent on the individual's professional background and JV

performance. Additionally, the temporal relationship of the JVs played a role in perspectives on some of the themes, with participants noting a change in certain themes over time. While the themes have been grouped into superordinate and subordinate themes for the purpose of the data analysis, interrelationships exist between these themes.

**Table 1**

*Superordinate and Subordinate Themes*

Superordinate Theme	Subordinate Themes
Identity Influences	Nephrology as an elite identity Managerial desire for collaboration Using a patient-first approach Learning the business is rewarding
Building collaborative relationships	Trust through communication Trust enables collaboration Lack of understanding and trust
The power struggle is real	The quest for control Ineffective leadership Finding compromise
Two sides to the joint venture	Money is one thing Overemphasis on financials

**Table 2***Participant Expression of Subordinate Themes*

	JV1		JV2		JV3		JV4		JV5		JV6	
	MGR1	MD1	MGR2	MD2	MGR3	MD3	MGR4	MD4	MGR5	MD5	MGR6	MD6
Identity Influences												
Nephrology as an elite identity	-	↑	↓	↑	↑	↑	↑	↑	↑	↑	↓	↑
Managerial desire for collaboration	↑	-	↓	-	↑	-	↑	-	↑	-	↓	-
Using a patient-first approach	↑	↑	↓	↑	↑	↑	↑	↑	↑	↓	-	↓
Learning the business is rewarding	-	↑	-	↑	-	↑	-	↑	-	↑	↑	↑
Building collaborative relationships												
Trust through communication	↑	↑	↑	↑	↑	↑	↑	↑	↑	↑	↓	↓
Trust builds collaboration	↑	↑	-	↑	↑	↑	↑	↑↓	↑	↓	↓	↓
Lack of understanding and trust	↓	↓	↑	↑	↑	↑	↑	↑	↓	↑	↑	↑
The power struggle is real												
The quest for control	-	↑	↑	↑	↑↓	↑	↑↓	↑	↑	-	↓	↑
Ineffective leadership	↓	↑	↑	↑	↓	↑↓	↑	↑	↓	↑	↑	↑
Finding compromise	↑	↑	-	↑	↑	↑	↑↓	↑	↑	-	-	-
Two sides to the joint venture												
Money is one thing	↑	↑	↑	↑	↑	↑	↑	↑	↑	↑	↑	↑
Overemphasis on financials	↑	↑	↑	↓	↑↓	↑	↑	↑	-	-	-	↑

*Note.* Upward and downward arrows represent a positive and negative directionality in the participant expression of the theme. An upward and downward arrow indicates the participant shared evidence of both positive and negative perceptions regarding the thematic analysis. A dash indicates the participant provided insufficient information to determine a response to the theme.

## **Identity Influences**

Elements of social identity permeated much of the discourse during the participant interviews, creating a superordinate theme associated with how social identity influenced the perspectives and behaviors of physicians and managers. This superordinate theme captures the underlying role of social identity that governs how the participants think about their professional roles and the interactions with one another in the JV context. These underlying differences serve as the foundation for understanding how being attentive to differences creates trust and collaboration while neglecting differences increases IPC. Physicians tended to present perspectives suggestive of social identity influences more frequently and with greater emphasis than did the manager counterparts, creating subordinate themes of nephrology as an elite identity and managerial desire for collaboration. Two subordinate themes that appealed to the physician identity and, to a lesser extent, the managerial identity emerged; using a patient-first approach and learning the business is rewarding. The first two subordinate themes apply across the entire population of physicians and managers, where the last two subordinate themes explore the interactions within dyads and the differentiation of high- and low-performing ventures.

### ***Nephrology as an Elite Identity***

The nephrologist participants demonstrated close alignment on their view of the nephrology subspecialty as an elite subspecialty. The participants shared common perceptions of the complexity of nephrology, a desire to help this sick population of patients, and a belief that only the few can rise to the challenge of caring for these patients. This elite identity status manifests as a high desire for control, autonomy, and interest in developing expertise, consistent with the medical professionalism ideology. MD1 captured this perspective, stating,

You know, nephrology is complex. A lot of times, you're dealing with patients that are pretty sick. They have a lot of comorbidities. I just felt like I was good at compartmentalizing all those issues and managing them all in one fell swoop.

MD2 shared this sentiment and provided some insight into the perceived exclusivity of nephrology in his statement,

When I was in my residency, I was drawn to nephrology. It's a glamorous subspecialty. You have to have a lot of math skills and the ability to interact with patients. I find the kidney interesting because of how it interacts with multiple other organs, making my background in internal medicine that much more important.

MD3 further reinforced the status of nephrologists, declaring,

I chose the nephrology track because I thought it was just so complex and so amazing. Nobody understood what a nephrologist was talking about during rounds. And that's part of the mythology. The kidney has a medulla and cortex too, just like the brain. The complexity in that is what I really enjoy.

Similar sentiments from MD4, who stated, "I could see the nephrologists taking better care of everybody," and MD5 who indicated, "nephrology is very challenging, I find these patients were the sickest in the hospitals and I thought I would be able to do a good job with them."

The physician comments imply an elite identity status. The use of words like *complexity*, *mythology*, and *glamour* suggests a perception of superior expertise and ability that exceeds that of other physicians, creating an elite subgroup within an elite group. The adoption of this elite identity permeates interactions with managerial counterparts and contributes to the understanding of the emergence of IPC. The physicians all described the belief in their capabilities to manage through the complexities and comorbidities of this difficult population of patients. This belief

signaled perceptions of expertise, problem-solving, and a prioritization of patient care, situating these physicians as uniquely capable of controlling patient care and outcomes.

The prioritization of patient outcomes and a desire for control proved central to the physicians' decision to become a JV partner. MD6 indicated he became a JV partner to “gain knowledge (about the dialysis business) and affect the structure of taking care of the dialysis patients and seeing if I could influence the clinical decisions that are made with products that are presented to us as medical directors.” MD2 also expressed the desire for control beyond that of a medical director relationship when he stated,

We do have medical directorships in the dialysis clinics, but the medical director relationship doesn't give the medical director much control over the business. I saw ownership as a joint venture partner as a way to gain some control in the clinic but also as a financial investment...We wanted to have some say in the business.

Similarly, MD1 expressed a desire for control, saying, “having a seat at the table, so to speak. You can help carve out decisions for stuff that comes up in terms of patient care, products, protocols, and algorithms.” MD4 went so far as to state he felt the need to “protect his patients from the corporation.” Each of the physician participants served as medical directors for the Company where they provide medical oversight of the operations of the Company's dialysis clinics to ensure dialysis delivery meets quality standards. These statements suggest this oversight lacks the desired level of control for these participants. The expression of a lack of control and desire to influence care delivery and protect patients suggests an inherent mistrust in the dialysis company and, by extension, the managers who are responsible for dialysis operations. This mistrust, a form of IPC, stems from threats to physician autonomy, control, and expertise that is inherent in the nephrologists' elite identity.

Three of the physician participants referenced challenges in understanding the dialysis business and a hesitance to ask questions of the managerial counterparts. This experience is best exemplified by MD4 as he described his difficulties early in the venture:

The information was out there; I just couldn't understand it. That's the problem. I'm just sitting there trying to get through the meeting, you know. Then I would go home and have to look it up online. I was just inept in business, which I am. Obviously, this wasn't something that was taught in medical school. You're not taught the business of medicine. You have no clue most times.

MD2 expressed a similar experience, stating, "in retrospect, we didn't understand much of the financial information and should have asked more questions to better understand the business we were getting into." Fortunately, both MD4 and MD2 eventually took more active roles in engaging with their managerial counterparts, but the reluctance to ask questions resulted in lost time and strained relationships with their respective counterparts. The reluctance to ask questions can be attributed to the *glamour* and *mythology* of the nephrology subspecialty that reflects expertise and competence in all aspects of healthcare. Despite a lack of formalized training on the business aspects of healthcare broadly and dialysis specifically the physicians demonstrated reticence to show weakness to their managerial counterparts. The hesitance to ask questions is further compounded by the initial mistrust experienced early in the formation of the JV.

### ***Managerial Desire for Collaboration***

The managers represented a very different perspective on the formation of JVs with physician partners, with a heavy emphasis on recruiting physician partnership and collaboration, resulting from their financial investment in the business. The managers purported a desire to stimulate physician engagement and collaborative interactions through the physician investment



in the business. In practice, the managers sought to create physician alignment to organizational goals, indicative of a managerial ideology. MGR3 described the purpose of a JV as “a collaboration between two entities to have a successful, both financially and quality medical entity.” MGR4 echoed that sentiment,

From my perspective, it is to form partnerships with physicians or physician groups to improve the quality of our dialysis clinics where they are invested. This might sound like a canned response, but I really truly believe that it is to provide better quality to our dialysis patients and improve the outcomes.

The managerial participants all supported the concept of collaborative relationships. However, some participants represented a desire to generate changes in physician behavior through their financial investment in the business. MGR5 stated,

So, it’s a motivating factor to stay involved in all aspects of it, especially when they are very astute to the fact that better quality means better results financially. Patients that live longer, patients that don’t crash in. So, there’s a lot of benefits, quality benefits that we know over time are connected to the business. It’s a motivating factor to dig into those things, but also change behavior on their side.

MGR4 stipulated that “we’ve gotten great financial outcomes and our partners are enjoying that and are thankful for it, as I am. But I would really like to see the quality really, really improve.” Similarly, MGR2 connected physician engagement with the financial investment, indicating,

But we, from a company point of view, want the physicians to have them (JVs) for the education, and they also have the financial interest. They’re going to get more engaged with quality with good consequences for the company and for the patient, fortunately. For

us, it's important to engage the physicians because they see the benefit of the JV as well as an investment.

On the surface, the comments from the managers suggested a desire to form JV partnerships to stimulate collaboration and engagement. However, the mention of financial interest as a motivating factor implies a desire to create physician alignment to organizational goals. The managers all focused on quality, but the desire for alignment to organizational goals signals an attempt to control and change physician behavior rather than to stimulate collaboration and engagement, creating a source of IPC. Attempts to gain control and create alignment to organizational goals is consistent with a managerial ideology of control of systems and processes and emphasis on the financial performance of the organization.

### ***Using a Patient First Approach***

Most participants stressed the importance of a patient-centric approach. A patient-centric approach involves the use of proactive strategies to collaborate to improve patient care and outcomes, regardless of financial outcomes. In practice, a patient-centric approach involves interprofessional collaboration to improve individual and population outcomes. All physicians strongly acknowledged the importance of the patient. Notably, the higher-performing ventures described patient-centric strategies within the JV, whereas the lowest two performing JVs simply noted they were not asked to compromise patient care. MD6 stated, “you have patients that are in critical need of things and I think it's my job to try to relieve the burden as much as I can; physically, economically, and emotionally.” MD3 echoed this sentiment in his comments about being a physician, “just understanding that I can improve on their lifestyle and understanding that I can make a change, especially for those that are suffering from what I consider a terminal illness, and improving their lifestyle as much as I can.” MD4 explained how he prioritized

patient care in the context of the JV, “so as far as my reconciliation, my ownership in the practice or ownership in the business, was to make sure that the corporation continued down the path that was best for the patient.” Each of the physicians demonstrated a high priority on the care of the patient.

The managers of the JV partnerships echoed similar sentiments. MGR4 captured the importance of balancing the patient and financials in her statement:

So, keeping the quality there and the patient’s health and well-being at the forefront of everybody’s minds really helps you balance that. And then the costs become secondary.

You know, I learned many, many years ago, that if you take care of the patient, the finances will follow into place. And that’s absolutely true.

MGR3 echoed MGR4’s sentiments. When describing how the physicians gained trust in the clinical staff of a home program, MGR1 attributed the trust and relationship to a patient-centric approach:

She had to turn them around with how they managed initiating dialysis from a home therapy standpoint, to keep patients from crashing in. So, I think that that was a big turning point for them...prioritizing the patients’ experience and also physician relationships determines whether they trust you or not. How the staff manages the patients determines what they are willing to trust you on. It’s all built on relationships and trust.

The experiences in JV5 and JV6 contained little evidence of patient-centric initiatives, but both MD4 and MD6 emphasized they were never asked to compromise patient care. MD4 noted,

I don't think at any point in time anybody said you're overusing resources or you can't do this, or you can't do that. We have never been stopped to use a medication that was effective for the patient. My point is that there's nothing that I was asked to do to save money and compromise patient care.

Failure to acknowledge the importance of the patient stimulated relationship stress with MD1. Referencing a manager who did not participate in this study, MD1 noted, "I have a patient-centered outlook on things. And she has an administration centered outlook on things. And sometimes those things don't mesh very well. So, her and I have never really gotten along very well." Similarly, MGR4 described relationship stress when describing physicians who over prioritize financials, stating,

Sometimes there's those out there that don't seem to care that much. And I have a tough time with that. I can respect them for being a physician. But I have a really hard time finding respect for physicians that don't seem to care. It really does make it hard when you know that their top priority is not patient care.

MGR3 identified similar issues with physician greed and lost respect when describing the behaviors of the senior physicians in JV3.

The prioritization of the patient acted as a differentiator in performance amongst the JVs in this study. Participants in JVs one through four all described efforts to collaborate on patient-centric initiatives, with JV1 and JV2 emphasizing specific interactions. These patient-centric collaborations created trust in these higher-performing ventures. Conversely, in JV5 and JV6, the managers respected physician decision-making on patient care but evidenced fewer interactions to collaborate on quality outcomes, suggestive of a passive or laissez-faire approach to collaboration on patient care. Participants viewed deviance from a patient-centric approach

negatively, recognizing the prototypical norm for physicians that emphasizes the importance of caring for the patient. Using a patient-centric approach created opportunities to build trust and team identity amongst the higher-performing ventures, mitigating sources of IPC and allowing the emergence of collaborative interactions.

### ***Learning the Business is Rewarding***

Gaining exposure to the business of dialysis proved universally rewarding to the physician participants. The physicians' training to become a nephrologist provided scant information about the business of medicine. Learning the business generated newfound respect for the challenges managers face in operating the dialysis business. This lack of understanding created identity threat to physician expertise, stimulating IPC in the form of mistrust and tensions with managerial counterparts. MD4 described his experience of learning the dialysis business,

The most rewarding part of it has been learning the business of dialysis. I had a cursory understanding of it, I guess. But as I became part of the JV, that understanding grew deeper and the complexity of it and how very difficult it is to run this business. You know, I appreciate, just that a new appreciation for the company and what you guys do, because it's not easy.

MD5 echoed this sentiment, describing his learning experience and opportunities to interface with his managerial counterparts,

I think it was a very fruitful experience being a JV partner...I've learned a lot about dialyzer cost, about staffing costs, about medication cost...We're trying to learn more about the business of dialysis, the business of medicine. I enjoy, although I don't have any business training, but I do enjoy talking to people who do. It gives me an insight as to what's behind the curtain.

In addition to building trust and relationships, as described by MD4 and MD5, gaining insight created opportunities to change physician behavior. MD2 shared how learning the business changed how he practiced nephrology,

I think learning about the dialysis business has been the most rewarding for me. But I like the business side. Financially, this has been a good opportunity for me. I think my partners agree...I always do what's best for my patient, I prioritize patient care. However, there are often different approaches that lead to the same outcomes for the patient. Now that I understand some of the cost issues, I may make choices that are less costly and similarly effective for the patient.

Learning the dialysis business created a shift in the perspectives of the physician partners and facilitated relationship development with the managerial counterparts. The physicians described the experience using words like *rewarding* and *fruitful*. Learning the business appeals to the nephrologist desire for expertise, competence, and problem-solving. Developing an understanding of the business also seems to help reduce the internal conflict between caring for the patient and managing the business. Learning the business reduced identity salience in the physician participants, mitigating IPC resulting from physician identity threat. Unfortunately, learning the business appeared unidirectional: none of the participants referenced efforts by the managers to learn more about the nephrology business.

### **Building Collaborative Relationships**

The company pursued the formation of JV relationships with the intention of stimulating collaboration and engagement with physician partners. In practice, variability exists on the degree of collaboration that exists between physicians and managers in JVs. Collaborative relationships involve mutual engagement in problem-solving, negotiations, planning, and

implementing initiatives. For example, collaboration took the form of activities such as mutual problem-solving to enhance patient care delivery in JV1, integrating clinical and financial discussions to facilitate planning and interventions in JV2, and finding compromise when negotiating agreements in JV3. MGR5, the most senior manager interviewed in this study, expressed his concern about collaboration, indicating,

You know, we throw the word collaboration around as part of our stuff. I don't think people know what collaboration is; they just regurgitate it because somebody told them to. But they don't really understand it and they have bosses that don't understand it.

It is not surprising that JVs experience variability in collaboration. Building relationships lies at the foundation of creating collaboration. MGR3 explained,

I think any new joint venture bringing two new partners together, there's going to be that level of anxiety. But somebody has to be the grown-up in the relationship and make it work. Because it needs to work on behalf of the patient.

The importance of building collaborative relationships emerged as a superordinate theme.

Subordinate themes emphasize building trust through communication, creating collaboration from trust, and the role of lack of understanding in creating mistrust.

### ***Trust Through Communication***

Generally, all the participants commented on the importance of communication to build trust and create opportunities for relationships between the physicians and the managers.

However, differences existed between high- and low-performing JVs. As discussed previously, the physicians entered the JV relationship with a high degree of mistrust that arose from a desire for control and lack of understanding. The use of open, frequent, consistent, and transparent

communication between the managers and the physicians proved critical to overcoming mistrust.

In JV1, MGR1 expressed the importance of communication, particularly around patient care,

They have to see that we're going to consistently make that happen. And we can't really fall on our commitment to having what they need to take care of their patients.

Sometimes it's communication. Having timely communication. So just having that open conversation, whether it's good, whether it's bad, just, you know, just being upfront and painting the true picture and what can we do to support it, what can we do to change it, or what is the timeline getting it where you want it to be?

MGR1 emphasized that not only did she use open communication with the physicians, but so did the clinical manager in the home program, stating,

She has a great communication style. I think she's very frank with them. You know, she, she tells it like it is. I think they respect that. Even if sometimes, they may not like it.

They respect it because she's proven herself over time to be of value to the outcomes of their patients.

MD1 expressed appreciation for MGR1 and the clinical manager's efforts, affirming, "I deal with MGR1 all the time. She's been great to work with on suggestions for the clinic for patient care issues, all these things dealing with difficult patients." But MD1 expressed frustration with MGR2, who is also a board member stating,

I don't think MGR2 contributes a damn bit to it, to be honest with you. I think he's a name, and he's on the calls here and there. But I don't see him inputting to this joint venture. I think this is driven by some excellent staff members. I think it's driven by your docs that are in the joint venture... That's just my opinion.

In contrast, MGR2 espoused the importance of communication in a partnership, declaring,



Education is important so that they understand that it takes a long time to build the business... Communication is key to the success of the JV in the long term. What is important for me, Jeff, for success is communication. Keep them in the loop. What we're doing and why. It will help them get confidence and see the big picture of the long-term. While JV1 demonstrated the highest clinical and financial outcomes in the group and strong relationships with those closest to the business, relationship strain exists in the disconnect between MGR2's purported behaviors and those perceived by the physician partner.

MD2 echoed the importance of communication but noted it took some time to get to a level of communication that met the physicians' needs, explaining

Finally, we pushed back on the presentations and asked for changes to the information that was being presented. We also asked for clarification on what was driving the financial performance of the business. The managers were responsive to our demands and provided the information we requested. Today, I have a much better understanding of the nephrology business because of these changes. There should have been more explanation or training about the business earlier on. We needed to be more educated about the business. It took us almost two years to get the information we need in a format that worked for us. I think because we have such open communication now, we've been able to establish trust. The biggest and most important thing is communication.

The partners in JV3 similarly noted challenges associated with mistrust early in the relationship. In JV3, transparency and consistency proved effective in overcoming mistrust. MGR3 stipulated, "I think the transparency is extremely important; I mean they are your partner, for goodness sake." MD3 appreciated the importance of transparency, stating,

MGR3 is very truthful when it comes to really hard questions. He is very forward with it...And that's what I think most partners want. I think people in your position and other leaders, they all have something in common. And that commonality is leadership, integrity, honesty, and addressing concerns...Consistency I think, is the key, in that consistency is important when it comes to all the joint ventures...That truth gets to the point in a much quicker response in negotiation than trying to go around everything.

The experiences in JV5 and JV6 contrasted those of the higher-performing ventures. The JV6 partners represented a less enthusiastic approach to communication that focused more on reporting financials and no mentions of communications centered on patients. While MGR6 stated, "of course, you always be open and upfront with them," MD6 expressed less appreciation for the communication style indicating, "I guess at least they're straightforward in what they present." The experiences in JV5 exist as an outlier, where MD5 expressed frustration with lack of transparency and difficulties communicating with managers in a previous joint venture relationship. When dealing with the JV5 managers he indicated,

Now, a certain number of people are involved with the JV, and we can approach them. Call them. You can go up the ladder. So, it's been a good experience...As a medical director, we get updated on everything. But suppose, there's a tile that's broken in the lobby and it needs to be repaired. Though it's a small cost, it's going to show up on financials as a repair job. If you asked them what the cost is going to be. I mean, they're pretty open about letting you talk to the BioMed or the person who's going to be dealing with this to get an approximate cost.

For MD5, the focus on reporting on items that affected financials built a high degree of trust, leaving much of the operations of the clinic to the managers without providing much oversight or

review. Tragically, this led to issues during an inspection that resulted in the implementation of a monitor in the facility, a costly outcome that created strain and a lack of trust in the relationship.

Communication influenced the formation of trusting relationships. The communication patterns appeared unidirectional, with both physicians and managers describing managerial communication processes with little discussion about physician communication style. The influence of proactive and transparent communication in the higher-performing ventures stimulated trusting relationships. Through effective communication processes, managers demonstrated they had the best interests of the business, the physicians and the patients at heart, lessening physician concerns regarding power and control in the business, building relationships between the parties. Patient-centric approaches that appeal to the physician identity proved particularly effective at building trust. Conversely, communication in JV5 and JV6 focused on reporting financials. While MD5 initially accepted this approach, the consequence of a monitor created strain in the relationship. The emphasis on the financials met the physicians' needs as an investor but failed to appeal to the medical professionalism ideology, leading to quality challenges in these ventures. Notably, relationship development, as in JVs two through four, took a long time and only occurred after the physicians took a more proactive role in the process, suggesting the need for attention to communication, education, and relationship development early in the formation of the ventures. Effective communication plays a central role in the mitigation of IPC and the formation of collaborative relationships.

Developing relationships with the few appeared adequate. MGR1 expressed that the clinic manager, a nonboard member, is critical to the relationship, explaining, "I think they see her as a support, as a contributor to the outcomes of the patients and the longevity of the patients." MD1 shared MGR1's opinion stating, "if you've got an excellent nurse and clinical

manager, there's nothing that'll stop you." As stated previously, MD1 described a poor opinion of two of the board members in the JV. Similarly, MD2 stated,

We have a really good relationship with the FMC folks. We don't see MGR2 as much, but he's really busy. As the RVP, he's got a lot of responsibilities. But we work very closely with Bonnie (board member) and Barb (nonboard member). Barb is great! I've never met MGR5 (board member). I don't think he's ever come to a meeting.

MD2 later expressed his desire to engage those who are closer to the business, reporting, "the RVP is a poor liaison for the business. He's too busy. Bring in others who are closer to the business or the problem to talk with and work to resolve the issue. People like Barb are great." The same is true amongst the physicians. When describing the relationship shift in JV3, MGR3 indicated the relationship changed as a result of the influence of the younger physicians in the group, stating, "it was the young blood coming in that says, OK, we're not going to do it that way." While describing a negotiation between the physicians and managers, MD5 described his efforts to try to get his physician partners to trust the managers, explaining, "I was just trying to get over that lack of trust and the motivations behind the activity of the JV." These experiences confirm the necessity for broader relationship development across all parties in the JV, along with the need to recruit the best representation to the board.

Participants from JVs one through four represented that relationships developed between themselves and key members of the JV, or other pivotal company employees, through regular interactions and communication. These relationships created a sense of teamwork and collaboration. Importantly, relationship development tended to occur with those who were closest to the operations of the clinic or amongst physician partners who took a leadership role within their groups, as in JVs two through four. Trust proved difficult to develop when board

members failed to interact regularly, contributing to the prioritization of individual identity constructs. For example, JVs one through three all described situations where they had little exposure or had never met some of their board members. JV6, characterized by little interaction other than financial reporting, best represents a lack of trust from the physician partners and an emphasis on individual outcomes through their shareholder perspective as a JV partner.

### ***Trust Builds Collaboration***

Collaboration and partnership grew from trusting relationships. The higher-performing ventures featured stronger perceptions of trust and collaboration, where JVs five and six failed to describe any collaborative interactions. The trust builds collaboration theme emerged from participant feedback suggesting that trusting relationships allowed the emergence of collaborative activities. Collaboration took the form of mutual engagement in JV activities and evidenced a concern for the perspectives of others or open-mindedness during interactions. The participants from JV1 described close collaboration on initiatives to improve patient outcomes and to grow the business. MGR1 described how the physician partners interfaced with the clinical staff, stating, “when there is a hard patient, they send them to this manager. They are very much in collaboration with the staff, with the unit, and they really trust the process there.” MD1 echoed this perspective, sharing,

I will recommend patients to the home therapy clinic. A lot of people can say, oh, it’s because you’re part of the J.V. and you’re getting a cut for that. OK, maybe that’s true. But I think the biggest reason is that I have full confidence in the staff and the nurses. By sending one of my patients there for care, I know it won’t be a burden, an additional burden on me. That with the experience and the training that those staff have, they can solve a lot of the issues themselves. Instead of saying, oh, this is the problem. Well, let

me call your doctor and see what to do. No, they take the initiative to say, OK, well, let's try this, this, and this, and I'll let your doctor know. It's night and day.

Here, MD1 demonstrated a great deal of trust and a willingness to relinquish some control over the care of his patients to the clinical staff. MGR3 described similar collaborative engagements with MD3, indicating,

I think the relationship is in a really good place now. And I think when you use the magic word collaboration, you also have to use consistency. We don't go on there and make big demands. We go in as a partnership and discuss things, whether it's, no matter what it is, a medication or buying machines or whatever we need in these days or this quarter, it is sitting there and discussing and not pushing it down their throats, which you can do, I mean, in all essence you can. But that creates a horrible relationship.

The JV3 relationship struggled with collaboration early on. However, with the younger physicians taking a more active role, the JV experienced a shift that now echoes MGR3's position. MD3 described the current relationship, explaining, "and that's what I've tried to make the group understand, that we don't have to be competitive. Let's collaborate because The company wants us to collaborate, and there's enough for everybody." A similar evolution of the partnership occurred in JV4; MGR4 expressed her view of this evolution, stating,

We just got into a routine of sharing information and making things happen. Getting facilities open and getting the JV formed, getting facilities credentialed. Really talking to them about the issues in the clinic so that they knew that I knew what I was talking about. Getting them comfortable with everything. And it just evolved from there.

MD4 had a similar opinion, sharing,

I learned a lot about trust, my trust in the people I was working with. And it was the communication, that openness to understand the concerns of all parties and the willingness to address it. And that also made it more comfortable, as a physician, being a part of the JV. And that they were just regular people trying to do a job, trying to do what the corporation needs and at the same time, trying to balance that with being ethical and moral in their decisions. And I saw that struggle. I appreciate that. And there are a lot of people in the JV who are very helpful to me in terms of negotiating deals and stuff like that.

Through transparent communication, the managers established trust with the physician partners, creating the opportunity to build collaborative partnerships. Building trust mitigated elements of physician identity related to control, expertise, and care of the patient. Importantly, the emergence of physician leadership in JVs two through four played a central role in creating the space for communication, building trusting relationships, and ultimately collaboration between the partners. Interactions demonstrated inclusion and open-mindedness that valued the individual perspectives, decreasing individual identity salience and mitigating IPC. Notably, the participants in JVs five and six made no references to collaborative interactions.

### ***Lack of Understanding and Trust***

The absence of understanding, particularly early in the formation of JVs, created a barrier to trust. Physician inexperience with the dialysis business resulted in mistrust in the managerial counterparts. The lack of understanding manifested as frustration with the information that managers shared and at times some difficult conversations and arguments between the partners. Mistrust strained the relationship and created self-centered behaviors. Except for JV1, the

participants described situations where lack of understanding stimulated mistrust. MGR2 described the early interactions with the physician partners as hostile,

This was our first JV with this group. We had to kind of educate the physicians...What does it mean to be a JV partner? When we had these first meetings, the physicians weren't getting it. They didn't have a basic understanding of what it takes to be in a JV...We had some hard talks with the physicians to explain it's a long-term investment, and it takes time to see results in the investment as we're building it up and growing it out.... there really were hostile questions about the cost of operations.

MD2 expressed a similar perception concerning the early interactions in the JV, stating,

There wasn't any training when we became partners. We had our board meetings, and the finance people would give us presentations, but there wasn't any transparency to the data. We were frustrated with the business and the relationship with the company was strained... I didn't realize how much I didn't know about the business when I made the decision to invest in the clinic. When the initial financial information was provided, they should have provided more education on the process and the financials. I didn't understand the risks in the business. The first two years in the venture were challenging.

While both the relationship and the performance in JV2 improved over time, two years is a long time to endure strained relationships. A similar experience occurred in JV3, MGR3 explained,

I think sometimes both sides go into it a little bit too much for the wrong reasons... I think that from the physician's side of it, they go in automatically having a level of distress, and I'm not sure why you'd ever go into business with someone you don't trust immediately. I haven't figured that out yet...it was immediate distrust... There were some



heated arguments. There were demands. There were threats. We didn't understand why.

We had never done anything.

MD3 shed some light on why the relationship started off poorly,

My first impression was that the company would never have your back. You've got to look out for yourself.... There was some hesitancy in regard to what this partnership is like, with the transparency that goes along with JVs. Just like, you know, the product side, not really knowing what's going on. And we understand that it's business. That's what frustrates a lot of the partners in regard to the joint venture.

MD5 shared similar concerns about the company when he first became a JV partner, sharing,

I got a lot of warnings from other physicians saying that we're going to get screwed because the company is enormous. You're just going to get lost in that. You're going to be one of the twenty thousand physicians. So nobody is going to listen to you. They're not going to care. You're not going to get paid...And there was fear. I thought that there's going to be a lot of costs that are going to get put on us...And, so I was very scared, actually, to be honest with you.

After six years and the participation in three JVs, MD6 continues to have concerns about the management fees charged by the company for services rendered to the JV, stating, "I guess one of the things that are unclear to me is what the management fees pay for. I think that needs to be spelled out more. Because it is sort of irritating to see, management fees always."

In the absence of understanding, the physicians tended towards assuming the worst of the company and the managers. Words like *hostile*, *threats*, *hesitancy*, and *fear* document the anxiety, mistrust, and IPC in the relationship. The salience of the physician identity in these situations exists due to perceived threats to physician control and expertise. Managers lessened

the physician identity salience through education and communication, though this process tended to take a long time to resolve the physician's concerns. This delay may be attributed to difficulty in explaining the business and lack of attention to team-building processes early in the relationship. A focus on the financials further contributed to the physician's frustrations by emphasizing alignment to organizational objectives rather than seeking to stimulate engagement over patient-centric initiatives. Finally, for physicians, investing in a JV is a personal process: the physicians make a personal financial investment, accounting for the fear and frustration experienced by the physicians. This personal investment, coupled with a lack of business background, created a source of strain and conflict amongst the physician investors.

### **The Power Struggle is Real**

As described in previous sections, physicians and managers enter JV relationships for different and sometimes conflicting reasons, creating the potential for power struggles and conflict. This superordinate theme explores interprofessional interactions and the emergence of perceptions of collaboration or conflict amongst the participants. Transactional approaches to leadership and efforts to stimulate alignment to organizational goals engendered perceptions of conflict and enhanced individual identity. Conversely, when managers emphasized inclusion and compromise, perceptions of collaboration and a sense of team emerged.

### ***The Quest for Control***

The participants described frequent examples of power struggles. Physicians typically joined JVs to exercise control to improve patient care delivery. Conversely, managers who occupy leadership roles and corporate responsibility for the business often resisted relinquishing control in the business, favoring a business as usual approach. The desire for control frequently

led to early conflict in the JV relationship. MGR3 described the difficulties in the early days of JV3, sharing,

The relationship was certainly not OK at first. It was combative: anything that you wanted was negative. I mean, it was not good at first...You just knew it was going be war when you went in there and there was nothing that you did or didn't do. It was just we're going to throw this at you and see if it sticks.

Interestingly, MD3 described a version of trench warfare when talking about how the physicians managed negotiations on strategies coming from the company, explaining,

We kick it down the road...We wait and find out to what degree are they willing to budge on it. And, the company does the same thing with us. We'll delay things and delay things and delay things until it boils to a boiling point and something has to be made or done.

MD3 shared later that current interactions are more positive and collaborative, but even as recently as two years ago, the approach proved combative. MGR2 described his desire for control when he stated, "to be honest, I don't really wait for their decision, because we do the best for the clinic and for patient safety. I keep them in the loop." But this approach failed to acknowledge MD2's interests in the business. MD2 indicated,

I saw ownership as a joint venture partner as a way to gain some control in the clinic...We want to have some say in the business. We really expect them to communicate. They might just want us to do what they say.

The expectation of communication led MD2 to take a more active role in demanding input into the business and better communication from the managers, leading to a more collaborative relationship today. When describing goal setting, MGR4 stated,

The goals are our specific goals for the market generally. The goals come from our goals for the clinics. So, we set those goals at the first of the year every year and then walk the doctors through it every quarter, where we are and where we stand.

MGR4 expressed this process works today, but early in the relationship the physicians resisted corporate initiatives. MD4 shared that early in the relationship he believed he had to protect the patients, stating,

At least from my perspective, you just have to be able to have a voice in the decisions that were being made that affected the business, make sure that those decisions didn't have a deleterious effect on the clinical processes that were going on that affect patient care.

This desire for control led to early tension that resolved as MD3 learned to trust the company managers, sharing,

It took some time and some struggles when we first started out...However, the people that we deal with tend to be straightforward. I particularly enjoy their willingness to listen and to alleviate my concerns, and to go that extra step.

Identity played a central role in the conflict and tension in these cases. Words like *combative* and *struggles* demonstrated a spectrum of conflict that occurred early in the JV relationship. Physician mistrust permeated the early relationship, where the physicians questioned the capability and intentions of their managerial counterparts. This mistrust increased the medical professionalism desire for control over patient care, activating an individual orientation and IPC. The managers historically enjoyed control of the business and maintained responsibilities to the organization, leading them to continue to try to control the operations of the business. This focus on business processes and organizational goals appealed to the

managerial ideology and focused the managers on individual needs. Building trusting relationships through effective communications facilitated overcoming these initial conflicts in the JVs.

### ***Ineffective Leadership***

Ineffective leadership behaviors contributed to conflict and power struggles that exist in JV relationships. Ineffective leadership refers to leader behaviors that stimulate IPC or fail to generate collaboration. Failing to attend to the perspectives of others and efforts to control behaviors reflect ineffective leadership behaviors. Most of the participants reported collaborative relationships with at least some of the members of the JV board. In JV2, JV3, and JV5, the emergent leadership from the physicians created opportunities for the FMC managers to listen and respond, creating an inclusive environment. However, participants shared some challenges with leadership. In JV1, where close collaboration exists between MD1, MGR1, and the clinical staff exists, a senior leader of the organization attempted to force an initiative on the physician partners. MD1 described the interaction, stating, “he was literally screaming, spit was flying from his mouth in our office, screaming at us not to take it, that we were not good partners if we did. He royally screwed things up.” MGR2 was present during this exchange and the physicians found him guilty by association; MD1 shared,

The ultimatum approach quickly doomed Bill (senior leader) and MGR2’s relationship with the practice. It was a complete loss of trust between the parties. Absolutely gone.

Not even one percent. And I think that that’s part of the issue with MGR2 today...I’ll be honest with you. He’s literally invisible to me

This extreme example of a commanding approach to the relationship nearly cost the entire relationship with the company: the physician partners contemplated ending their relationship

with the company. MGR2 subsequently took a laissez-faire approach to the venture that has only further compromised the relationship.

There are subtler versions of trying to direct physician behavior in JV3 and JV4. Similar issues with a directive approach occurred early in JV3. When describing how leader behaviors negatively affected the early relationship, MGR3 stated, “I’d say the first five years we didn’t have a good relationship; it was always the company pushing things down their throat that they didn’t want to do.” MGR3 described how the relationship improved with a more inclusive approach, sharing that today, “we don’t go in there and make big demands. We go in as a partnership and discuss things...it is sitting there and discussing and not pushing it down their throats.” MGR4 shared her approach, indicating,

We tell them what the company has decided, and we can change it if they make a comment about it or if they have a difference of opinion. But my experience is they’ve been pretty much satisfied with what our goals are. They are good partners, as difficult as they can be. They do, you know, follow our objectives and they do take our recommendations. Sometimes you have to show seven or eight times, but they make baby steps each time.

A conflict exists in MGR4’s statement where she indicated the physicians accepted goals when the goals are pushed down to them. MGR4’s perspective reflects the physicians are difficult and have to be told what to do many times, suggestive of passive resistance, a form of conflict. MD4 recognized how the company pushed objectives down to the partners, stating, “they are the managers and pretty much call the shots,” evidencing a lack of physician engagement in the goals of the venture.

A laissez-fair approach to leadership permeated JV4 and JV5. MGR2, a board member in JV2 and JV5, described his approach to JV5, stating,

I let my directors of operations deal with it...I let it go until it's been resolved. I would say don't hesitate to reach out to me when they can't resolve the problem with the director of operations or clinic manager...I'll reach out myself to the partner and say we have to spend this money, and I want to say just that. I told him we're going to do it, but it's a courtesy call.

MGR2's laissez-faire approach in this clinic led to tragic outcomes when the clinic experienced problems during an inspection. MD5 expressed his dismay, saying, "I kind of got surprised because we thought we were doing pretty good." A similar approach occurred in JV6 where MGR6 shared,

We'll tell them the things that we're doing. But I guess we've never really asked them, what do you think or what do you feel? I'll let them know we do have a missed treatment initiative, and this is what the team at the clinic is doing. And they never say they're opposed to it and have never offered anything. But on the other hand, I've really never asked them, do you have any other suggestions or thoughts? We've never really sat down and came up with a plan.

MD6 assumed a similar laissez-faire approach to the JV, indicating, "I don't view myself as a leader...I'm sure somebody else would address those problems." These laissez-faire approaches to leadership failed to meaningfully engage in a collaborative partnership.

The failed leadership approaches described in this section enhance IPC and threaten collaboration and engagement by creating issues with control. While JVs one through four described collaborative relationships, leader behaviors in these ventures occasionally took on

commanding or directive tones. These approaches devalued the physicians' elite identity status and failed to recruit physician expertise and problem-solving skills. While the managers sought control, the physicians retreated from the initiatives, demonstrating a lack of engagement. The lack of engagement represents a form of control and IPC through active or passive resistance. The laissez-faire approach proved similarly ineffective. In the absence of leadership, no one focused on problems, leading to disengaged physicians and poor performance in the business.

### ***Finding Compromise***

In contrast to how negative leader behaviors stimulated individual efforts to exert control, efforts to collaborate to find compromise mitigated power struggles. Compromise includes using an inclusive approach to recognize and respect the perspectives of others while seeking to find common ground. In practice, avoiding win-lose scenarios by understanding the needs of the other party and making concessions to meet those needs results in collaborative interactions. The perspectives of the participants formed stark contrasts between the high- and low-performing JVs, where the high-performing ventures actively sought to find a compromise and approached the relationship with a team orientation. MGR5, the most senior manager in the study, shared his philosophy on compromise, explaining,

You had to find their motivation. What are they trying to get to? And then the ability to work through them not trusting anything you say and you just keep being professional and keep giving them answers and keep trying to get there with them, within reason...And eventually through professionalism and reasonableness they come around...And sometimes you got to be straightforward too, once you establish trust. You've got to go back and tell them this isn't going to work. No, that's asking too much. You've got to convince them of it.



The perspectives of the managers largely echoed MGR5's sentiment and permeated into the physician relationship. When describing some of the conflicts the physicians had with senior leadership, MGR1 stated, "I kind of stay out of those pieces and just try to manage everything from what my desired outcome is and stay positive to make sure they're getting what they need from me and my team." MGR1's comments acknowledge the needs and perspectives of both parties. Describing the results of the conflict with Bill, MD1 shared,

Our thinking was, why can't there be a mutually beneficial continuation of this relationship? What's good for the company is good for our practice...The parties (referring to Bill and MGR2) have moved on. The practice is still here. The company is still here. We're still able to come to an agreement on our partnership and what is mutually beneficial for everybody involved.

When describing how MGR3 facilitated the change in the relationship with the physician partners in JV3, MGR3 emphasized,

From my point of view, it's been just a level of consistency. It's not always no. Not always yes. But we'll get through it. We'll solve the problems. If something happens, we work through that and we come to a resolution. That's the approach I've really taken with the younger guys. It's just; I'm here, we're all in this together. We can both be very successful.

MD3 acknowledged appreciation of MGR3's approach, acknowledging,

We were a little bit too strict on negotiations when it came to the company...Let's try to meet in the middle somewhere. Whether I give a little here, you give a little there. There's some compromise in all that. And I think that is what changed in the group...Previously, it was just like, no, we're not doing this. And the company would be

like, yes; we have to do this... We work through things and I think that's really important to move forward.

The evolution of the relationship in JV3 reflects a shift from conflict to collaboration that hinged around consistency in communication and a willingness to seek compromise.

Efforts to find compromise occurred in JV4, though MGR4 expressed some frustration in the fairness of the results and the lack of appreciation by the physician partners. MGR4 shared,

The management agreement, we got to an impasse on that... It took everybody getting involved to get that one resolved... I will say they have not said anything about appreciating my efforts on their management agreement... They don't care about the work that was put in at all. They wanted what they wanted. And it was still somewhat of a compromise on their part and our part. But they got the better deal. And that's all they care about.

Conversely, MD4 expressed satisfaction with the outcomes of negotiations with the company, stating, "and when I had to negotiate contracts with you guys, you were always very upfront. I would tell you my concerns, and you would listen. Maybe we could do this, and maybe we could do that? And I appreciate that." While the parties found compromise, the imbalanced outcome and lack of appreciation frustrated MGR4, a result that is outside the awareness of the physicians.

Efforts to find compromise resulted in fewer issues with control, less IPC, and greater collaboration between the physicians and managers. The use of words and phrases like *meet in the middle*, *we're in this together*, and *mutually beneficial* suggested inclusiveness and open-mindedness that created feelings of teamwork, lessening individual efforts to exert control. However, MGR4's experience identifies a potential concern with how the lack of equity,

fairness, and appreciation threatens the team identity and reinforces a shift towards the individual identity construct. Notably, the participants in JV5 and JV6 made no references concerning compromise.

### **Two Sides to the Joint Venture**

This superordinate theme explores the balance of financial and quality discussions amongst JV board members. The JV board meetings created a regular opportunity for the board members to meet and discuss the business. These meetings, however, often overemphasize the financial aspects of the business, neglecting emphasis on patient care and quality outcomes. While physicians purportedly entered into JVs to gain control over patient care and managers claimed a desire to stimulate engagement, in practice, JVs often lead to quarterly reports that do little to satisfy either. Describing JV board meetings, MGR3 shared,

The suffering goes both ways. It's me sitting there watching and listening while someone else reads the slides and goes, any questions? No. Any questions. No questions. Is there money in the bank? No. AAAH! You finally got their attention.

The participants reported general satisfaction with board meetings and the financial reporting but shared that quality discussions typically occur secondarily or as an afterthought. These observations led to the emergence of two subordinate themes: money is one thing and overemphasis on financials.

### ***Money is One Thing***

The financial relationship confounds the purported rationale for participation in JVs from both physicians and managers. While physicians emphasized a desire to gain control over patient care, managers expressed an interest in building collaboration and physician engagement. However, the financials influence the relationship in high- and low-performing ventures, though

the experience differs based on the performance of the clinic(s). The money is one thing subordinate theme represents the perspective that the financial investment in the joint venture takes precedence over collaboration on clinical outcomes. As a financial investment, a sense of duty to the investors emerged that threatened efforts to stimulate clinical collaboration. MGR1 and MD1 shared a focus on financials; MD1 stipulated that

I think the JV was a way to sort of diversify your revenue stream. And let's be honest. I mean, part of the reason people join joint ventures is to be monetarily rewarded. Let's use the premise of being monetarily rewarded as a reason for joining a JV, right. Because, as medical directors, you have some control over algorithms and protocols and patient care directives. I mean, you're already involved in that. Your voice may not carry as much weight, but you're already involved in it. Now, being in a joint venture, what's the impetus for taking a financial risk to join a joint venture? It's being monetarily rewarded. And I don't think that would surprise anybody.

MGR1 expressed a similar emphasis on the financial performance of the JV, indicating,

We focus on the financial piece a lot more in our JV programs because we want to be able to share these outcomes, where this money is going. I think the physicians are engaged. They care about what's being said, and they're definitely paying attention to the dollars.

MGR2 is also a board member in JV1, as well as several other JVs in this group, and he further emphasized the role of financials, stating, "the real reason is not for the patient, it's for financials. The issue, as well as the possibility of problems, that tie it to financials, then it sways them."

MGR3 described a nuanced financial emphasis with the physician partners in JV3. Describing the senior physician investors, he stated, “money, It’s all about the money.” MGR3 described the interactions with some of the directors of operations and the senior physicians, saying, “they saw greediness of the physicians. And the two different types of individuals they were. And they lost all respect for them. They really did.” MGR3 described the relationship with the junior physician partners slightly differently stating that “the money is not the most important thing. It’s important, but it’s not THE most important.” MD3, one of the junior physicians, similarly struggled with the financial emphasis of his senior partners, stating, “there’s always a degree of greed when it comes to any topic that we do in medicine.”

Some participants shared the perspective the investment resembled investing in the stock market. The participants from JV6 described the relationship more like a silent partnership or investing in a business as a shareholder rather than a partnership. MD6 described his frustration with his physician partners declaring,

I mean, the joint venture participants, some never show up for the quarterly meeting. I mean, there’s an engagement of doctors that’s also important. And that is what you’re interested in. I mean, I’m interested in business and medicine to a certain extent also. And other partners in the joint venture aren’t. They’re only interested in the shareholder part of it. And if they’re not getting what they expect, they’ll sell their share.

The two directors of operations, MGR1 and MGR6, echoed this mentality of treating physician partners as shareholders rather than partners. MGR6 described her responsibility to report to the physician investors in her statement, “there was going to be more involvement from the partners and, I have more than just FMC to answer to, even other minority partners.” MGR1 expressed a similar feeling of responsibility to the physician investors:

It's because this is a for-profit organization where the physicians have part ownership, are vested in what happens and how it happens. We are managing the process to make sure that we're managing resources appropriately so that the JV is profitable for the company and our JV partners.

But not all partners focused purely on financials. MD4 described the challenge of balancing the patient and financials, "it's hard to separate the practice of medicine and the business of medicine. Learning to not compromise one or the other. You have to remember that I was here, first of all, to serve my patients and not myself." MGR4 acknowledged that balance in MD4,

So, you know, like with our JV partners. They have high expectations of the company to really deliver for them both on quality and finances. But they also can have a side to them that shows that they really care about the patient, they really care about the joint venture, and they really care about the clinic.

The focus on the financials of the JV business confounds the relationship between the physicians and the managers by introducing a source of IPC that appeals to individual identities. Emphasis on financials is consistent with the managerial ideology but creates a conflict for the physician identity, where the physicians seek to reconcile their obligations to the patient and their financial interests. The two directors of operations, and to a lesser extent MGR4, experienced a sense of duty to the physicians and responsibility to work for rather than work with the physician partners. The work for orientation likely arises from the director of operations' lower positional status within the hierarchical organization of the company, coupled with the elite status of the physician partners, creating a feeling of subordination to the physician

partner. This subordination threatens the team identity and encourages the salience of the physician's elite identity.

### ***Overemphasis on Financials***

As a business relationship, it is not surprising the quarterly JV board meetings focus on the financial well-being of the business. As investors, the physicians expected reporting on the performance of the business, and the managers typically satisfied these expectations. The board meetings typically focused on financial discussions: clinical discussions typically occurred as an afterthought or occurred in other settings, an outcome in conflict with the rationale for forming the JV relationship. Except for JV2, discussions regarding quality carried a lower priority.

MGR1 shared,

The financial piece is what we focus on a lot more in our JV programs, because we want to be able to share these outcomes, where this money is going...Revenue, insurance, and so many other pieces and then all the compliance pieces to make sure that from a regulatory, compliance, and quality standpoint we address what could impact the financial piece. It's just making sure that everybody is staying informed of whatever could potentially impact the business.

Having acknowledged previously that quality discussions occurred with the clinical staff and at medical director meetings, MD1 acknowledged his approval of the JV board meeting content, indicating,

I find the board meetings effective in terms of explaining the numbers and where they got them...I find it beneficial, and I find it to the depth of what I would prefer. I mean, like I said, I don't have a master's in business to lean back on. And nor do I have the time to interrogate anybody about why was the housekeeping cost two thousand dollars more this

month or this quarter than it was last quarter? That's just not the purpose of those meetings either.

MD3 shared a positive opinion of the JV board meeting, stating,

I think they're very worthwhile. I think looking at the degree where each variable affects the JV down to the bottom dollar is very important...It's mainly financials like how we can improve on the overall subsets of the financials; it is very financially oriented when it comes to those quarterly meetings. Like how can we improve on missed treatments?

Where can we save and cut costs? So, it's very operational metric oriented. With quality, of course.

In this description of board meetings, quality occurred as an afterthought. Though MD3 conflated quality initiatives, such as missed treatments, with financial outcomes, suggesting either some difficulty parsing quality and financial discussions or that quality discussions arose from the financial discourse. MGR3 represented an alternative view, sharing, "we talk about the quality initiatives. Now we talk about them just as much as we do the financial side, in reality." MGR4 acknowledged that meetings often focus on finances but that quality plays a role in the meeting, explaining,

You know, with JVs, a lot of times, it can be all about the finances. But that's really not the true picture because it's about the quality as well...Generally, I would say that the board meetings are effective... And I think it is for the physicians, too. To really understand what's happening financially in the J.V. and why. So, the financials are first and then quality is presented.

In this example, quality is part of the presentation, but the interview revealed little indication of the effectiveness of this approach from MD4. Finally, MGR6 acknowledged that quality



discussions lacked the emphasis in detail relative to the financial discussions, sharing, “we definitely spend more on the financial side, than we do on the quality side. We review it, but it’s not as in detail.” MD6 failed to recognize quality discourse in his characterization of board meetings, sharing, “the meeting is only quarterly, it only lasts for about a half an hour and the presentation by the accountant is informative.” MD6’s comments suggest very little emphasis on quality in JV6.

In contrast to the other JVs, JV2 acted as an outlier with an emphasis on both financial and quality outcomes. MD2 expressed early frustration with the JV board meetings that resulted in substantive changes to the structure of the meetings, stating,

When the joint venture was first formed, the presentations were just that. The finance people would just present the metrics to us. Some of the metrics didn’t make sense and sometimes it felt like they weren’t very transparent...We did something really useful in our board meetings. We consolidated our board meetings with our other JV. We also created time to do our medical director quality meetings during the JV board meetings. By having the meetings at the same time, we’re able to focus on both the financial performance of the venture but also how the clinic is doing on quality. This brings a larger group of people to the table in our discussions. This has been very helpful...combining the meetings we have an opportunity to have a lot of dialogue about both the financial performance and the patients.

Changing the structure of the meetings in JV2 resulted in the integration of clinical and financial discussions, inviting a broader group to collaborate on the performance of the JV.

The emphasis on financials exists in stark contrast to the purported reasons for engaging in JVs. While the physicians intended to exert control over care delivery, concerns over their

personal financial investment predominated. Coupled with managerial desire to emphasize cost control and efficiencies, the parties found comfort in meetings that emphasized the financial side of the business. While quality discussions continued to occur in medical director meetings, most of the physician participants acknowledged that medical directorship failed to grant desired levels of control, as discussed previously. Similarly, managerial desire for collaborative partnerships became subordinate to financial presentations that are the standard in all JVs in the company. Consequently, the board meetings often failed to achieve the desired levels of collaboration, necessitating interactions outside the board meeting structure. For both physicians and managers, the focus on financials appealed to individual identity elements rather than a team identity. The overemphasis on financials acts as a source of IPC through activation of individual identity that creates a barrier to the desired collaborative relationship. Notably, the JV2 structure created a team identity that transcended the individual board members by recruiting a broad group of participants to collaborate on clinical and financial outcomes.

## **Conclusions**

This research study sought to understand the influence of leadership behaviors on the manifestation of IPC and collaboration in the context of a chronic dialysis JV setting. The three research questions in this study were:

**Q1.** How do joint venture board members think about the influence of leadership behaviors on the social identities of themselves and other board members?

**Q2.** How do joint venture board members think about the influence of communication processes on the social identities of themselves and other board members?

**Q3.** How do joint venture board members think about the role of individual and team identity in the context of a mature joint venture relationship?

The IPA methodology enabled an analysis that moved beyond participants' descriptions of their experiences to interpret the meaning-making processes related to collaboration and conflict in this context. The hermeneutic element of IPA facilitated this interpretation by engaging with features of existing theoretical constructs such as social identity theory, medical professionalism, and managerialism. The results suggested that leadership behaviors differentiate high- versus low-performing joint ventures. Controlling and laissez-faire leadership approaches stimulated identity threat in the physicians, where inclusive leadership behaviors reduced individual identity salience and promoted a collaborative relationship. Trust issues predominated the early relationship, creating power struggles and emphasizing individual identity. Effective communication practices enabled higher-performing ventures to build trusting and collaborative relationships. Through inclusion, open-mindedness, and effective communication individual identity salience decreased, allowing the emergence of a team identity in the higher-performing ventures, a relationship not seen in the two lowest-performing ventures.

### ***Leadership and Social Identity***

The role of leadership behaviors demonstrated nuanced interactions with the social identities of the participants. Scenarios where managers sought to exercise a commanding or directive leadership approach utilized organizational hierarchy and positional status to exercise control, attempting to bring physician behavior into alignment with organizational goals. These behaviors leaned heavily on components of the managerial ideology, inclusive of creating alignment to organizational initiatives, emphasis on costs and processes, and the use of hierarchical status. Physician reactions resulted in a range of responses spanning from heated arguments to passive resistance. This controlling approach stimulated identity threat associated with the physician elite status, patient-centric approach to healthcare delivery, autonomy, and

expertise. The managerial efforts to control behavior and the resulting threat to physician identity emphasized individual identities, creating conflict and tension.

Laissez-faire leadership generated similarly negative interactions. The physicians expressed frustration with the lack of leadership and presence from these board members. This frustration grew from feelings of disrespect to the physician's elite identity and individual concerns surrounding the personal financial investment in the JV. Alternatively, managers expressed less concern with disengaged physicians, indicating the ability to manage the business without the physician partners. This managerial response appeals to the managerial desire for control over business processes and financial performance.

Conversely, when physician and manager leaders focused on communication, collaboration, and compromise, the parties developed trust that proved resilient in the face of challenging situations. Managerial efforts to utilize a patient-centric approach further improved collaborative relationships and physician engagement. Efforts to build collaboration and compromise stimulated perspectives of inclusion and open-mindedness. By demonstrating inclusiveness and open-mindedness, physicians and managers acknowledged the individual needs and priorities of their counterparts, forming trusting relationships that mitigated individual identity concerns. Higher-performing ventures demonstrated greater attention to collaboration and compromise than lower-performing ventures.

### ***Communication and Social Identity***

Effective communication played a central role in mitigating individual social identity salience. Both physicians and managers described early issues with mistrust, arising from physician perceptions of managers prioritizing profit at the expense of patient care. Physician lack of understanding of the dialysis business and organizational objectives further complicated

mistrust. Physicians frequently noted concerns over the lack of transparency. The initial mistrust from physicians stemmed from the medical professionalism ideology elements of elite status, expertise, and a patient-centric approach to healthcare. Managerial efforts to engage in frequent, consistent, and transparent communication improved physician understanding of the business, a rewarding outcome for physicians, and enabled the development of trusting relationships, particularly in JVs one through four. Manager communication processes facilitated education for the physicians, appealing to the physician's desire for expertise and created trust by demonstrating a patient-centric approach. Universally, the physicians appreciated the opportunity to learn about the business. By mitigating identity threats through communication processes, managers and physicians formed trust that led to collaborative relationships.

Communication processes differed based on the performance of the JV and the hierarchical position of the manager within the organization. Participants in JVs five and six, lower-performing JVs, described communications as reports where higher-performing ventures, including JV4 described interactions as a dialogue. Similarly, managers at the director of operations level described communication processes that emphasized reporting to the physician partners. The directors of operations experienced a feeling of subordination based on their lower hierarchical status in the organization and their view of the physician as an elite identity, reinforcing the physicians' belief in elite status. Conversely, the reporting approach utilized by MGR2 in JV5 stemmed from a managerial effort to control the business. These approaches prioritized different elements of the managerial ideology, creating ineffective processes in communicating with physician partners.

### *Individual Versus Team Identity*

The purported rationale for entering JV relationships by both physicians and managers experienced a disconnect with the lived experience of the partnership. While the physicians emphasized a desire for control over patient care, part of the medical professionalism ideology, they also noted the importance of the financial investment, an individual motivation. Meanwhile, managers sought to build collaboration to improve both clinical and financial outcomes by creating alignment to organizational goals, consistent with a managerial ideology. In practice, the JV board meetings, a primary interface between the physicians and managers, overemphasized the financial performance of the JV: quality discussions typically occurred as an afterthought. The physicians' personal sensitivities to the financial returns on their investments facilitated an acceptance of the financial focus. Financial discussions appealed to the managerial ideology and created a sense of comfort when engaging with physician counterparts. Focusing on the financials increased the salience of individual identity constructs. By focusing on the financials, neither party achieved the outcomes they desired when they entered the JV.

Despite the early financial orientation, the higher-performing ventures experienced a shift towards a team identity. Consistent and transparent communication helped physicians learn the business and develop trusting relationships with their managerial colleagues. Through trusting relationships, the salience of the physician and managerial identities decreased, allowing the emergence of team identity and collaborative partnership. A cycle emerged in the highest performing ventures suggesting that communication built trust, trust built relationships, and relationships facilitated collaboration and compromise. The collaboration and compromise created dialogue and communication that restarted the cycle. Notably, collaborative relationships with just a few board members or others involved in the JV relationship proved sufficient to

stimulate collaborative relationships, with a clear differentiation favoring high- versus low-performing ventures. JV1 and JV2 demonstrated a high degree of collaborative engagement, coincidentally achieving some of the highest clinical and financial outcomes in the operations group.

## **Chapter 5: Discussion, Conclusions, and Recommendations**

The purpose of this phenomenological qualitative research study was to understand the influence of leadership behaviors on the manifestation of IPC and collaboration in dialysis JVs. This chapter begins with a review of the research questions and key findings in this study. Subsequent sections include a discussion regarding the interpretation of the study results in the context of the extant literature and how the research results fit within the context of the social identity theory theoretical framework and the four worlds of the general hospital conceptual framework. Additional sections emphasize the implications for practice and recommendations for future research. The chapter concludes with a summary of key points.

### **Discussion**

Medical professionalism and managerialism ideologies played a central role in how the participants reacted to leader behaviors and communication processes that resulted in either IPC or collaboration in the JV partnership. The data analysis revealed four superordinate themes that contributed to answering the research questions, including: (a) identity influence, (b) building collaborative relationships, (c) the power struggle is real, and (d) two sides to the joint venture. Some overlap exists between these superordinate themes and suggests that inattention to the individual identities of the self and others increases individual identity salience, leading to mistrust, power struggles, and conflict. Conversely, demonstrating inclusive behaviors and open-mindedness through dialogue, information sharing, collaboration, and compromise stimulated the formation of trusting relationships that mitigated individual identity salience in favor of the formation of a team identity. Ideology differences predominated the early relationship, stimulating individual ideologies that created interprofessional conflict and tension. Individual and team identity salience evolved with the JV partners over time, suggestive of a temporal



relationship within these themes. Higher-performing JVs demonstrated greater attention to interprofessional differences and perspectives than did lower-performing ventures, allowing greater collaboration and compromise in higher-performing ventures through the creation of a team identity.

### ***Identity Influences***

Medical professionalism and managerialism ideologies influenced how the physicians and managers interacted. The medical professionalism ideology forms an elite identity construct that prioritizes patient care, professional camaraderie and resists managerial efforts that seek to control behaviors (Andersson, 2015; Skirbekk et al., 2018). The physician participants universally described the nephrology subspecialty using words like *complex*, *mythology*, and *glamorous*, suggesting a perception of an elite identity within the elite physician identity. The physicians rationalized their choices to join JV relationships as a mechanism to gain control over organizational behavior to protect physician autonomy and patient care delivery from organizational initiatives. Conversely, managers typically prioritize organizational policies, processes, and financial outcomes that are pushed down through the organization using hierarchical positional status as a source of control (Salvatore et al., 2018; Skirbekk et al., 2018). The manager participants purported a desire for collaboration but described behaviors that sought to push organizational initiatives down to physicians and focused on the financial performance of the JV to stimulate physician alignment to organizational goals. Importantly, managers at the director of operations level assumed a subordinated role to the physicians, presumably due to the lower hierarchical status within the company and the perceived elite status of their physician counterparts. The influence of ideology differences created barriers for effective interactions in this study, a result that is consistent with prior research.

The ideology differences between medical professionalism and managerialism played a central role in conflict and created barriers to engagement and alignment in the JV context, particularly early in the JV relationship, similar to prior research. Keller et al. (2019) reported that while physicians and managers believe in the importance of collaboration, cultural differences confound efforts to build teamwork and collaboration. Previous studies demonstrated the failure to attend to the ideology differences in interprofessional relationships resulted in identity threats, stimulating conflict and tension and decreasing innovation and organizational effectiveness (Mitchell et al., 2015, 2018; Salvatore et al., 2018). Mistrust in the early relationship evolved from ideology differences that sought to exercise control in the interprofessional relationship, stimulating power struggles. This mistrust prioritized individual identity salience, creating a barrier to compromise, collaboration, and innovation. Inattention to the influences of the medical professionalism and managerialism ideologies fostered conflict in the physician and manager relationship.

Appealing to ideology differences decreased individual identity salience and facilitated the development of collaborative relationships that differentiated high- versus low-performing JVs. The Mayo Clinic experience, along with other studies in acute settings, demonstrated that focusing initiatives on the patient and creating a shared vision, values, and norms, appealed to the medical professional ideology, creating collaboration, innovation, and financial success of the organization (Shanafelt et al., 2015; Skillman et al., 2017; Spaulding et al., 2014; West et al., 2018). Additionally, researchers found that incorporating both intrinsic and extrinsic motivations improved physician engagement and satisfaction: extrinsic motivations are necessary but insufficient to stimulate desired collaborative relationships (Herzer & Pronovost, 2015; Phipps-Taylor & Shortell, 2016). The differentiation of high- versus low-performing joint ventures

resulted from behaviors similar to those found in the prior research. Relationships in the higher-performing ventures shifted to prioritize patient-centric dialogue and respected individual differences, reducing individual identity salience that allowed the emergence of teamwork and collaboration. A financial orientation predominated in interactions in the lower-performing ventures, suggesting that a focus on the patient partially differentiates the performance of the JVs. None of the participants shared any experiences with creating a common vision, values, or norms, a potential area for improvement.

Learning the business appealed to the physician participants. Prior research found that physicians' lack of business training created barriers to effectiveness in business settings, but education on business issues stimulated engagement and satisfaction (Keller et al., 2019; Skillman et al., 2017). Consistent with prior research, the physician participants shared that learning the dialysis business proved personally rewarding: the opportunity to learn appeals to the medical professionalism ideology by increasing physician expertise. Creating common understanding between the physicians and managers opened possibilities for greater collaboration within the higher-performing ventures.

### ***Building Collaborative Relationships***

The physicians and managers described how mistrust characterized the early relationship in the JVs. Historic reform initiatives created an environment of mistrust between physicians and managers as each battled for power and control (Kirkpatrick et al., 2016; Martin et al., 2015). This mistrust created barriers for physician engagement in manager-initiated reform efforts (Bååthe & Norbäck, 2013; Spaulding et al., 2014). As in the prior research, mistrust created a significant barrier to collaboration. Physician and manager participants described efforts to try to increase control in the JV relationship, triggering tensions and mistrust, particularly early in the

relationship. Physicians held strong negative perceptions of their managerial counterparts. In the absence of trust, participants assumed the worst of their counterparts. Perceptions of information withholding stimulated anxiety and fear that produced resistance to collaboration by reinforcing the individual identity.

This study supported previous research by suggesting that trust emerged from effective communication practices. Research in health systems and acute settings found that educating physicians about the business and organizational needs facilitated physician engagement in problem-solving and decision-making processes that appealed to the medical professionalism ideology (Shanafelt et al., 2016; Spaulding et al., 2014; West et al., 2018). Similarly, engaging in frequent, proactive, open, and transparent communication increased physician trust and stimulated physician engagement (Folkman et al., 2019; Skirbekk et al., 2018; Spaulding et al., 2014). Physician participants described early frustration with a lack of understanding and perceived lack of transparency that created tension and hostility in the relationship. Managerial efforts to educate physicians and demonstrating transparency in communications provoked the formation of trust that introduced opportunities for relationship development. Participants in higher-performing JVs characterized interprofessional communication processes as more effective and satisfying than those in lower-performing ventures. Unfortunately, building effective communication took a long time, even in the higher-performing ventures, suggesting building effective communication patterns that meet the needs of both physicians and managers should occur earlier in the relationship.

The participants described trust as a critical success factor in the formation of collaborative partnerships. In the Mayo Clinic experience, along with other healthcare systems, open communication allowed the creation of constructive physician-manager relationships that

stimulated trust, respect, and camaraderie that encouraged collaboration, partnership, and the emergence of team identity (Gadolin & Andersson, 2017; Suelflow, 2016; Swensen et al., 2016). Communication processes that emphasized inclusion and open-mindedness created space for debate and dialogue that allow for greater collaboration and enhanced team identity (Mitchell et al., 2015, 2018; Mitchell & Boyle, 2015). Similar to the Mayo Clinic experience and studies in other health systems, managerial efforts to engage in consistent, open, and transparent dialogue mitigated conflict with the medical professionalism identity elements of expertise, status, and problem-solving skills, decreasing individual identity salience. The creation of trust and the mitigation of individual identities led to a willingness to relinquish control and seek opportunities for collaboration and compromise. These effects predominated higher-performing ventures with no examples of this type of relationship development in lower-performing ventures.

### ***The Power Struggle is Real***

Ideology differences introduced power struggles as each party sought to gain control over healthcare delivery. Keller et al. (2019) found that physician and manager identities reflected different priorities associated with patient care and organizational commitment, decision-making processes, communication preferences, and preferred leadership style. Efforts by managers that utilized strategies and structures to force physician alignment to organizational goals stimulated identity threat and physician resistance (Keller et al., 2019; Martin et al., 2015; Storkholm et al., 2017). Similarly, prior research found that physician threats to managerial identity created conflict, tension, and frustration (Keller et al., 2019; Salvatore et al., 2018). The present study supports the previous literature. Study participants reported efforts to seek control via the JV relationship: physicians sought to retain autonomy and protect patients while managers sought to

create alignment to organizational objectives. Words like *combative* and *struggles* demonstrated the conflict that occurred early in the JV relationship. Communication processes, as discussed previously, and leadership style played important roles in the power struggles.

Directive and controlling behaviors served as barriers to trust, relationship development, and collaboration. Researchers found that managerial leadership behaviors that attempt to exercise dominance and control without seeking physician input increased identity threat and physician resistance (Cain et al., 2019; Gadolin & Andersson, 2017; Keller et al., 2019). An overreliance on hierarchical structures and positional authority demonstrated similarly poor physician response (Almost et al., 2016; Folkman et al., 2019). The present study supports this literature by suggesting that managerial efforts to force compliance through commands and ultimatums created overt affective conflict amongst the physician participants. Pushing directives and strategies down to physicians resulted in passive resistance by the physician partners. These approaches devalued physician expertise and autonomy by creating sensations such as lack of equity and fairness, jeopardizing trust, and causing the physicians to revert to individual patient care and a general disregard for managerial initiatives.

Conversely, inclusive leadership behaviors positively influenced physician engagement and collaboration. When managers utilized inclusive leader behaviors, emphasized strategies that conformed to the patient-centric norms of physicians, and encouraged communication sharing and debate, physician engagement and collaboration improved organizational outcomes (Herd et al., 2016; Herzer & Pronovost, 2015; Mitchell et al., 2014). Accepting differences and focusing on strengths projected sensations of value and respect that enabled the emergence of team identity (Cain et al., 2019; Ellemers et al., 2013; Mitchell et al., 2018). Higher-performing ventures used words like *we're in this together* and *mutually beneficial*, suggesting greater

sensitivity to inclusiveness and open-mindedness that enhanced sensations of teamwork and decreased perceptions of control, similar to prior research in this area. Participants in the highest performing JVs described close collaborative relationships that valued the contributions of their counterparts: physicians in the three highest performing ventures described their desire to protect and engage with those managers and others they felt contributed most to the success of the JV. Higher-performing JVs sought more compromise and enjoyed closer relationships than those in lower-performing ventures. Inclusive leadership behaviors differentiated the performance of the high- and low-performing JVs through the creation of a team identity.

### ***Two Sides to the Joint Venture***

Balancing the clinical and financial aspects of the business proved challenging for the participants. Skirbekk et al. (2018) found that managers typically agree with physicians about the importance of patient clinical outcomes, but meetings largely focused on financial performance and budgetary issues, leaving patient care as an afterthought. The present study demonstrated markedly similar results. Physician participants reported a desire to influence patient care delivery, while managers sought to stimulate physician engagement to improve both clinical and financial outcomes. Unfortunately, participants reported that board meetings typically emphasized financial performance and budgetary concerns. Reporting on financials fell into a comfort zone for managerial participants. Some of the managers reported a sense of duty to protect the physicians' investment as a rationale for focusing on the financial outcomes of the business. The personal financial investment by the physicians facilitated physician acceptance of the financial reporting process in lieu of engaging in dialogue over clinical processes. The overemphasis on the financial aspects of the business drowned out clinical issues, creating misalignment to the purported rationale for forming the JV relationship.

Finding a balance between clinical and financial performance of the JV differentiated high- and low-performing ventures. Prior research suggests that while satisfaction of financial interests for physicians is an important factor in physician leadership, an overreliance on financials stimulates average performance, low organizational commitment, and conflict with managerial initiatives (Almost et al., 2016; Phipps-Taylor & Shortell, 2016; Sfantou et al., 2017). This study supports the concept that money is important but insufficient to deliver the desired level of engagement and collaboration. Physician participants reported a lack of control and influence on patient care associated with their role as medical directors as a reason for becoming a JV partner. The emphasis on financials in the JV resulted in lower-performing JVs resorting back to their medical director role to gain the influence they desired. Conversely, JV1 found workaround relationships outside the JV meeting to exercise the desired control and eventually collaboration as the relationships developed. JV2 integrated the JV board meeting and medical director meeting to create equal emphasis on clinical and financial outcomes across a broader group of participants. Higher-performing ventures found ways to integrate clinical and financial outcomes, creating a collaborative environment that reflected a team identity.

### **Implications for Theory and Research**

The social identity theory theoretical framework and the four worlds of the general hospital conceptual framework introduced in Chapter 2 influenced the interpretation of the participant data. The flexibility of IPA allows researchers to engage with extant literature and theoretical frameworks during the cycles of analysis and meaning-making processes (Larkin et al., 2006; Peat et al., 2019). While alternative interpretations of the participant data are possible, these frameworks facilitated the meaning-making processes during the data analysis. The following sections will discuss how these frameworks contributed to the data analysis.



### ***Social Identity Theory***

SIT postulates that one's identity is socially constructed by one's membership in social groups (Hogg et al., 1995; Stets & Burke, 2000). Membership in a social group is subject to normative and self-enhancement processes that create common values and norms that allow the formation of a shared ideology that creates stability and solidarity in the group (Hogg et al., 1995; Stets & Burke, 2000). In this study, the physician participants described a strong identification with their status as nephrologists and as physicians. The nephrologists described an ideology that valued expertise, autonomy, problem-solving skills, and a patient-centric approach. The education, training, and socialization of the nephrologists created an elite ideology: participants depicted nephrology as a *mythologic* and *glamorous* subspecialty that enhanced perceptions of ability and expertise in the care of their patients.

Conversely, the managers described an ideology oriented towards business outcomes and organizational hierarchy. The managers described the importance of processes and efficiencies to drive financial outcomes. Managers reported pressures to conform to directives driven down through the organization. Attempts to push down initiatives from the organization to the physician partners, rather than collaborating on strategic goals, evidenced the alignment to organizational goals rather than efforts to seek collaboration. The emphasis on the financial performance of the JVs represented a comfort zone for the managers that aligned with organizational goals.

The salience of social identities explains the emergence of IPC or collaboration in the context of a dialysis JV. SIT stipulates that individuals belong to multiple social groups and that context influences the salience of social identity (Hogg et al., 1995). Activation of one social identity may trigger identity threat, accentuating stereotypes and dissimilarities that trigger

protective responses that demonize the out-group (Hogg, 2016; Hogg et al., 1995). Conversely, attending to the formation of a new social group with shared norms and values that preserves other higher-order social identities increases group commitment and collaborative processes (Hogg et al., 1995). The creation of a dialysis JV results in the formation of a new social group that brings together physicians and managers. Managerial efforts to force alignment to organizational goals threatened the higher-order medical professionalism ideology, creating conflict and mistrust. However, when physicians and managers built trusting collaborative relationships, the salience of the JV board membership increased while the salience of the managerialism and medical professionalism ideologies decreased. This shift explains the formation of a new team identity that facilitated the collaboration and partnership in the higher-performing JVs.

### ***The Four Worlds of the General Hospital Model***

The four worlds of the general hospital model explains the formation of medical professionalism and managerialism ideologies that result from the social identities of the physicians and managers. This model describes two cleavages that separate physicians and managers: alignment to the organization and a focus on the patient (Glouberman & Mintzberg, 2001). While managers expressed concern for patients, behaviors and priorities emphasized alignment to organizational goals, processes, and financial performance. The hierarchical structures of the organization created a source of power that was differentiated based on the participants' hierarchical position in the company. Directive efforts to push down initiatives on the physicians and the focus on financials in the JV meetings evidence this alignment to the organization. Conversely, the physicians demonstrated a prioritization of the patients. The nephrologists chose the profession to care for patients. The physicians became JV partners to

gain more control over care delivery processes to protect the patient from the company. The two cleavages explain how physicians and managers differentiate and prioritize their roles in healthcare delivery, leading to power struggles and conflict evidenced by the early mistrust and power struggles described by the participants.

### **Implications for Practice**

While the physician and manager dyads in this study described unique experiences, common themes emerged that differentiated the high- versus the low-performing JVs. These emergent themes supported prior research. Based on the research findings, the following recommendations provide guidance to physicians and managers in dialysis JVs on how leader behaviors can avoid triggering IPC and instead promote interprofessional collaboration and the formation of a team identity.

Early conflict in the JV relationships evolved from power struggles, with each party attempting to gain more control in the relationship. The intention of the dialysis JV is to form a financial relationship that stimulates interprofessional collaboration between physicians and managers to improve clinical and financial outcomes. Efforts to gain control over the other party stymie collaborative efforts by stimulating identity threat and producing conflict and tension in the relationship. Parties to future JV relationships should carefully consider the motivations for forming the JV relationship. The creation of a strategic plan outlining opportunities for collaboration prior to the formation of the JV may create the opportunity to gauge the motivations of all parties to determine if the JV is a viable relationship.

Board member selection needs to incorporate those who can contribute most to the venture. In this study, one of the managerial board members occupies a board position in 16 JVs. Some physician participants indicated they had never met this board member. Some physicians

complained that board members at the regional vice-president level were too busy and are not close enough to the business to provide any useful input into the venture, calling for those who are closest to the venture and the market problems to participate. While higher-performing JVs reported good relationships with their counterparts, the quality of relationships tended to be with a small group rather than all board members. Board member selection needs to consider the value board members bring to the business. Replacing absent board members with those closest to the business, members from the business development team for example, would create opportunities for stronger relationships at the local level to engage in collaborative initiatives.

Board members need to attend to the formation of a team identity early in the relationship. One of the significant findings in this study is the high degree of mistrust that predominates the early relationship between the physicians and managers. Discussions about a common vision, mission, values, and norms were notably absent in the participant feedback. Further, very little dialogue occurred regarding strategic planning and goal-setting processes. Engaging in open and transparent dialogue around mission, vision, values, norms, and goals will facilitate the emergence of a team identity much earlier in the relationship. Physicians and managers should seek to engage physician problem-solving skills in the goal-setting process. Attending to team identity formation early in the relationship will minimize directive leadership behaviors in favor of inclusive leadership approaches.

Board members need to practice inclusion. As JV relationships matured, participants in the higher-performing ventures, including JV4, described a better understanding of the perspectives of their counterparts. Understanding the perspectives of others enabled the emergence of collaboration and compromise through the creation of a team identity. Board members need to seek to understand the perspectives of others by engaging in inclusive

behaviors. Implicit in this recommendation is the need to understand how different ideologies affect the behavior of themselves and their counterparts.

Board members need to create time for education. Physician participants acknowledged a limited understanding of the dialysis business when they entered the JV relationship. While the higher-performing physicians learned the business over the first couple years of the relationship, the lower-performing physicians still struggle with aspects of the business. None of the participants acknowledged managerial understanding of the nephrology business. Lack of understanding contributes to mistrust in the JV relationship. Implementing formalized training for the physician partners will flatten the learning curve and reduce mistrust issues that contribute to conflict and tension, allowing the physicians to engage more collaboratively. Conversely, physicians need to take time to educate managers about the challenges of the nephrology practice so the managers understand the complicated issues affecting the physicians and the predialysis patient population.

Board members need to communicate. Participants noted the importance of effective communication at building trust, the foundation for relationship development and collaboration. Board members need to engage in frequent, proactive, open, and transparent communication with the JV partners. Emphasizing dialogue from a patient-centric approach, rather than allowing quality discussions to emerge from financial discussions may shift the dialogue to stimulate problem-solving skills that improve both clinical and financial outcomes. Creating the space for dialogue and constructive debate during board meetings will contribute to feelings of inclusion and openness to the perspectives of others, mitigating individual identity salience and allowing the emergence of a team identity.

Board meetings need to create a balance between financial reporting and collaboration on quality initiatives. Board meetings frequently take the form of a financial report, with quality discussions occurring as an afterthought. Participants emphasized the importance of the financial performance of the business and that meetings typically met their needs related to financials. However, higher-performing ventures implemented initiatives to engage in quality discussions. The integration of joint venture and medical director meetings, as in JV2, serves as a best practice on how to expand the dialogue to give equal voice to both clinical and financial performance of the business.

### **Recommendations for Future Research**

This study provided a useful starting point to understand the relationship between leadership behaviors and IPC and collaboration in the context of a dialysis JV. The study design intentionally recruited a small homogenous sample of physicians and manager board members in mature JVs from one operations group. This approach sought homogeneity based on geographic influences. However, board composition in this operations group identified managers who participated in multiple JV boards, requiring the recruitment of managerial participants at three different hierarchical positions within the organization. A larger study in multiple operations groups would allow more homogeneity in the positional status of the participants. Given the managerial experiences and perspectives differed based on positional hierarchy, studies of these managerial positions could elaborate on the role of positional status on IPC and collaboration.

The temporal influence on relationship development supports the use of a longitudinal study design to investigate how relationships develop in real-time. This study recruited participants in mature JV relationships, excluding any JV with less than one year of operations and requiring all board members to have more than one-year tenure on the board. The current

study identified that mistrust predominates the early relationship. Results also suggested that a deviation from the purported goals of the venture to a focus on the financial performance of the JV occurred early in the relationship. A longitudinal study would provide insight into relationship development and deviations from the desired outcomes of the business relationship. Researchers could also use a longitudinal design to evaluate the impact of implementing recommendations such as engaging in strategic planning initiatives or implementing physician education tactics early in the JV relationship.

Researchers might consider narrowing the study to focus on a single case study or a cross-case study. The current study limited participation to one physician and one managerial board member. The participants identified that other people influence the JV experience, such as the clinical manager, business development personnel, other board members, and nonboard member physicians, for example. A case study that includes all board members and others who are directly involved in the JV would elaborate on the complexities of the interactions and interrelationships of these actors. Researchers could sustain the comparative approach found in this study by doing a cross-case analysis with a broader participant sample within a high- and low-performing case.

Similarly, conducting a study that includes clinical managers and nursing staff would prove interesting. Nurses in these positions represent another professional role and unique identity construct, as seen in the four worlds of the general hospital conceptual model. Nurses play a central role in direct patient care and frequently interact with both physicians and managers and may play a role in the IPC or collaboration in the JV context.

Researchers may find quantitative research studies interesting in this context. The present study identified the importance of inclusivity in building a team identity in higher-performing

JVs. Researchers might utilize a quantitative study design to investigate the relationship between inclusive leadership and JV performance, mediated by the formation of a team identity.

Finally, it may be useful to investigate the effectiveness of specific leadership styles in the JV context. The present study investigated leader behaviors in a generic sense without tying the behavior to a specific leadership style. The company trains all managers in servant leadership. While servant leadership demonstrated effectiveness in the healthcare context, a transformational leadership style improved engagement in challenging and dynamic situations (Jiang & Chen, 2018; Ribeiro et al., 2018). Researchers might consider a quantitative study design investigating the relationship between group-level transformational leadership domains and JV performance.

## **Conclusion**

The shift in healthcare reimbursement from cost control to value-based medicine resulted in increasingly complex initiatives that necessitate physician engagement and collaboration to achieve the required clinical and financial outcomes. The dialysis industry responded to the changes to healthcare reform with initiatives such as the formation of JV relationships intended to increase collaboration between physicians and managers to deliver improved clinical and financial outcomes. However, dialysis JVs often experience IPC that threatens collaborative processes needed to deliver desired clinical and financial performance outcomes. The purpose of this study was to understand the influence of leadership behaviors on the manifestation of IPC and collaboration in dialysis JVs.

In the present study, leader behaviors influenced IPC and collaboration between the physician and manager participants. The study results revealed four superordinate themes in the data: (a) identity influence, (b) building collaborative relationships, (c) the power struggle is real,



and (d) two sides to the joint venture. Leaders in higher-performing ventures overcame ideology differences and pervasive mistrust by practicing inclusive behaviors and effective communication, avoiding directive or controlling behaviors, and by integrating a patient-centric approach.

Leader behaviors that neglected or attended to ideology differences between physicians and managers differentiated JV performance in this study. Physicians and managers prioritized different aspects of healthcare delivery. Inattention to professional ideologies stimulated conflict, power struggles, and mistrust in the JV relationship, compromising the desired engagement and collaboration between the parties. Trust issues prioritized individual identity salience and demonized the other party. When interactions attended to the ideology differences by respecting individual perspectives, identity threat decreased, allowing the emergence of collaborative interactions and team identity. While all JVs described initial conflicts, the higher-performing ventures overcame these issues by embracing inclusion, open-mindedness norms, and effective communication practices.

Higher-performing JVs built collaborative relationships on a foundation of trust. Lack of business training, perceived lack of transparency, and physician preconceptions of their managerial counterparts created pervasive mistrust in the early JV relationship. Leaders in higher-performing ventures overcame mistrust by engaging in frequent, open, and transparent communication. Effective communication practices built trust that allowed the emergence of collaborative partnerships. Early mistrust may be attributed to ideology differences that demonized the other party. Creating trust mitigated individual identity salience and allowed the emergence of a new team identity associated with the membership as JV partners.

Leaders in higher-performing JVs practiced inclusive leadership behaviors. Physician motivations to join the JV centered on efforts to gain more control over decisions that affect patient care. Conversely, managerial leaders often sought to control physician behavior and create alignment to organizational goals. The desire to control stimulated power struggles and emphasized individual identity salience. However, leaders who practiced inclusion during communication processes created shared understanding of the perspectives of others, stimulating efforts to find compromise and collaboration. By practicing inclusion, the higher-performing ventures facilitated the emergence of a team identity.

Overemphasis on financial outcomes stymied collaborative processes and hindered JV performance. Mistrust and poor communication predominated early JV relationships. Consequently, JV board meetings overemphasized the financial performance of the business. The financial focus aligns with the managerial ideology, creating an area of comfort and source of power to create alignment to organizational goals. Physicians reported unfamiliarity with the financial data, further emphasizing the communication challenges. Physicians reported the importance of the JV investment as a revenue stream, creating comfort with financial reporting associated with the physicians' personal financial investment in the business. However, the financial investment alone failed to engage physicians in collaborative processes, suggesting the financial results are important but inadequate to stimulate engagement and collaboration. Higher-performing ventures found ways to integrate clinical and financial outcomes, creating a collaborative environment that reflected a team identity.

This study sought to understand how leadership behaviors influenced IPC and collaboration between physician and manager board members in dialysis JVs. The results of the present study suggest that when leader behaviors attend to the social identities of the self and

others, individual identity salience decreases, allowing the emergence of a team identity. The use of effective communication processes overcame early mistrust and allowed the emergence of trusting and collaborative relationships that differentiated high- and low-performing ventures. Similarly, leaders in higher-performing ventures practiced inclusive behaviors that valued the perspectives of others. Finally, by integrating a focus on quality in JV communications and initiatives, collaboration and compromise improved in the higher-performing ventures. Communication, inclusion, and integrating quality into the JV dialogue overcame IPC by creating a team identity that improved collaboration and performance of the JVs.

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## **Appendix A: Interview Question Map**

### **Research Questions**

**Q1.** How do joint venture board members think about the influence of leadership behaviors on the social identities of themselves and other board members?

**Q2.** How do joint venture board members think about the influence of communication processes on the social identities of themselves and other board members?

**Q3.** How do joint venture board members think about the role of individual and team identity in the context of a mature joint venture relationship?

### **Domains**

**D1:** Managerialism – Primary to Q1 and Q2 with some interaction in Q3

- a) Financial outcomes
- b) Exclusion of physicians in decision-making/System control
- c) Emphasis on efficiency
- d) Governance and control – Organizational alignment
- e) Reliance on hierarchy
- f) Emphasis on financial incentives

**D2:** Medical Professionalism – Primary to Q1 and Q2 with some interaction in Q3

- a) Autonomy
- b) Patient-centric
- c) Quality
- d) Problem-solving
- e) Responsibility for the patient over the system
- f) Physician ethos
- g) Expertise

**D3:** Leader Behaviors – Primary to Q1 and Q3 with some interaction in Q2

- a) Control – Dominant/Directive/Transactional
  - Emphasis on financial incentives
  - Hierarchy
  - Organizational alignment
  - Information withholding
  - Extrinsic motivations
- b) Inclusive
  - Intrinsic motivations
  - Value individual differences
  - Open communication/Debate
  - Shared decision-making
  - Transparency
  - Intrinsic motivations

- c) Open-mindedness norms
  - Vision
  - Mission
  - Values
  - Organizational Needs
- d) Teamwork/Collaboration

**D4:** Identity team vs. individual – Primary interaction in Q3 with some interaction in Q1 and Q2

- a) Identity salience
- b) Outcome salience
- c) Organizational/Team commitment
- d) Inclusive environment
- e) Open-mindedness norms
- f) Communication/Debate
- g) Individual needs/perspectives

### Research Questions

Interview Question	Research Question(s)	Domain(s)
1. Could you tell me what influenced you to become a nephrologist/dialysis operations manager?	Q1, Q3	D1, D2
2. To what extent has this career choice been what you expected?	Q1, Q3	D1, D2
3. How would you describe the purpose of the joint venture?	Q1, Q3	D1, D2, D4
4. To what extent has your membership as a JV board member been what you expected?	Q3	D1, D2, D3, D4
5. Could you describe a typical interaction between yourself and your physician/manager partners in the joint venture?	Q1, Q2	D3, D4
6. How, if at all, has your relationship with your partner evolved over time?	Q1, Q2, Q3	D3, D4
7. What experience(s) have been the most rewarding or challenging since you joined the joint venture?	Q1, Q2, Q3	D1, D2, D4
8. Could you tell me about how an important decision was made or not made in the joint venture?	Q1, Q2	D3, D4
9. If you could change anything about decision-making processes with your partners, what would it be?	Q1, Q2, Q3	D1, D2, D3, D4

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10. Could you describe a time when your partner was open to or ignored one of your ideas?	Q2, Q3	D3, D4
11. How are the communication practices with your partner now compared to when you first started working together?	Q3	D3, D4
12. If you could change anything about how communication occurs with your partners, what would it be?	Q1, Q2, Q3	D3, D4
13. If there was one thing your joint venture partner could change about you, what do you think it would be?	Q1, Q2, Q3	D3, D4
14. If there was one thing you could change about your joint venture partner, what would it be?	Q1, Q2, Q3	D3, D4

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## **Appendix B: Interview Guide**

Date: \_\_\_\_\_

Participant: \_\_\_\_\_

Joint Venture: \_\_\_\_\_

Formation Date of JV: \_\_\_\_\_

Board Member Since: \_\_\_\_\_

Physician/Manager: \_\_\_\_\_

### **Introduction/Overview**

Before we start with the interview, I would like to review a few items about my research study. First and most importantly, thank you for agreeing to participate. As described in the consent form, your participation in this study is voluntary: you may feel free to withdraw from this study at any time without consequence. Your participation is also confidential. Complete anonymity cannot be guaranteed because a counterpart on the JV board will also participate. However, any specific information shared today will be deidentified to support your confidentiality. As a reminder, this interview is being recorded. Are we ok to continue?

The purpose of the research study is to explore how leadership behaviors influence collaboration or conflict in the dialysis joint venture setting. Collaboration and conflict run across a wide spectrum of experience. Today, I'm simply asking you to share your experiences. There are no right or wrong answers. Do you have any questions? OK, let's jump into the questions. I am going to take some notes to help with my recollection of this interview; please disregard me as I take these notes.

### **Interview Questions**

1. Could you tell me what influenced you to become a nephrologist/dialysis operations

manager?

2. To what extent has this career choice been what you expected?
3. How would you describe the purpose of the joint venture?
4. To what extent has your membership as a JV board member been what you expected?
5. Could you describe a typical interaction between yourself and your physician/manager partners in the joint venture?
6. How, if at all, has your relationship with your partner evolved over time?
7. What experience(s) have been the most rewarding or challenging since you joined the joint venture?
8. Could you tell me about how an important decision was made or not made in the joint venture?
9. If you could change anything about decision-making processes with your partners, what would it be?
10. Could you describe a time when your partner was open to or ignored one of your ideas?
11. How are the communication practices with your partner now compared to when you first started working together?
12. If you could change anything about how communication occurs with your partners, what would it be?
13. If there was one thing your joint venture partner could change about you, what do you think it would be?
14. If there was one thing you could change about your joint venture partner, what would it be?



### Appendix C: Email to Prospective Participants

Hello \_\_\_\_\_,

I am a doctoral candidate at Abilene Christian University, and I am in the process of recruiting participants for a research study. I am recruiting physicians and managers from dialysis joint venture management boards to participate in interviews to discuss how leadership behaviors influence collaboration or conflict in dialysis joint venture boards. I am emailing you to request that you consider participating in my research study.

Research supports that physician and manager collaboration and engagement are often confounded by differences in education, experiences, and perspectives that result in the prioritization of different aspects of healthcare delivery. It is important to understand how leader behaviors influence collaboration and conflict in this dialysis joint venture setting to maximize the desired clinical and financial outcomes of the venture.

I would appreciate the opportunity to spend about 45-60 minutes in a videoconference setting to discuss your experiences as a joint venture board member. Your participation is voluntary, and you may withdraw your consent at any time without consequence. Your participation and information will be kept confidential.

A consent form is attached for your review and signature. The consent form provides additional information about the study. Please let me know if you have any questions about the research study and if you are willing to participate. I will need the consent form signed by yourself and your physician/manager counterpart in the joint venture before proceeding with setting up interviews. If I don't hear from you in the next two days, I'll reach out to you via phone to follow up on any questions or concerns you may have.

Thank you for your consideration!

Jeff Stevey

Jeff Stevey  
XXXXXX@acu.edu  
XXXXXXXXXX@XXXXXXXX.com  
 XXX-XXX-XXXX

## **Appendix D: Telephone Transcript With Prospective Participants**

Hi \_\_\_\_\_,

Per my email on \_\_\_\_\_, I am a doctoral candidate at Abilene Christian University, and I am in the process of recruiting participants for a research study. I am recruiting physicians and managers from dialysis joint venture management boards to participate in interviews to discuss how leadership behaviors influence collaboration or conflict in dialysis joint venture boards. I am emailing you to request that you consider participating in my research study.

Your participation in this research study is voluntary and in no way will influence your ownership or participation in study site joint venture(s) nor your employment at the study site. You may refuse to participate, and you may withdraw your consent to participate at any time without fear of any reprisal.

I would appreciate the opportunity to spend about 45-60 minutes in a videoconference setting to discuss your experiences as a joint venture board member. Your feedback would help build an understanding of how leader behaviors influence collaboration and conflict in the dialysis joint venture setting to maximize the desired clinical and financial outcomes of the venture.

Would you be interested in participating?

### **Yes Response:**

Thank you for agreeing to participate. I'm going to resend to you a copy of the consent form for this research study. Could you sign and return this form in the next day or so? Once I have the consent form signed by your physician/manager counterpart, I'll reach out to you to schedule our interview. Thank you.

### **No Response:**

Thank you for your consideration. I appreciate your decision. This conversation and your decision not to participate will be kept confidential. Please don't hesitate to reach out to me if you have any concerns about this research study in the future. Have a great day.

## **Appendix E: Consent Form**

### **Introduction**

Healthcare delivery is a complex system that is often confounded by differences in education, experiences, and perspectives of different professions responsible for different functions within the system. Current healthcare reform initiatives that emphasize value-based medicine are predicated on the importance of collaboration and engagement between physicians and managers to improve both quality and financial outcomes. Unfortunately, differences in education, experiences, perspectives, and priorities often confound efforts to collaborate, resulting in a spectrum of tension to overt conflict. Dialysis joint ventures are intended to stimulate collaboration and engagement between physicians and managers at the joint venture board level. However, collaboration and engagement are often disrupted by professional differences, compromising the desired clinical and financial performance outcomes. It is imperative to understand how leader behaviors play a role in stimulating cooperation or conflict in the dialysis joint venture setting to maximize the desired outcomes.

You may have the opportunity to participate in a research study. Jeff Stevey, the investigator in this study, is a doctoral candidate at Abilene Christian University and an employee in the study site's Corporate Development department. This form provides important information about the purpose of the dissertation research. This form details important information about information collection, voluntary participation, confidentiality, storage and use of information, and the risks and benefits associated with your participation. Please read this form carefully and feel free to ask any questions you may have about the research study and your role as a participant in the study.

### **Purpose and Description**

The purpose of this study is to understand the influence of leadership behaviors on the manifestation of collaboration and conflict between physicians and managers in dialysis joint ventures. This research study will recruit physician and manager dyads to participate in individual interviews: a total of six dyads will be recruited. The interview will explore your experiences in dialysis joint ventures.

If you and your physician/manager counterpart both agree to participate, you will be asked to participate individually in a 45 to 60-minute videoconference interview. Videoconference interviews will utilize either Microsoft Teams or Zoom videoconference platforms. During the interview, you will be asked to share your experiences and perspectives on the interview protocol questions. You will also be invited to share any other information or feedback you deem relevant.

### **Risks and Benefits**

There are risks and benefits involved in your participation in this research study. The following list identifies foreseeable risks associated with your participation in this study:

1. Social risks – Participation may change your perception of the performance of the joint venture and the relationship with your fellow board member(s). While social risks may be serious in some settings, your risk in this context is considered minimal.
2. Confidentiality risk – The investigator will take steps to ensure the confidentiality and anonymity of participant feedback. However, because the research study recruits dyads from individual joint ventures, complete anonymity is not possible. Individual quotes will be used in the final report and may be identifiable by the counterpart in the venture. Otherwise, identities will be blinded, and participant information will not be released without consent. The risk of lost confidentiality is moderate and could have serious consequences.
3. Economic risk – There are no anticipated economic risks in this study.
4. Psychological risks – Participation may challenge perceptions of efficacy as a joint venture board member. Psychological risks may be serious, but the risk in this research study is considered minimal.
5. Legal risks – Participation may reveal situations that are violations of healthcare legal statutes or joint venture definitive documents. The legal risk may be serious, but the likelihood is considered rare.

There are corresponding benefits to participation in this research study. The following are a list of potential benefits, though there are no guarantees these benefits will be conferred to the participants.

1. Social benefits – Participation in this study may change your perception of leadership, collaboration, and teamwork in this context, benefiting the performance of the joint venture and enhancing the relationship with your joint venture board member counterpart.
2. Psychological benefits – Participation may enhance feelings of self-awareness and self-efficacy, improving confidence in one's leadership ability and ability to collaborate with others.

### **Privacy and Confidentiality**

Your privacy and confidentiality will be preserved to the extent allowable by law. Information on participation will be confined to the research team, inclusive of the investigator, the investigator's dissertation committee, and the Abilene Christian University Institutional Review Board, as applicable.

All information collected during your participation in the interview, inclusive of personal information, audio and video recordings, and any electronic communications will be stored on a password-protected cloud drive. Transcription of participant interviews will utilize the NVivo 11 cloud-based transcription service with password protection. Any hard copy information will be stored in a locked file. The information collected for this research study will not be used for any

future research purposes without your informed consent. All participant information will be destroyed or deleted after five years.

### **Voluntary Participation**

Your participation in this research study is voluntary and in no way will influence your ownership or participation in the study site joint venture(s) nor your employment at the study site. You may refuse to participate, and you may withdraw your consent to participate at any time without fear of any reprisal.

### **Consent to Participate**

I volunteer and consent to participate in the research study conducted by Jeff Stevey, a doctoral candidate at Abilene Christian University. I understand that the research study is designed to collect information about leadership behaviors, collaboration, and conflict in the dialysis joint venture setting. I understand that I will be one of 12 participants constituting the six dyads recruited for this research study.

1. My participation in this study is voluntary. I understand I will not be paid to participate. I may withdraw my consent to participate at any time without consequence. My decision to decline to participate or withdraw of consent will not be communicated to anyone in my joint venture or at the study site.
2. I understand that most interviewees will find the discussion interesting and thought-provoking. However, if I feel uncomfortable, I have the right to decline to answer a question or to end the interview.
3. I understand the risks and benefits of this research, as defined in this document. I understand that there may be unanticipated risks associated with this research and that I will be notified of any risks are identified while conducting the research.
4. I understand that I may be removed from the research study if my participation is no longer necessary or if the investigator believes that continued participation is no longer in my best interest.
5. Participation in the study will involve a 45 to a 60-minute interview between myself and the investigator, Jeff Stevey. The interview will be recorded either on the videoconference platform or with a handheld recording device. If I decide not to agree to an audio recording, I will not be able to participate in the study.
6. I understand that my participation will be kept confidential to the extent permissible by law. Information regarding my participation or use of information collected in conjunction with this research study will only be released with my informed consent.
7. Only the investigator, Jeff Stevey, and I will be present during the interview. Only the investigator, Jeff Stevey, will have access to the raw information. Deidentified transcripts

and other source material may be provided to the investigator's dissertation committee if necessary. Deidentified quotations may be used in the final research report. No information about my participation will be shared with my joint venture partners nor the study site

8. I understand that this research study has been reviewed and approved by the Abilene Christian University Institutional Review Board (IRB). For research problems or questions regarding subjects or participation, the IRB may be contacted through \_\_\_\_\_.
9. I have read and understood the explanation of the research study provided to me. I have had the opportunity to have all of my questions answered to my satisfaction, and I voluntarily agree to participate in this study.
10. I have been given a copy of this consent form for my records.

\_\_\_\_\_  
Printed Name of Participant

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Investigator

\_\_\_\_\_  
Signature of Investigator

\_\_\_\_\_  
Date

### Contact Information

If you have any questions about this research study before or after signing this consent form, please feel free to contact the investigator, Jeff Stevey at XXXXXXX@acu.edu or at Jeffrey.T.Stevey@XXXXXXX.com, or at XXX-XXX-XXXX. If you prefer to speak to someone other than the investigator, please contact the investigator's dissertation committee chair, Cecilia Hegamin-Younger, at XXXXXXX@acu.edu or XXX-XXX-XXXX. If you have any questions regarding IRB approval or human research at Abilene Christian University, please contact \_\_\_\_\_ at \_\_\_\_\_ or \_\_\_\_\_.

### Appendix F: Sample Exploratory Comments and Thematic Analysis

Exploratory Comments: Descriptive comments in regular text, linguistic comments in italics, and interpretative comments underlined.

#### MD Exploratory Comments and Thematic Analysis

Thematic Analysis		Time	Comment	Exploratory Comments
Early: Can't trust FMC Early: Mistrust created conflict and the desire to win at all costs  Consistency a critical success factor to build trust  Compromise a critical success factor to build trust	MD	35:05	So, my first impression was initially was that The company will never have your back. You've got to look. Look out for yourself. But as I've grown into my position, I've realized there's obviously two sides to every story. Their side and our group's side and the truth. And I think I've brought about a reasonable balance and that balance is, I think we were at fault. Basically, we've been a little bit too strict on negotiations when it came to The company coming to the table with this and trying to find what is reasonable, what is not reasonable. Because it was, you know, like XXXXX or XXXXX like, and it could be just you. I don't know. But before that, it seemed like it took 10 years to build XXXXX. XXXXX took forever. And finally, I was like, I want to take the head position and just go with it.	Early: The early relationship with FMC was fraught with trust issues. Perception that FMC will not treat partners fairly. <u>Expectation of fairness in relationships</u> Different perspectives to any story Physician group responded by trying to win in all negotiations. This desire to win created a lot of delays and struggles with the FMC relationship. <i>We were at fault</i> FMC acted to try to find reasonable compromise <u>Consistency and efforts to find compromise were critical success factors to building trust and the relationship</u>
	JS	36:25	So you said that initially you felt like The company didn't have your back. What prompted that sensation?	
MD social identity created institutionalized learning and mistrust of outsiders.	MD	36:42	That was just learning from the senior leaders of what goes on.	Early mistrust in FMC was institutionalized learning.
	JS	36:50	The senior leaders of your group?	

<p>Early: institutionalized mistrust from senior partners</p> <p>Lack of transparency creates trust issues</p> <p>Individual Identity: Integrity and trust</p> <p>Importance of relationships</p>	MD	36:51	<p>That's right. That's right. Understanding the negotiation process when it came to lease agreements, supply agreements and things like that. So, my business acumen, obviously, was nil coming out of my fellowship. And then as I've learned the process and understanding the process of what it entails and when I get a 40-page lease, that's, that's a little, I think, over the top. You know, and I think it's used to cover their bases, which I think at some point, you know, is a handshake ok? Or is it so bad that we require a 40-page lease agreement? And I think that's the concern also is like when you say you've gotta watch out because 40 pages is a lot. It's going to go get down to the nitty gritty of the details.</p>	<p>Medical school and the fellowship failed to prepare him for the business aspect of medicine. Had to develop business acumen.</p> <p><u>Individual identity preferences</u></p> <p><u>relationships based on integrity and trust.</u></p> <p>Why are legal documents so long?</p> <p><i>You've gotta watch out</i></p> <p><i>Is a handshake ok?</i></p> <p><u>Are they trying to get one over on me?</u></p> <p><u>Can't we just trust one another?</u></p>
	JS	38:13	<p>What was it that was the turning point, do you think? You had this sort of healthy skepticism coming in. What was it that helped develop some relationship or trust that that has led you to where you are now?</p>	
<p>Relationship cycle of communication, trust, and relationships</p> <p>Consistency a critical success factor to build trust</p> <p>Communication a critical success factor to build trust</p> <p>Trust creates resilience in relationships</p>	MD	38:30	<p>Experience and relationships with people who I trust in. People who actually give me an answer when I ask a question, such as RVP, yourself, you know, and other partners in the JV. And understanding that there is some consistency in what they do. The company leadership, like understanding the reason behind a protocol or a logarithm when it comes down. And it's not simply, look, we're just trying to make your lives difficult, or we're trying to say that we're going to try to pinch a dime here and things of that sort. And we know there's always some, I guess, we won't always understand what comes down and why it came down, like given the extra pay for COVID, I think was great, but then they just stopped it, for the nurses. And I thought that was really</p>	<p>The relationship cycle: Experiences with consistent open communication built trust that allowed relationships to flourish.</p> <p><u>Building relationships is important</u></p> <p>Consistency and open communication coming from multiple sources within FMC decreased his initial misgivings with the organization.</p> <p><u>Consistency with open communication are the foundation of trusting relationships.</u></p> <p>Trusting relationships provides resilience when the relationship is</p>



Sees the relationship with FMC as a partnership or team			tough for some of those nurses who were working overtime for it, to keep this company open and to do what the company asked of them. And yet that, that additional bonus was taken back. And I know it's back to the bottom dollar and cutting costs and increasing profit. But at the same time, I think it goes back to, you know, these are families. These are people who are exposing themselves and they're trying to meet a goal for your organization.	strained or if information isn't shared proactively.  Desire to protect the FMC staff. <u>The staff are part of his team.</u>
	JS	40:08	It sounds like you have a certain expectation of fairness to the staff there?	
Sees the relationship with FMC as a partnership or team  Importance of relationships Individual identity preference for fair treatment	MD	40:13	Definitely, because these, I think, are my soldiers, my pawns, and I think they are pawns. I mean, they are. And, and I try to be as transparent as I possibly can and at times to think what I consider is reasonable. As a leader to not allow them to be taken advantage of.	<i>My soldiers, my pawns...</i> Desire to protect the FMC staff. <u>The staff are part of his team.</u> FMC is a big organization and the leadership don't always consider the impact to the little guy on the front-line. Sees himself as a leader that needs to protect his team.
	JS	48:49	Within your practice, you make a decision first and then there's a common face to The company. What if the decision isn't necessarily in line with what the RVP and The company are trying to do? How do you work through those types of issues?	
Past: Kick conflict down the road until it reaches a boiling point.  Win-Lose approach to conflict resolution is dysfunctional	MD	49:11	We kick it down the road. We do. I mean, we do. I think that's the. We wait and find out how, to what degree are they willing to budge on it. And, The company does the same thing with us. We'll delay things and delay things and delay things until it boils to a boiling point and something has to be made or done. And we try to work out the logistics. And that's I think	Have experienced intractable conflict that has resulted in stalemates in the negotiations. Becomes a waiting game to see who blinks first.  <i>Past: Conflict...kick it down the road</i> <i>Past: Delay to a boiling point</i>

<p>Conflict resolution through compromise builds/preserves relationships</p> <p>Group needed to change: MD emergent leadership</p> <p>Directive leadership threatens the MD ideology</p> <p>Directive leadership creates mistrust/tension</p>		<p>that's where every leader is good at saying nothing's black and white. Let's try to meet in the middle somewhere. Whether it, I give a little here, you take a little there. There's some compromise in all that. And I think that's what's changed also in the group. It was it was very, very black and white. Previously, it's just like, no, we're not doing this. And The company would be like, yes, we have to do this. Just like Schedulewise. Schedulewise was quite difficult for us. We saw empty chairs. This is here to stay. I'm sorry. And we would video tape and show all these empty chairs while we were rounding and we were like, how is this efficient? Just simply how. And, you know, and we pushed and pushed and pushed. The company said no, this is staying and we're opening third shifts and things like that just to make ends meet. But we understood it came from the top and there was supposedly, you know, all this the studies that show it was an improvement or it would save time. And so it's just kind of standard now. But change is sometimes difficult. But I'd, I do not agree with Schedulewise. I just tell you upfront.</p>	<p>In more recent times, both parties have learned to create compromise. Change in the group leadership focused on learning to compromise rather than engage in trench warfare.</p> <p><u>Compromise is far more effective than fighting out win-lose outcomes. Compromise demonstrates value to the relationship.</u></p> <p>Corporate decisions/directives don't always make sense. Create tension.</p> <p><u>Objects to being told what to do.</u> <u>MD Ideology: Control</u></p>
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### RVP Exploratory Comments and Thematic Analysis

Thematic Analysis		Time	Comment	Exploratory Comments
	JS	17:27	What do you figure is driving that (physician anxiety)? Do you have any thoughts?	
Absence of information creates anxiety mistrust	RVP	17:32	Well, I think it's different reasons. I think it's you know, you get such a large company. And I mean, if you're us, if you're if you're new to the world and you don't have that relationship in another way, like the medical directorship or some other affiliation, you go with this company. It's a, you know, usually big company or, you know, you hear things and they ask you to sign these documents. And then I guess there's a level of anxiety to begin with. But, you know, so you've got that point of view. You've got like the XXXXX, guys, it was really you know, it wasn't their decision to join us. You know, because they were acquired in the XXXXX transaction, it wasn't you know, they had their relationship with XXXXX that started from day one. I mean, they actually created the joint venture with them. And then suddenly here comes even bigger people, bigger company. And it was immediate, there was no, it was immediate distrust. And, you know, a level of, um, it wasn't good. I'm trying to think of the appropriate word, but it was it was. There were some heated arguments. There were demands. There were threats. There were. And from our point of view, we didn't understand why. We had never done anything. I mean, it was sort of like you, (didn't finish thought). It's sort of like when I came to the region, you know, stepping back, I came up here after the XXXXX acquisition occurred in April. I came in July to a region office that was full of people from XXXXX, except they all left, except like two people. Well, why did they	Initial anxieties from the size of the company, legal documents, and reputation created instant anxiety and mistrust  <u>With the lack of information, one assumes or believes the worst.</u>  Wasn't their decision to join. The JV with FMC was forced on them through the acquisition FMC forced a lot of initiatives on the physicians, creating heated arguments, demands, threats from partners. Couldn't understand their frustration. <i>Didn't understand why. We had never done anything.</i>  FMC bad reputation based on misinformation  Preconceived notions of FMC <i>Immediate agitation and confrontation</i> Immediate mistrust <u>Important to identify and overcome trust issues early in a relationship.</u>
Company reputation and preconceived notions created a barrier to relationship development				
Anxiety and mistrust stimulate conflict				
Leaders build trust				

			<p>leave? Well, we heard about it. What did you hear?</p> <p>Well, it's you count Band-Aids and you're awful people and all of this kind of stuff. Well yeah, we count Band-Aids, but doesn't make us terrible people, you know. So, there was a lot of misinformation on a lot of what seemed to have been, you know, preconceived notions of what we were doing. And it was immediate agitation and confrontation. And going forward, you know, so there is that level of mistrust and I think there's levels of mistrust.</p>	<p><u>Leaders build trust</u></p>
<p>New JVs have anxiety and mistrust</p> <p>Relationship cycle: need to build trust to build relationships</p>	RVP	20:26	<p>I think that's that could have been, you know, they probably had that same level of mistrust when they (Tupelo) started the joint venture with renal care group. I think it's just hereditary and it's part of it. And I think any de novo joint venture with two new partners together. There's going to be that level of anxiety. But it's somebody has to be the grown up in relationship and make it work because it. It needs to work on behalf of the patient.</p>	<p>Anxiety and mistrust are not necessarily unique to acquired JVs. Experience with similar anxieties in other JVs.</p> <p><i>Someone has to be the grown up and make it work. It needs to work on behalf of the patient.</i></p> <p><u>Patients have to come first</u></p> <p><u>Leaders build trust and through trust relationships can develop</u></p>
	JS	20:58	<p>So, I mean, obviously you've had a chance to work with the XXXXX JV now for a long period of time. How would you characterize that level of trust today?</p>	
<p>MD emergent leadership changed practice engagement</p> <p>Shift in the social identity of the physician group: changing norms</p> <p>Partner desire for collaboration and compromise</p>	RVP	21:16	<p>It has shifted between what I call the older generation in the partnership, and that's with the doctors themselves, with the younger group and in the younger group have gone in with a different attitude. We want to be different than what's occurred before and create a partnership and make this work. So I think that I think that dynamics of the partnership have changed, you know, between who the who the players are, you know, who's running the portion of the joint venture from the doctors side, you know, and that's and that's flipped.</p>	<p>Older versus newer doctors have different perspectives. Younger doctors want a different relationship. Desire to collaborate and partner. Dynamics of partnership have changed based on physician leadership on their side.</p> <p><u>Partners need a leader too. FMC can't do it alone.</u></p> <p><u>Mutual engagement in the partnership</u></p>

	JS	28:28	To what extent do you think that your participation on this J.V. board with XXXXX has been what you expected or what you hoped that it would be?	
Hostility and conflict strain partnership Consistency in leadership a critical success factor Compromise in conflict resolution a critical success factor Leaders compromise	RVP	28:54	It was certainly not at first, OK, because it was combative, you know, in anything that you wanted was negative. I mean, it was it was not good at first. I mean, it really was not. And, you know, I think now it's I don't dread them like I used to. Oh, it used to be. You expect. You just knew it was going to be war when you went in there and there was nothing that you did or didn't do. It was just we're going to throw this at you and see if it sticks. But I think, you know, for my part, I hope it's been a level of consistency. You know, I believe if you're in this partnership, that if you're both a little bit unhappy here, everything is OK. I'm saying that, you know, if you both don't get everything you want, then you've got a good partnership.	Early: The relationship with this group was combative, creating a lot of strain in the relationship. <i>Knew it was going to be war</i> Consistency and compromise changed relationship <u>Leaders act with consistency</u> <u>Leaders find ways to compromise</u> Can't always get what you want
Leaders act consistently Leaders compromise Leaders collaborate: use of inclusive leadership Conflict resolution using compromise or seeking win-win outcomes	RVP	30:25	But I think it's from my point of view, it's been just a level of consistency. You know, it's not always knows no. Not always yes. But we'll get through it. We'll solve the problems. If something happens. We work through that. And we come to a resolution. And that's the approach. And I know that's the approach I've really taken with the younger guys. You know, it's just I'm here. We're all in this together. We can both be very successful. But there's limits to what I can do.	<u>Consistency as the foundation for successful conflict resolution.</u> <i>Problems come up, work through them and solve the issue.</i> Positive orientation to conflict resolution where the partners work collaboratively to solve problems <i>We're in this together. We can both be very successful.</i> <u>Leaders find ways to compromise</u> <u>Leaders collaborate</u>

### Appendix G: Building Subordinate Themes

Subordinate Theme	Emergent Themes	Quote
Building relationships through trust	<p>Communication builds trusts</p> <p>Leader inclusivity builds trust</p> <p>Leader consistency builds trust</p> <p>Leaders act with integrity</p> <p>Trust builds relationships</p> <p>Trust creates relationship resiliency</p>	<p>He's very truthful when it comes to really hard questions. He, he's very forward with it...And that's what I think most partners want. (25:20)</p> <p>I think people in your position and The company leadership, you know, they all have something in common. And that commonality is leadership, its integrity, its honesty, its, it's, it's addressing the concerns. (29:36)</p> <p>Consistency I think is the key, in that consistency is important when it comes to all the joint ventures. (32:17)</p> <p>That truth gets to the point in a much quicker response in negotiation than trying to go around everything. (33:09)</p> <p>Experience and relationships with people who I trust in. People who actually give me an answer when I ask a question...and understanding that there is some consistency in what they do. (38:30)</p> <p>He shot me straight. He was like, I you know, I looked at that e-mail two or three times and I was like, that's so simple, yet</p>

		so effective because he didn't try to make any excuses. (55:46)
Compromise enhances team identity	Trust facilitates compromise Desire to build consensus Leaders find alternative solutions Leaders compromise	<p>We've been a little bit too strict on negotiations when it came to The company coming to the table with this and trying to find what is reasonable, what is not reasonable. (35:05)</p> <p>Let's try to meet in the middle somewhere. Whether it, I give a little here, you take a little there. There's some compromise in all that. And I think that's what's changed also in the group. It was it was very, very black and white. Previously, it's just like, no, we're not doing this. And The company would be like, yes, we have to do this. (49:11)</p> <p>We work through things and I think that's really important to move forward. (57:25)</p> <p>I think you all have been quite upfront with me and I take it back and try to work with the group and come to an understanding of some compromise. (1:01:26)</p> <p>And that's what I've tried to make the group understand that we don't have to be competitive. Let's collaborate because The company wants us to collaborate and there's enough for everybody. (1:04:18)</p>
Directive leadership stifles engagement	Corporate decisions don't make sense Leaders have lost touch with front line	I've learned how leaders work and how they influence, whether in, in how they go

	<p>Ultimatums don't work</p> <p>Explain why</p> <p>Desire for a voice in decisions</p>	<p>about when there is an issue. As far as constructive criticism or how they address their concerns in a way that is not always ultimatums. (21:06)</p> <p>What's going on and he's taking orders from way up and it's very difficult in their position to, I guess, see what the vision is and try to relay that to us. (23:30)</p> <p>Do as you're told and not as I do kind of stuff and I think that that frustrated the group also. (58:56)</p>
Mistrust stifles engagement (early)	<p>Mistrust stimulates win-lose mentality</p> <p>Mistrust creates trench warfare</p> <p>Institutionalized mistrust</p>	<p>So, my first impression was initially was that the company will never have your back. You've got to look. Look out for yourself. (35:05)</p> <p>That was just learning from the senior leaders of what goes on. (36:42)</p> <p>We kick it down the road. We do. I mean, we do. I think that's the. We wait and find out how, to what degree are they willing to budge on it. And, The company does the same thing with us. We'll delay things and delay things and delay things until it boils to a boiling point and something has to be made or done. (49:11)</p> <p>And I use their views to kind of a compromise and find understanding of</p>



		what we're, what they are, what's considered reasonable for them. (51:32)
Inclusive leadership stimulates engagement	<p>Establish shared vision</p> <p>Leader inclusion</p> <p>Leader open-mindedness</p> <p>Transparent communication practices</p>	<p>I think they acknowledged the concerns that we acknowledge or addressed to them. And they understand and are quite open to any concerns that we have, to find a solution to it. (16:56)</p> <p>XXXXX doesn't try to tell everybody what to do. (25:20)</p> <p>I've always tried to be honest with XXXXX and try to get, if he asked me a question, I'll try to get it done. And if I ask him a question, he hops on it pretty quickly and just tries to explain his position and as we do. (26:07)</p> <p>I think transparency is really important to me as a partner, and understanding that the views of what you're doing, because I understand. I mean, I think most people in any partnership understands that there's good communication and a, an explanation of what needs to be done and why it needs to be done. (57:42)</p> <p>I think if simply, and we may not like it, but being up front and transparent, I think says a lot in a partnership. And I think that's most important. (1:00:23)</p>
Miscommunication threatens relationship	<p>Lacking information, assume the worst</p> <p>Information withholding is unfair</p>	There's always some, some, hesitancy in regard to this partnership is like, with the

	<p>Leaders own challenging conversations          Be transparent, even if I won't like it          Explain what/why</p>	<p>transparency that goes along with JVs.          Just like, you know, the product side, not really knowing what's going on. And we understand that because it's business. And I think that's what, what frustrates a lot of the partners in regard to the joint venture. (31:08)</p> <p>I think a lot of joint venture partners had is, why can't we buy these machines, why are we leasing when we have the option to buy and things of that sort. (31:08)</p> <p>But going around and not addressing the question or not quite understand and not giving us a reason on what's going on, I think it infuriates the group or all your joint venture partners. (1:00:23)</p>
Balancing finance and quality in board meetings	<p>Get to quality through financials          Difficult to differentiate quality and money          Meetings overemphasize financials          Valuable learning experience</p>	<p>I think they're very worthwhile. I think looking at the degree where each variable affects the JV down to the bottom dollar is very important. (44:20)</p> <p>It's mainly financials like how we can improve on the overall subsets of you know, the financials, it is very financially oriented when it comes to those quarterly meetings. like how can we improve on missed treatments? Where can we save and cut costs? So it's very, very operationally, operational metric oriented. With quality, of course. (45:50)</p>

Placing the patient first	Desire to improve patient suffering Struggles with patient suffering/loss MD Ideology: Helping profession MD Ideology: Patient first	It's tough no matter what you do when somebody is suffering. I'll put it that way. It's never easy. (8:17)  Just understanding that I can improve on their lifestyle and understand that I can make a change, especially for those that are suffering. Almost out, what I consider a terminal illness and to improve on their lifestyle as much as they can. (9:32)
Difficult personalities threaten partnership	Win-lose approach is dysfunctional Internal practice conflict Unfair treatment by partners MD greed	Because there's always a degree of greed when it comes to any topic that we do in medicine. (10:15)  I am one voice in a large partnership...and I think that's where there's always conflict within a group. (12:10)  There's always conflict in the group. (18:18)
The physician elite identity	Autonomy Control Expertise Problem-solving	I chose the nephrology track because I thought it was just so complex and so amazing that, that nobody understood what a nephrologist was talking about on rounds when they were talking. And that's part of the mythology. (3:37)  The kidney had a medulla and cortex too, just like the brain. And so that the complexity in that in itself was what I really enjoy...just the critical thinking in regard to electrolytes and physiology. (4:28)

		<p>And when it comes to that in a group, you have a voice, but you also have the autonomy of what you do with your own patients. And so if I don't, if I disagree with the group, I still do what I think I need to do for that patient. (13:24)</p>
The individual identity	<p>Excellence Fairness/Equity Integrity Work ethic Relationships are important</p>	<p>...let's just keep business where it is, but let's just have a discussion and just, just have an enjoyable night. And I think that goes a long way when it comes to a partnership. (28:10)</p> <p>I think at some point, you know, is a handshake ok? (36:51)</p> <p>As a leader to not allow them to be taken advantage of. (40:48)</p> <p>...but they always gave me the grit and the integrity to, to continue to work hard, not be average. (41:25)</p> <p>And then investing yourself and spending the extra time, no matter how hard it is. (41:25)</p>

## **Appendix H: Joint Venture Cases**

### **JV1: MD1 and MGR1**

JV1 is ranked first in the operations group. JV1 was formed in 2016: MD1 is an original JV board member, and MGR1 joined the board in early 2019. JV1 consists of two clinics, one outpatient dialysis clinic, and one home dialysis program. The locations of these clinics are in a major metropolitan area in an affluent part of the city. MD1 has practiced nephrology for nine years. There are three other physician investors in this JV. MGR1 is a DO and a registered nurse (RN) with over 20 years of experience in the Company and five years of experience as a DO. As a manager and a nurse, MGR1 has a hybrid background that includes both the control and care orientation in the Care-Cure-Control-Community Model, see Figure 1 (Glouberman & Mintzberg, 2001). I worked with MD1 on the formation of this JV but did not have previous experiences with MGR1.

MD1 was quite animated and demonstrated a high degree of candor in the description of his experiences with this JV. While overall, he and his partners are genuinely pleased about the performance of the venture, there were some significant challenges with some of the senior FMC leaders that persist to this day, despite the fact the primary offender is no longer with the organization. Overall, they are very pleased with MGR1, the clinic manager of the home program, and ancillary staff. Conversely, MD1 expressed negative opinions of the other JV board members. MD1 views the success of the venture as not a derivative of the relationship at the board level but rather with the staff at the operational level of clinic.

As an RN and DO, MGR1 has been in leadership roles for nearly her entire career. Internally, Shonta is very focused on team development and ensuring that processes are followed but demonstrated a strong focus on caring for patients: this is suggestive of a hybrid ideology. In

her interactions with the JV, she remained largely focused on the financials and alignment to Company goals. MGR1 has a long relationship with MD1 and expressed an emphasis on using open communication to build a trusting relationship.

#### **JV2: MD2 and MGR2**

JV2 is ranked fourth in the operations group. The JV was formed in 2016: MD2 and MGR2 are founding members of the JV board. This JV has one outpatient dialysis clinic and is in a major metropolitan area. MD2 has practiced nephrology for 15 years. There are 13 other physicians involved in this JV. MGR2 has been in the nephrology industry for 23 years and with the Company for eight years as a regional vice president of operations. MGR2 currently serves on the board of directors for 10 JVs in his region. MGR2 comes from a managerial background and does not have any direct clinical care experience. I have worked very closely with MGR2 on the formation of multiple JVs in his region, and we worked together in my prior roles in the Company. I also have a prior relationship with MD2 from previous roles and from the formation of JV2.

MD2 was engaged and overwhelmingly positive and upbeat, even when addressing situations that were challenging early in the JV. MD2 prioritizes patient care but demonstrated interest in the dialysis business. The JV experienced some initial missteps and challenges that have been overcome. Prior to the formation of the JV, the relationship with FMC was strained by interactions that led the investors to mistrust FMC. Repeatedly, MD2 made reference to needing more information before forming the venture and early in the JV. Only after the physicians made it clear what their expectations were and FMC managers met these needs the relationship shifted and communication and engagement patterns changed. At present, MD2 represented the relationship is very good and the joint venture meetings are productive, with good attendance by

many of the physician investors. The JV 2 board meetings merged the JV board meeting with medical director quality meetings to create an opportunity to discuss both financial and quality outcomes, a unique format in this operations group. MD2 indicated involvement from others outside the JV board, such as the business development team, that proved critical to the ongoing success of the JV.

MGR2 indicated that early in the JV, the physicians lacked understanding of the financials, creating a sense of anxiety and mistrust. This led to an emphasis on the financials as the managers sought to educate the physicians. MGR2 sees communication and education as the key to overcoming this mistrust. MGR2 expressed the desire for the MDs to simply acknowledge that FMC knows what we're doing and to let us do what needs to be done in the business, indicative of a managerial ideology of control and focus on processes and efficiencies. MGR2 believes that physician behavior is motivated by focusing on financials. MGR2 indicated physicians only focus on quality when it affects financials and that he thinks MDs get kickbacks from "buddies" when they refer to them. MGR2 also stipulated that JVs board meetings focus on financials and quality is an afterthought. MGR2 expressed a desire for more control and focused on processes. When MDs don't do what he wants, he would prefer to have more control over their behavior.

### **JV3: MD3 and MGR3**

JV3 is ranked fifth in the operations group. This JV was acquired through an acquisition in 2006. MD3 joined the board in 2012, and MGR3 became a board member after the acquisition in 2006. JV3 is the third-largest JV in the operations group with 10 outpatient dialysis clinics and two home dialysis programs. MD3 has practiced nephrology for 13 years. There are seven other nephrologists involved in this JV. MGR3 is a regional vice president of operations who has been

in this role for 14 years. MGR3 comes from a managerial background and does not have any direct clinical care experience. I have worked very closely with both MD3 and MGR3 during the past five years and have good personal and business relationships with both parties. JV3 was

MD3 noted some historical tensions between the physician group and later himself and FMC; he noted the relationship is much better today. A big part of that shift resulted not from a change of behaviors by the Company, but rather a change initiated by some of the younger physicians in the group, himself included. Historic conflicts embodied a sense of trench warfare with significant losses experienced by both partners. Today, there is a stronger sense of partnership and collaboration that results in more accommodation and win-win scenarios. Dr. MGR3 views the primary individuals he works with at the Company as embodying a high degree of integrity, consistency, and a focus on collaboration and compromise. MD3 indicated that directives from executive leadership levels that occur outside the control of those he interacts with most frequently stimulate anger and frustration by the physician partners. The local leadership team, including MGR3, is held in high regard, with interactions marked with trust that was born out of honesty, transparency, and regular communication.

MGR3 had a calm and humble demeanor throughout the interview. MGR3 places value on building trusting relationships and enjoys helping others become successful in their roles. MGR3 expressed interest in collaboration and partnership. Establishing trust is seen as the first step in relationship development. MGR3 suggested trust is formed through open and proactive communication and through trying to find compromise during conflict, rather than creating win-lose scenarios. MGR3 stated the early relationship with JV3 was marked with mistrust and that tensions persisted for a long time. MGR3 echoed MD3's comments concerning change that had to occur in the physician practice that resulted in the opportunity to improve the relationship with



the Company and the partnership in JV3. MGR3 stated that the relationship is far more trusting and collaborative today. MGR3 indicated that the JV board meetings equally balance quality and financials. The Company used to take a more directive approach but is now more collaborative.

#### **JV4: MD4 and MGR4**

JV4 is ranked 19<sup>th</sup> in the operations group. JV4 was formed in 2009, and both MD4 and MGR4 were founding members of the board of directors. JV4 operates four outpatient dialysis clinics in a small city with poor socioeconomic status, presumably influencing the financial and clinical outcomes of this JV. MD4 has practiced nephrology for 35 years. There are three other physician members in this JV. MGR4 is an RN and a regional vice-president of operations. MGR4 has worked in the dialysis industry for 38 years and has been in her regional vice-president role for 15 years. As a manager and a nurse, MGR4 has a hybrid background that includes both the control and care orientation in the Care-Cure-Control-Community Model, see Figure 1 (Glouberman & Mintzberg, 2001). I have worked closely with both MD4 and MGR4 in my tenure in the Company.

MD4 was genuinely interested in trying to be helpful and share his experiences. Because of the long history as a nephrologist and as a JV partner, he was able to share how his perspective shifted over time and how the relationship has grown in this venture. While he was initially skeptical of big companies, he found that the people he works with at FMC are genuinely interested in trying to do the right things for patients. MD4 believes that physicians should have ownership in healthcare delivery because it creates an opportunity to ensure the business of healthcare is balanced with the importance of focusing on patient quality. MD4 also wants to make sure that he can protect the patient from the conflicting priorities of big business. MD4 is committed to providing the best patient care, even if that means personal and financial

sacrifices on his part. MD4 expressed that he assumed a leadership role within his group when interfacing with Company personnel. While MD4 expressed that he trusts MGR4 and the other members of the JV board, the other physician owners have less experience and trust in these individuals, despite the long tenure as JV partners.

MGR4 has a long tenure in dialysis and as regional vice president. MGR4 comes across as empathetic and stated that relationships are extremely important to her. As an RN by training, MGR4 keeps the patient at the forefront. While MGR4 is responsible for the financials, in her view, if you take good care of the patient, the financials will follow. MGR4 has a long relationship with the physician partners. While perhaps there were some initial misgivings with the physician partners, MGR4 feels she established trust by engaging in frequent open communication. MGR4 was somewhat mournful when she spoke about how little the physicians acknowledged the work and compromises that were done on their behalf. MGR4 also expressed a desire to have the physicians engage more in the business. Finding compromise was a central theme in how MGR4 deals with conflict. Overall, MGR4 indicated a good working relationship with the physician partners.

#### **JV5: MD5 and MGR5**

JV5 is ranked 23<sup>rd</sup> in the operations group. The JV was formed in 2008 with another dialysis provider. This JV is in a small city with a lower socioeconomic status. The venture was acquired through an acquisition in 2012. MD5 was a founding member of the board, while Al joined the board in 2012. MD5 has been a nephrologist for 13 years. There is one other physician involved in the venture. Al is a group vice president of operations, the senior-most position that serves as a board member in this operations group. Al currently occupies a board position in 16 JVs. Al has been with the company for more than 30 years and in the current position for 15

years. AI comes from a managerial background and does not have any direct clinical care experience. AI does have family members who are physicians, giving him insight into the challenges and sacrifices associated with practicing medicine. MGR2, from JV2 is also a board member in this JV and proactively shared comments regarding this venture during our interview. I have worked very closely with AI in a variety of positions during my tenure in the company and have had some limited interactions with MD5.

MD5 has experience as a JV partner with two dialysis providers, with markedly different experiences. MD5 expressed a strong preference for teamwork and partnership, behaviors that were absent with the original dialysis organization. However, his impression of open communication, access to leaders, and a venue to have his concerns answered with the current dialysis provider created a high degree of trust. In fact, he conceded that he probably trusted the company too much, leading to some inspection issues and the implementation of a monitor in the clinic that created a significant financial strain on the business. As a result, MD5 took more control of the business. Relationships are extremely important to MD5. He repeatedly expressed that he valued the JV relationship and felt he was treated fairly as a partner. MD5 described communication as reports, rather than open dialogue. While finances are important to MD5, the patient always comes first.

AI conceded early in the interview that he had limited experience with JV5. Rather, his stories and examples typically occurred in other JVs. AI showed a great deal of empathy for the challenges physicians face in their professional careers. His stories reflected behaviors that sought to collaborate and partner to create win-win outcomes. AI places value on integrity and building trust with physician partners: trust acts as the cornerstone of collaboration. Jeff acknowledged that self-centered behaviors and rigidly following company guidance and

performance expectations create barriers to forming trusting relationships: the physicians know when their needs are not being represented. AI described an inclusive approach to his leadership style, emphasizing the importance of the individuality of physicians and the unique skills and experiences physicians can bring to the relationship. AI's early experiences and mentors established a balance between finances and quality that influences how he interacts with physician partners.

#### **JV6: MD6 and MGR6**

The partners in JV6 are involved in the 24<sup>th</sup> and 26<sup>th</sup> ranked JVs in the operations group. The JVs were formed in 2017 and 2014 respectively. Each JV has one dialysis clinic; both are in a metropolitan area with lower socioeconomic status. MD6 is a founding member of both JVs; each has two other physician partners. MD6 has been a nephrologist for 22 years. MGR6 is a director of operations and has six years of experience in the role. MGR6 comes from a managerial background and does not have any direct clinical care experience. I have worked with MD6 in multiple roles within the company: I formed the 24<sup>th</sup> ranked JV with MD6. I have no prior experience with MGR6.

MD6 portrayed a flat affect but was most animated when discussing patient care issues. MD6 and his other physician partners have experienced some trying issues in their JVs, specifically some capital calls. While MD6 indicated positive opinions regarding the local FMC team, he did express concerns about transparency, changes to the reported information in the board meetings, frustrations with company initiatives, and the turnover of some of the local leadership team. MD6 noted that he has learned a lot about the dialysis business but that it took some time. MD6 indicated frustration with policies that he viewed as detrimental towards patient care. MD6 stated that his partners are not engaged and see themselves purely as shareholders: he

thinks FMC would prefer more engagement. Some of the partners are looking to exit the JVs. Interactions with the managers are typically reports on information and efforts to roll out policies and procedures. There is little evidence of a collaborative relationship and the leadership style on both sides of this relationship resembles a laissez-faire leadership approach.

MGR6 came to her director of operations role through a business development background and recently completed her master's in business administration degree, shaping a managerial ideology. MGR6 has limited exposure to JVs, with only exposure to three ventures with similar physician partners. All the ventures are performing poorly. Danielle frequently made comments about reporting to or informing the physician partners about issues. She has a sensitivity to the relationship where she sees her role in the relationship as working for rather than working with the physicians in this venture. The interactions with the physician partners are largely focused on the financial performance of the business, and when there are issues, it is incumbent upon the company to fix the problems. Overall, there is a lack of engagement from the physicians. When asked if she would change anything, she stipulated that she would not change the relationship, nor would the physicians. The lack of engagement keeps the focus on financials and company control of the business.

## Appendix I: Institutional Review Board Approval

### ABILENE CHRISTIAN UNIVERSITY

*Educating Students for Christian Service and Leadership Throughout the World*

**Office of Research and Sponsored Programs**

320 Hardin Administration Building, ACU Box 29103, Abilene, Texas 79699-9103  
325-674-2885



July 21, 2020

Jeffrey Stevey  
Department of Graduate and Professional Studies  
Abilene Christian University

Dear Jeff,

On behalf of the Institutional Review Board, I am pleased to inform you that your project titled "An Interpretative Phenomenological Analysis of Leadership and Interprofessional Conflict in a Chronic Joint Venture Setting",

(IRB# 20-101 ) is exempt from review under Federal Policy for the Protection of Human Subjects.

If at any time the details of this project change, please resubmit to the IRB so the committee can determine whether or not the exempt status is still applicable.

I wish you well with your work.

Sincerely,

*Megan Roth*

Megan Roth, Ph.D.  
Director of Research and Sponsored Programs