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Creating Sustainable Change in the Interprofessional Academic Primary Care Setting: An Appreciative Inquiry Approach

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Abstract

Background: There is a global shift toward integrated care approaches in primary care. Understanding how to optimize healthcare team effectiveness is of utmost interest in Canada, where primary care reform targets the development of interprofessional teams of providers collaborating to improve patient care. This article presents findings from a longitudinal study of one primary healthcare team in transformation. A theory-based organizational change model is applied to understanding the processes of change in interprofessional healthcare teams.

Methods and Findings: We report findings from two years after the implementation of an intervention to advance teamwork in one family health team in Ontario. The intervention was informed by the Appreciative Inquiry (AI) approach. Fifty hours of unstructured clinic observations and interviews were conducted. The findings revealed that a change in team practice, such as patient-centredness, and formal and informal communication opportunities, precede change in team discourse—the way that members speak and think about themselves as an integrated team.

Conclusions: The evolution of teamwork in the family practice setting is a gradual, steady process that begins with important changes in the way that things are done (i.e., first-order change), and with continued support and nurturance, can eventually lead to changes in the way that members think and speak about their team (i.e., second-order change).

Keywords: Primary care; Teamwork; Organizational change; Appreciative inquiry; Social construction; Communication.

Introduction

There is a global shift toward team-based or integrated care approaches in primary care. As such, there is a broad interest in advancing our understanding of teams and collaboration as principles or concepts [1-3], exploring health professionals' experiences enacting these concepts [4-10], and promoting team collaboration as an effective form of primary care practice and delivery [11-12]. Understanding how to optimize healthcare team effectiveness, including both operational and individual dimensions, is of utmost interest in Canada, where primary care reform has targeted the development of interprofessional teams of providers collaborating to improve access and delivery of care. The Family Health Team, or FHT (pronounced F-I-T), is the model established in the province of Ontario whereby physicians, nurses, and various other healthcare professionals come together to provide coordinated patient care, improve organizational efficiencies, and enhance provider job

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satisfaction [13]. Nearly two hundred FHTs in various stages of development currently exist across the province,

Despite the rapid growth of teams and the new chronic disease management programs offered to serve more patients, there is little professional development support for providers involved in this transformation [13]. Furthermore, little is known about how effective teamwork happens or is developed in changing family practice settings [11]. Some survey research conducted in the UK by Poulton and West [14] and West and Poulton [15] indicates a correlation between team processes, such as shared objectives, and team effectiveness, as measured by teamwork, organizational efficiency, healthcare practice, and patient-centred care. More recently, Canadian research in interprofessional primary care has called attention to the relational aspects of teams, i.e., the importance of clear role understanding among providers [16-17], team education and teambuilding [18], and creating opportunities for collaboration via optimal design and use of time and physical space [19]. These findings certainly provide some early direction for targeting efforts to enhance team members' communication and collaboration processes at the practice level in FHTs. Further research is needed, however, to fully understand the individual-level factors and processes by which teams change in order to support the transformation of primary care providers into effective family practice teams.

The study: Appreciative inquiry as an approach to change

In 2005, two authors on this paper (LGC & IO) embarked on a collaborative multi-sited research endeavour to understand the state of interprofessional communication and collaboration in three Canadian healthcare settings: general internal medicine, primary care, and rehabilitative care [20]. Findings from our partners in general internal medicine and rehabilitative care have been published elsewhere [21-25]. In primary care, ethnographic research was conducted in three different sites where the new FHT model was being implemented. When the study began, new personnel were being added to these FHTs, new programs were being designed, and new space was being built to accommodate them. At that time, the research focused on the individual aspects of team collaboration, as compared with the organizational- and institutional-level factors, which, at the time, were also evolving. Specifically, the aim was to understand when, how, and why interprofessional communication and collaboration were facilitated or impeded in practice. The findings showed that well-designed physical space, coupled with both formal and informal opportunities for face-to-face communication, were critical for creating meaningful team relationships and advancing a team approach to care [19]. Role clarity and trust were also essential ingredients found for positive relationship development [17], particularly in sites where professional divisions or silos existed.

Cognizant that these findings identified the need to create opportunities for collaboration, develop role clarity, and build trust among health care professionals, an intervention was designed to help team members address these issues and was piloted within one FHT. The intervention involved five two-hour sessions held over 11 weeks (see Table 1 for the full description). The program included a number of

presentations, facilitated group discussions, and interactive activities, enabling the development of processes to optimize teamwork. It was informed by Appreciative Inquiry (AI), defined as "the art and practice of asking questions that strengthens a system's capacity to heighten positive potential" [26]. AI is an approach to social systems change based on social construction principles, which acknowledge that realities are situated and negotiated [27] and that what we know to be "true" is actually made and continually remade in interaction [28]. This is sometimes called "the communication perspective" [29], whereby the stories we tell about a system are argued to form the reality of the system itself.

Table 1
Appreciative inquiry intervention, 2007

Session number	Description of activities planned during the sessions
1	Presentation of 2005 research findings to FHT. Questions and discussion period followed.
2	Introduction and Ice-Breaker Interviews The History of Our Family Health Team thus Far Collaboration from the Patient Perspective (Video) Exploring the Possibilities of Collaboration for Patient Care and Provider Satisfaction Creating the Future We Want The Path Forward
3	Stereotyping exercise - small group reflections
4	Integrating new roles into the healthcare team, reflections, guest speaker, DVD clip
5	Vision development for the FHT Ceremonial toast to the team – sharing our successes to date Creating Common Ground Where do we go from here? Discussion of next steps Group photo

AI is part of an organizational development practice that has emerged in the last decade aiming "to shift system member thinking to a more positive and generative consciousness in order to achieve transformational change" [27]. The AI approach targets and maximizes opportunities for advancing change by encouraging system members to speak about their system in ways that generate new hopes, actions, and ideas for the future. AI engages system members in reflection upon, and sharing stories of, what works best in their system to co-create relevant and meaningful plans for changing it, and to enable a larger shift in mindset and consciousness about the system as a whole. In the organizational development literature, transformational shifts in a system such as this are called "second-order change," that is, "a change in the identity of a system and qualitative changes in the state of being of that system" [30]. Second-order change transforms a system by giving people a more generative

way of talking about their work, experiencing it, and living it. AI aims to help system members achieve this by developing the necessary skill to speak and act in a more generative way, helping them to recognize that other peoples' stories about and within the system are also valid and true [31].

To better understand the course of transformative organizational change in the FHT, the authors of this paper returned to the site of the original research two years after the AI intervention was completed. We sought to explore what, if anything, had changed about the team's approach and practice, and what we could learn about the individual-level factors that had influenced this change. During the post-intervention period, the FHT had continued to develop and advance its teamwork processes in a number of ways. Initiatives to enrol new patients, increase patient access to care, and improve team communication processes had been locally designed and implemented. In this article, we share our findings from this longitudinal study to offer a snapshot of the individual-level change processes in the FHT. We argue that the evolution of teamwork in the family practice setting is a steady, incremental process that begins with important changes in the way that things are done, and with continued support and nurturance, can eventually lead to changes in the way that members think and speak about their team. We consider the necessary incremental aspects of change that occur on an individual level in an evolving interprofessional family health team with the goal of informing other healthcare teams undergoing similar transitions in practice.

Methods

Setting, participants and ethics

The FHT is an inner-city practice located in a major city in Ontario. It is an academic training unit for medical and other health professions students, and provides specialized services in comprehensive Family Medicine (FM), including obstetrics, palliative care, and addictions. The FM group supports two areas of special interest: a FM Addiction Medicine Service, which provides inpatient and outpatient care to individuals (including pregnant women) with substance use disorders, and a Palliative Care Service, which provides in-hospital and home-based care. The physicians also provide consultant obstetrics care for family doctors who don't practice obstetrics, in addition to consulting on addictions and palliative care. The comprehensive FM practice places priority on providing care to marginalized populations, including newcomers to Canada, women who are survivors of violence, and individuals with severe mental health problems. Ten percent of FHT patients are uninsured.

The FM program within which the FHT exists is administered by the hospital's larger Women, Child and Family Health Program, while the interprofessional Palliative Care team is run by the hospital's Internal Medicine program, and the interprofessional Addiction Medicine team is run under that of Mental Health. The academic component of the FHT is administered by the university. It maintains a large FM residency program (25 residents), an undergraduate program (providing teaching to 16 core FM clerks per year), a number of fellowships in Addiction

Medicine and Palliative Care, and two funded departmental Research Scholars. As a core academic FM program, challenges exist with balancing clinical and academic responsibilities and with many of the physicians being in part-time practice because of their academic roles.

The FHT is physically spread over two locations, one within and one just outside of a hospital. This arrangement is a result not of intentional design but of the availability of space when the FHT was established. Within the hospital, a larger clinic has workspace for 10 clerical staff, 2 part-time clinic assistants, 3 full-time registered nurses, 21 physicians, and the family medicine residents (some with specialized practices as noted above). Across the street from the hospital, a second, smaller clinic houses seven different full-time interprofessional healthcare providers (HCPs), including a dietitian, social worker, pharmacist, nurse practitioner, patient education specialist, and a community outreach mental health and addictions worker.[1] This second site is staffed on a rotating basis by clerical personnel. Physicians and HCPs rotate their clinics between the two sites on a weekly basis.

Seventy-two team members participated in this research. In addition to those mentioned above, other participants included three administrative and management personnel, one casual nurse, one part-time dietitian, one part-time nurse practitioner, one research assistant, one medical student, one community liaison worker, and one health professional trainee.

Three different governance structures for FHTs exist: community-based, provider-based or a mix of community- and provider-based groups [32]. The FHT involved in our research is a provider-based structure in which the physician group has collectively entered into an agreement with the government for funding. The funding is then provided to the hospital to hire the HCPs and implement FHT programs. The governance structure of the FHT therefore has physicians operating autonomously in terms of compensation for services rendered, alongside other healthcare providers and administrative staff, who are hired, compensated, and managed via the larger institution. Although on paper the FHT appears to be centered on the work of physicians, in practice the approach of the family medicine unit is promoted as interprofessional and collaborative. Indeed, according to the provincial government, FHTs "are a group approach to healthcare," which allows physicians to "focus on complex medical issues" and patients to access different healthcare professionals according to their needs [33].

Institutional research ethics approval was obtained from the FHT's hospital and our university prior to data collection. Staff and trainees were all made aware of the research and were asked to give individual oral consent for inclusion in observations. In the case of interviews, we obtained written consent. No staff declined participation. Notices of the ongoing research were posted throughout the clinic for staff and patients. These notices explained the nature of the study and invited individuals to contact the researcher with any questions.

Data collection

One trained ethnographer [the primary author] conducted approximately 50 hours

of ethnographic research over four months, which included unstructured observations in the two FHT clinics and 26 interviews with FHT members. Interviews lasted, on average, one hour. All data were collected during weekday daytime clinic hours and included various scheduled team meetings. Data were recorded by hand and were later elaborated upon through reflective field notes by the ethnographer [34].

Data analysis

An inductive analysis of the data was conducted. The primary author coded field notes and interview transcripts iteratively in a cycle involving data collection and analysis. Emergent themes were discussed among the research team for agreement on general data categories, and to determine when saturation of the data was reached. Multiple interpretive frames, including discourse analysis framed by social construction communication theory, were applied.

Findings

Our findings are presented below as 1) team practice and 2) team discourse. Data on team practice entail the new ways of doing things in the FHT that improve provider communication processes. These are important changes that give patients improved access to more primary healthcare providers and allow those providers to offer an integrated, patient-centred approach. Team discourse refers to the way that team members think and speak about the FHT and the relationships of members therein. We present team members' perspectives and experiences of the changing nature of teamwork and the impact of these changes. We then discuss these changes in relation to the goals of the AI approach to sustainable change.

Team practice

Improved patient-centredness

FHT team members generally agreed that the new personnel and new processes implemented had enhanced the team's ability to provide patient-centred care. Continuity of care was believed to have improved over the past two years, according to one HCP, who also reported that "there's better use of the patients' time because they can come on one day and see three different [providers]." With a clinic that is "bigger and busier," one physician sensed that natural frustrations emerged for some patients who "don't like the processes like the phones ringing and the difficulty getting in, but know that the quality is good once they get inside." Another physician felt that the new interprofessional approach dramatically improved her patient care, explaining, "So many of the patients I was worried about, I finally see movement on." Field notes indicated that the clerical staff worked hard to facilitate patient access to providers, keeping up with the expanding patient enrolment and its impact on the number of incoming telephone calls, and the amount of booking and chart filing. In a short observation of three minutes' duration, one clerical staff member was seen concurrently attending to a new patient's enrolment at the recep-

tion desk, receiving a phone call from a patient for appointment scheduling, and responding to the booking request of a physician who stood at her shoulder. Quality of patient care motivated many of the staff, one of whom stated, "we have more work, but I think we have more satisfied patients." Another concurred that "there is never enough time do all of the work. It's a lot, but I love it." Attention to patient needs and staff commitment to their work was what drew one new member to join and stay in this FHT, as explained to the researcher:

> What attracts me to the team here is that, given the challenges with the patient population and the location, I'm still very impressed at how patient-centred the staff are. All of the staff are people who are dedicated to doing good in the community they serve. This is what unites people here. It's a stressful group of patients and we don't work in ideal conditions. I'm amazed that there isn't more tension around that. I think it generally has to do with a genuine commitment to the work on the part of the team.

Formal communication

Shortly after the new HCP personnel joined the FHT, it became clear that team members wanted and needed to create formalized opportunities to talk to one another about patients, beyond the traditional paper referral or consultation process. Indeed, one way of achieving the goal of opening access to more patients and providing an integrated approach to care was to have, for example, a patient education specialist whose expertise in educating patients was easily accessible. This would consequently alleviate pressure on nurses and physicians to provide this service within time-sensitive appointments that were also addressing other medical concerns. Thus, a number of formalized interprofessional meetings were developed by the FHT to increase team members' exposure to one another and to create purposeful opportunities for communicating about patients and clinical operations. This included a bi-monthly interprofessional case conference that aimed to improve the effectiveness of teamwork and patient care for complicated cases, and to provide an open forum for seeking other team members' support. During these conferences, which are divided into three separate interprofessional groups, team members select a case presenter, facilitator, and recorder on a rotating basis. Field notes illustrated that when these meetings functioned as expected, they were highly valued by team members. For instance, one clerical staff member explained that she liked doing the conferences because, "I tell [the doctors] things about the patient they don't know, and you understand the patients better when you participate." One HCP also found the conferences ideal for discussing commonly encountered patient issues, as she explained, "Even if we end up just talking about a certain population of clients and how to deal with them, they're really important and serve a purpose."

Observational field notes confirmed that when appropriate patient cases were brought forward, the concerns of all team members and the impact on everyone of challenging patients could be effectively addressed. This was illustrated by one

physician's awareness that clerical staff, in particular, might want to talk about one very ill patient who came to the clinic regularly.

> One physician says that she has a case that she thinks is relevant to everyone because when the patient comes into the clinic she knows that it's upsetting; she's specifically referring to the clerks. She says she shares the patient with the Nurse Practitioner and thinks it would be great to bring psychiatry and ethics into the conference if possible. The clerks are nodding and there is agreement in the room. The physician suggests that the other clerks [not part of this conference group] be invited as well because she knows how upsetting it is to see the patient for everyone - she's anorexic and, the physician says, she's wasting away.

To enhance clinic operations, another new team meeting was the "clinic huddle," which happens in the first five minutes of both morning and afternoon clinics. The huddle functioned to inform team members of any operational challenges or patient flow issues, and as one physician stated, "to get everyone to work as a team." Facilitated by clerical team members on a rotating basis, the expectation was that all team members who were present in the larger clinic would attend. Team members endorsed the value of the huddle for improving patient flow as a result of increased communication between team members. For example, a nurse explained that the huddle was "an opportunity for nurses to say when there were a lot of patients to see in a particular clinic so that the doctors knew there would not be a lot of nursing support available." The observational note below refers to the huddle and illustrates how a quick pre-clinic exchange could enhance operations for the afternoon.

> A physician asks the clerk if she can have her patients brought from the outer waiting room to the inner one when they arrive, as there was some misunderstanding with her scheduling and it seems patients are booked every 15 minutes, not every 30 minutes, as apparently requested. The clerk replies, "We don't usually do that," but then agrees to make an exception this time to keep the patient flow moving.

Given that role understanding and clarity had previously been identified as a challenge, a number of formal communication opportunities were designed to increase understandings of the scope of practice of the various HCPs among the team. One initiative called "Enhancing the Role of..." allowed for individual HCPs to present their work to the team and discuss how they can best work together. One physician explained that this meeting had helped to improve physicians' understandings of the HCPs' roles, and provided an opportunity for HCPs to showcase the work that they had been doing, discussing whatever barriers, if any, existed to enhancing their practice. Interprofessional chart reviews had also successfully targeted role understanding and increased consultation by the physicians to the HCPs, as one HCP stated, "Now there are doctors who will call me to have an appointment together. I think that the more time they spend with me the more comfortable they get."

Ad hoc communication

Over the last two years, the integration of the new HCPs and the physical expansion of the clinic across two sites had also provided new opportunities for ad hoc interprofessional consultations. In the newer clinic, the HCPs each have individual offices in addition to several exam rooms, which are shared with the physicians. One physician described her deep appreciation for the tranquility of the new smaller clinic, and the opportunity it now afforded her to work jointly with members of other professions. She stated, "I get to work closely with [the nurse practitioner] and [pharmacist], who I'll often pull into the room when I'm seeing a patient. And depending on which clerk is on rotation, I'll take the opportunity to engage her in the patient care more, like if she wanted to do patient height and weight."

The new interprofessional HCP group had themselves formed a close unit who consulted one another regularly in the new clinic. This was also attributed to their co-location and the frequency of interaction they had as a result. One HCP described the following scenario as case in point.

> Just yesterday I was seeing an older patient whose blood sugar level was very low. It was 4pm, end of day, and I called [the nurse practitioner], who was there in the office, to test the patient. She confirmed [my findings], and we arranged to get the patient in to see a resident the next day instead of waiting for her appointment in a couple of days from now. Our team is so cohesive and we love each other.

Observational field notes also revealed that when HCPs were present in the hospital clinic, informal hallway consultations occurred. In the larger clinic, seeing one another in the corridor or reception area created opportunities for quick yet meaningful exchanges that enhanced both patient care and team members' relations. The following field note illustrates such an encounter.

> In the exam room, a physician and nurse practitioner (NP) are talking. They finish and a few minutes later both walk into the reception. The NP is holding a chart and asks the physician about treatment for the patient, medication, and follow-up procedure. The physician advises the NP on these items and adds, "and have her see [dietitian], too. I say any chance you have to get an 18-year-old to see a nutritionist you should take it." The NP looks in agreement and says "Thanks, [first name of physician]."

Opportunity and willingness to informally approach one another when a sensitive patient matter arose were critical to the effectiveness of the team's patient-centred approach. A clerical staff member described two separate occasions in the recent past when providers "had pregnant patients coming in to get the results of ultrasounds, and the patients had lost their babies but didn't know yet." The providers informed all of the clerks ahead of time to be sensitive to this when registering the women. They were asked to put the patients in a private room and keep them comfortable.

Team discourse

Vision of the team

The AI intervention had offered team members a new approach for imagining their possibilities as a team and, in doing so, it encouraged them to develop an inclusive vision of the family practice unit as one team. Some members felt that our study had helped them begin breaking down the professional silos that had previously existed in the clinic, that is, creating new connections between the professionally distinct physician, nursing, and clerical groups. According to one physician, relationships here were similar to those among family members, where "the people really do care about the patients and one another, and are driven by a common compassion." Yet, participants also believed that the new vision of the inclusive team did not necessarily translate positively into practice. As one participant suggested, the vision of the group as a team reified the different professional identities and cultures of team members and the power differentials between the professions.

> I think that people see themselves as a team now; it may be a dysfunctional team, but at least now it's in their vocabulary. And I think people have a better understanding of one another's roles, although, there is, perhaps, more of an awareness of the hierarchy, with doctors at the top. Even the doctors hold the point of view that they have more power.

Participants also perceived the FHT to have various team configurations, which was revealed in their descriptions of the composition of the FHT and its specialized subteams (e.g., Palliative Care, Addiction Medicine). This observation suggested that, conceptually, the professional, and perhaps speciality-specific, silos reported in the pre-intervention period remained and that the FHT model introduced yet another level of professional distinctions. As one physician stated, "I feel like it's really two teams. The family health team is about working with the other healthcare providers.... Outside of that, with the clerical and the nurses, we still have our hiccups."

The field notes revealed that the new clinic space clearly created opportunities for some team members to work together in new ways. However, we found that this new space also introduced a new spatial barrier that, for some, negated the idea of an inclusive family practice team. The physical separation of the majority of physicians, nurses, clerical staff, and administrators from the HCPs created a new symbolic barrier that reinforced the perceived division between the professions. One nurse disappointedly explained, "We're separate, and the people who are supposed to be our partners in this model are not at our fingertips." Another team member based in the hospital clinic illustrated this perspective when explaining, "It's part of our interprofessional piece to have more people, in the physical sense, but we have to make an effort with those who are at the other site. It's still a challenge to see the two sites as one."

Language and hierarchy

Team members had focused on improving how and when they communicated with one another, in addition to the means by which communication happened. Yet, many did not feel that any advances in "basic communication" had been made. As a result, team members continued to feel as though relationships had not improved and respect for one another had not been developed. To this end, one physician explained that "basic communication causes stress even when it's not meaning to." Another participant agreed, stating, "People here just have poor communication skills in general." Team members still needed to "be aware of [their] surroundings and know how to interact with people appropriately."

For some, language use, in addition to communication skill, continued to reflect and reinforce the perceived importance and centrality of physicians by other team members, despite deliberate efforts on the part of physicians to create and participate in a collaborative environment. Prior to the original intervention, many participants who were not physicians felt somewhat alienated by the physician group, citing physicians' lack of participation in unit events and their lack of connectedness to the team. Staff experienced frustration with the individual work styles and different expectations of the 16 physicians with whom they were simultaneously working. In the current research, the historical hierarchical roles and relationships between the doctors and nurses, in particular, were believed to be deeply embedded in the culture of the clinic and impacted the way that these members conceptualized and spoke about their team. For instance, one nurse stated,

> I feel strongly that people use language in ways that reinforce the medically dominant culture. For example, when team members are talked about as physicians and non-physicians, that reinforces the importance of physicians. I don't refer to people as non-nurses. Though people are not conscious of doing it, it doesn't serve to advance the idea that we're all equal members of the team.

Another nurse confirmed that the language was critical to creating an environment where both providers and patients understood and valued the distinct roles and contributions of those who were not physicians. This is how the goals of the FHT could be achieved. She explained, "When I hear comments made by physicians like 'my nurse,' or even when patients call and ask, 'Are you doctor so-and-so's nurse?' I'm really bothered. I don't want to be thought of or spoken of as someone's property." In such instances, the nurse added, when between two professionals, it suggests that one person in the relationship deems him or herself as more important, and then true collaboration cannot happen.

Interview data suggested that other participants who were not physicians felt there was little possibility to dismantle or flatten the hierarchical structure in the FHT due to the medico-legal responsibilities that physicians held. One HCP, who initially told the researcher that the HCPs felt that they were the "hired help" to the physicians, later explained that physicians may have the last word in patient care, "but that's okay if it's in a situation where I might kill someone if they didn't." In

response to learning that some team members felt negatively about the FHT structure, one physician explained, "In our current system, the buck stops with the doctor. If anything goes wrong with a patient and the doctor is sued, the doctor is seen as responsible for the behaviour of the nurses, the clerical, and the other healthcare professionals. This is a universal phenomenon in Canada and is not unique to our FHT. Until this is changed, I really don't think that the hierarchical structure will change, and I think this is not really fair to comment on without the larger picture."

Overall, the physician perspective was arguably more positive about the incremental advances that the team had thus far made to operate as a collective. Accordingly, one physician explained that all of the programs are "met with a collaborative lens," but it seemed to her that "the work of the FHT overall is still seen as physician-led." The fact that "there shouldn't be a hierarchy in a highly functioning team" was clear to the physicians that we interviewed, one of whom stated that "everybody understands that's how it should play out . . . but there are still issues." From the perspective of the HCPs, the hierarchical structure "becomes an issue when we're told to do things instead of being asked." However, it was acknowledged that this was not an explicit or deliberate approach on the part of their physician colleagues, rather an unintended consequence of the way the system is currently structured and functions. As one HCP explained, "I think the physician group does try to be collegial and make it a team approach, and some of them really do try. But overall it's made distinct that we're here to help them accomplish what they need to do with the patient."

Nurture the team

Field notes indicated that team members recognized a real need to continue to nurture the team to achieve their goals. The belief that "teamwork has improved, but it's not perfect" was shared among participants. Existing efforts to advance the vision of team members as equal partners in the FHT included various "Design Teams," essentially interprofessional problem-solving groups that were co-chaired by a physician and staff person. Design Teams are charged with generating recommendations for changes in clinical and administrative process, including diabetes care, home visits, and the orientation of new patients. One participant explained, "When someone is called to be part of a design team, they see themselves as part of something. Nobody challenges the design teams and they participate in them, and this carries over to improve patient care." Other team-building activities, such as a bowling event, were viewed as helping to build team member relations and morale. "There's an acknowledgement that you have to nurture the team, that it's not just about the clinical work." To illustrate the need for continued attention to team building, one physician made an analogy to servicing a car, stating, "Just like a car needs a routine maintenance, so does the team. We need to figure out how to do some routine maintenance to service our team."

Discussion

Our findings illustrate the incremental ways that change in a system happens at the

individual level. We found that many important functional changes had taken place in the FHT since the AI intervention. The introduction of new meetings, programs, and people, for instance, changed the way that individuals organized themselves, the frequency with which they communicated face-to-face about patients, and the extent to which they interacted informally and socially with one another. This type of change in what system members do has been referred to as "first-order change," which is change in the system that does not alter the foundation or structure of the system itself [35]. Many participants experienced such changes positively as making progress toward increasing collaboration and achieving the collective FHT goals. Changes of this type resulted in more frequent and substantive contact among team members from different professions and an ability to draw a number of healthcare providers together with a shared focus on patient care.

The team in this study continues to work toward second-order change—a greater transformational shift in the team's identity and the way that members speak about and experience their group as a team. Bushe has described the identity states of teams as pre- and post-identity, distinguishing between those in which individuals are not primarily identified with the group (pre-identity) and those where most individuals are identified with the group and therefore construct a social identity as including membership therein (post-identity)[36]. The FHT was, and continues to be, characterized as a pre-identity team; even though they are all technically members therein, individuals continue to view the group as outside of their "meaning-making nexus" rather than within it [36]. Despite the interprofessional aims of the new meetings and activities to increase provider collaboration, and to some extent, level-off a perception of unevenly distributed professional power, for some members, the separate HCP clinical space and sheer design of the FHT governance structure have simultaneously reintroduced and reinforced a traditional sense of hierarchy and professional silos. With no formal changes made in the medico-legal structure of the healthcare system that reflects an interprofessional medico-legal responsibility, some members feel the interprofessional approach is incomplete [37]. And although team members regularly participated in case conferences and other interprofessional initiatives, many continued to think and speak about these activities as physician-led or centred. Language in the clinic continues to reflect an "us" and "them" perception between those who are unionized, hospital-hired staff and physicians. Changes in the way that members think about themselves as an integrated team, and the construction of a new story of how and why they work well together, are still in-progress.

Organizational theorists Bushe and Kassam [30] offer a starting point for considering the impact of different kinds of successful changes in a system and the extent to which they are transformational of the system as a whole. First, is there any new knowledge produced, or just new ways of doing things? Are there any new lenses or models for looking at old issues? And second, did a generative metaphor emerge, that is, new phrases or sayings that create new possibilities for action? According to Bushe and Kassam, when changes in the way that people think are coupled with an improvisational approach to change, transformative change in the

system is possible. Other changes, though successful in their own right, will not produce radical culture change. When applied to the system under study here, we learn that although team members successfully bought into the new ways of doing things in order to achieve individual and organizational FHT goals, there have been few substantive changes in the way that team members view the old issues that thwart optimal team functioning, such as the negative perceptions of professional unevenness and hierarchical structure. To this end, the introduction of new people and programs operates as a form of "first-order problem solving," which Tucker and Edmondson [38] have described as a quick, but only temporary, solution to a system's problem that leaves the underlying problems intact. In health services research, Lingard et al. [24] have applied this concept to the "interprofessional information workaround" on general internal medicine wards to understand staff members' use of adaptive strategies for communicating in complex healthcare environments. Our findings provide some new insight to the complexity of creating new interprofessional family health teams in sites where interprofessional tensions and a traditional hierarchical culture previously existed. In such instances, which can be characterized as complex adaptive systems, the ultimate goals and advantages of interprofessional care for the healthcare provider, such as improved job satisfaction and morale, may be more difficult to achieve, though not unachievable by any means. As stated by Ginsberg and Tregunno [39], in the advancement of IPC, substantive changes in how team members view and negotiate their place within their system are required to lead cultural changes in a system over the long term.

Conclusion

Findings from our research suggest that there are limitations to the impact of a short-term AI intervention for creating sustainable change. The experience of this FHT shows that team members must continue to build their skill and practice at working in a more generative way, incorporating this into their everyday language and communication. They must continue to uphold, for themselves, the question of how to practice as a cohesive, collaborative team, and reflect on their ways of thinking and talking about themselves as such. Envisioning a team-oriented future and collecting stories of the team at its best are not enough to embed any long-term conceptual changes within the individual or the system, no matter how motivated most of its members are. Stand-alone interventions do not provide enough opportunity for teams to develop the practice of collaboration; they remain fixed at a level of first-order change. Skill development around generative conversations is needed for continued change momentum.

Stories are powerful devices in this system. The introduction and acceptance of new stories and discourses within and about the system is critical to its ability to transform or shift. When team members continue to share stories and rationalizations of their world devoid of a team-based identity, they continue to participate in a deeply embedded cultural discourse that perpetuates perceptions of hierarchies and silos and negates the kinds of transformations that they all want to achieve. The

evolution and sustainability of the FHT model is greatly influenced by team members' willingness and ability to coordinate meaning that advances a team identity and approach so as to dismantle any structural barriers and collaborate in creating new stories of their new team.

Team transformation is an ongoing process; it is an evolution and investment that requires continuous nurturing, support, and leadership. It requires close attention to the unintended consequences of such critical factors as physical space and funding arrangements, which can inadvertently function to preserve structures in the system that divide and alienate some of its members and deeply impact peoples' perceptions of their roles and value in the system. This study has provided a much-needed snapshot in time of the hard work of one FHT to independently achieve success as an integrated interprofessional primary care team. It is hoped that other teams involved in similar transformations can benefit from this research.

Note

1. Healthcare provider (HCP) is the designation that is accepted and used in this setting for these professionals. As such, it is the designation that is used in this paper to refer to members of this group.

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