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Field Case Study Involving Qualitative Research of Police and Health Care Personnel Regarding their Collaborative Experiences with Military Personnel

Eric Ouellet

Elizabeth Anne Kirley

P. McKane

Canadian Forces College

Scientific Authority

Dr. Paul Chouinard
DRDC Centre for Security Science

Defence R&D Canada – Centre for Security Science

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Scientific Authority

Dr. Paul Chouinard

DRDC Centre for Security Science

Operational Research

Approved by

Dr. Denis Bergeron

DRDC Centre for Security Science

Head Decision Support Section

Approved for release by

Dr. Andrew Vallerand

DRDC Centre for Security Science

Document Review Panel Chairman

Abstract

This paper reviews the findings of a research project based on a field case study that involved qualitative research of current or former healthcare professionals from middle to upper management who are or were involved in senior decision-making linked to potential collaboration with the Canadian Forces and the police sector. Using Scott's three pillars of Institutional Analysis (IA) as a framework of analysis, the purpose of this research was to explore whether any attitudes or behaviours existed amongst healthcare personnel that would create social or cognitive barriers to institutional collaboration with police and/or military personnel in a public safety context by analysing the regulative, normative and cultural-cognitive pillars of the healthcare sector. The study found that there were significant potential social or cognitive barriers within the healthcare sector which influenced collaboration with the military or the police sectors.

Résumé

Le présent document passe en revue les conclusions d'un projet de recherche fondé sur une étude de cas sur le terrain portant sur la recherche qualitative de professionnels de la santé passés ou actuels, depuis les cadres intermédiaires jusqu'aux cadres supérieurs, qui participent ou ont participé à la prise de décision de haut niveau associée à une collaboration éventuelle avec les Forces canadiennes et la police. À l'aide des trois piliers d'analyse institutionnelle (AI) de Scott comme cadre d'analyse, la présente recherche vise à vérifier si certaines attitudes ou certains comportements se retrouvaient parmi le personnel médical susceptibles de créer des obstacles cognitifs ou sociaux à la collaboration institutionnelle avec la police et/ou le personnel militaire dans un contexte de sécurité publique, en analysant le pilier culturel cognitif, régulateur et normatif du secteur des soins de santé. L'étude a révélé qu'il existe d'importants obstacles possibles aux plans social et cognitif qui influencent la collaboration avec les secteurs militaire ou de la police

Executive summary

Field Case Study Involving Qualitative Research of Police and Health Care Personnel Regarding their Collaborative Experiences with Military Personnel

Ouellet, E; Kirley, E; McKane, P; DRDC CSS CR 2012-034; Defence R&D Canada – CSS; December 2012.

Introduction or background: This paper reviews the findings of a research project based on a field case study that involved qualitative research of current or former healthcare professionals from middle to upper management who are or were involved in senior decision-making linked to potential collaboration with the Canadian Forces and the police sector. Using Scott's three pillars of Institutional Analysis (IA) as a framework of analysis, the purpose of this research was to explore whether any attitudes or behaviours existed amongst healthcare personnel that would create social or cognitive barriers to institutional collaboration with police and/or military personnel in a public safety context by analysing the regulative, normative and cultural-cognitive pillars of the healthcare sector.

Results: Convenient or available subjects within the above-stated parameters were used to obtain a sampling wide enough to identify the key views and attitudes found in the healthcare sector, at the senior level, that may influence potential collaboration with the Canadian Forces and the police sector.

The study found that there were significant potential social or cognitive barriers within the healthcare sector which influenced collaboration with the military or the police sectors. Within the regulative pillar these included: legislation related to the protection of the privacy of personal health information and the legal autonomy of hospitals in Ontario, confusion around health-related legislation (particularly legislation related to the privacy of information and to public health), as well as constitutionally delineated government jurisdictions related to healthcare, policing, and the Canadian Forces. Within the normative pillar differences in terms of ideas related to the "appropriateness" of particular sectoral or institutional foci, activities and channels of communication, as well differing ideas around "authority" and "expertise" being vested in particular positions of seniority and/or training. Moreover, relationships across these sectors were deemed important since it was necessary for these sectors to work together (and therefore, mutual understanding was important). Finally, in terms of the cultural-cognitive pillar, different sectoral cultures ("law and order" versus "caring and compassionate"; "command and control" versus "independent, yet collaborative decision-making, as well as the common cultural "trait" of a reticence to share information that was common across all three sectors) and silos were considered potential significant barriers to inter-organizational collaboration. What is more, the lack of cross-sectoral relationships was identified as a critical potential barrier to inter-organizational collaboration since the lack of such relationships meant a lack of mutual understanding of each sector's capacities, limitations, and roles and responsibilities.

Sommaire

Étude de cas sur le terrain portant sur la recherche qualitative du personnel médical et de la police concernant leurs expériences de collaboration avec le personnel militaire.

Ouellet, E; Kirley, E; McKane, P; RDDC CSS CR 2012-034; R et D pour la défense Canada – CSS; Décembre 2012.

Introduction ou contexte : Le présent document passe en revue les conclusions d'un projet de recherche fondé sur une étude de cas sur le terrain portant sur la recherche qualitative de professionnels de la santé passés ou actuels, depuis les cadres intermédiaires jusqu'aux cadres supérieurs, participant ou ayant participé à la prise de décision de haut niveau associée à une collaboration éventuelle avec les Forces canadiennes et la police. À l'aide des trois piliers d'analyse institutionnelle (AI) de Scott comme cadre d'analyse, la présente recherche vise à vérifier si certaines attitudes ou certains comportements se retrouvent parmi le personnel médical susceptibles de créer des obstacles cognitifs ou sociaux à la collaboration institutionnelle avec la police et/ou le personnel militaire dans un contexte de sécurité publique, en analysant le pilier culturel-cognitif, régulateur et normatif du secteur des soins de santé.

Résultats : Des sujets appropriés ou disponibles, dans le cadre des paramètres ci-haut mentionnés, ont été utilisés afin d'obtenir un échantillonnage suffisamment grand pour identifier les principaux points de vue et comportements découverts dans le secteur des soins de santé, au niveau supérieur, susceptibles d'influencer une collaboration éventuelle avec les Forces canadiennes et le secteur de la police.

L'étude a révélé qu'il existe d'importants obstacles possibles aux plans social et cognitif qui influencent la collaboration avec les secteurs militaire ou de la police. Dans le cadre du pilier régulateur, notons les obstacles suivants : la législation relative à la protection des renseignements personnels en matière de santé et à l'autonomie juridique des hôpitaux en Ontario, la confusion entourant la législation relative à la santé (en particulier la législation relative à la confidentialité des renseignements et à la santé publique), de même que les compétences gouvernementales définies par la Constitution relatives aux soins de santé, à la police et aux Forces canadiennes. À l'intérieur du pilier normatif, des écarts en terme d'idées liées à la « pertinence » d'objectifs institutionnels ou sectoriels particuliers, d'activités ou de voies de communication, de même que des idées divergentes entourant « l'autorité » et « l'expertise » dévolue à certains postes d'ancienneté et/ou d'instruction. En outre, les relations entre ces secteurs étaient jugées importantes puisque ceux-ci avaient l'obligation de travailler ensemble (en conséquence, la compréhension réciproque était importante). Enfin, concernant le pilier cognitif-culturel, différentes cultures sectorielles (« la loi et l'ordre » par rapport « aux soins et à la compassion »), (« le commandement et le contrôle » par rapport « à la prise de décision indépendante, mais collaborative », de même que le « trait » culturel commun d'une réticence à partager l'information, commune aux trois secteurs) et des silos ont été considérés comme des obstacles potentiels importants à la collaboration entre les organisations. Enfin, le manque de relations entre les secteurs a été identifié comme un obstacle potentiel majeur à la collaboration entre les organisations, étant donné que le manque de telles relations entraîne un manque de

compréhension réciproque des capacités, des limites, des rôles et des responsabilités de chaque secteur.

Table of contents

1 Introduction

This paper reviews the findings of a research project based on a field case study involving qualitative research of professionals in the healthcare sector carried out between September 2009 and December 2010 in order to empirically validate an institutional framework developed to study inter-institutional collaboration between military and policing and healthcare organizations in Canada. "Collaboration" for the purpose of this case study can be defined as a process where two or more people work together in an intersection of common goals by sharing knowledge, learning, and building consensus.

The research question investigated whether any attitudes or behaviours existed amongst healthcare personnel that would create social or cognitive barriers to institutional collaboration with police and/or military personnel in a public safety context. The study population involved current or former healthcare professionals from middle to upper management who are or were involved in senior decision-making linked to potential collaboration with the Canadian Forces and the police sector. Personnel (or former personnel) from the Ontario healthcare sector were featured. Convenient or available subjects within the above-stated parameters were used to obtain a sampling wide enough to identify the key views and attitudes found in the healthcare sector, at the senior level, that may influence potential collaboration with the Canadian Forces and the police sector.

Using Scott's three pillars of Institutional Analysis (IA) as a framework of analysis this paper explores the regulative, normative and cultural-cognitive features impacting the healthcare sector's ability to collaborate with the military and police sectors in emergency planning, response, and management.

Effective multi-agency collaboration constitutes a formidable challenge. Collaborators have to deal with different operational procedures, terminology, corporate culture, and organizational priorities. Oftentimes, the collaborators are also facing an environment where time constraints and political considerations can become serious limiting factors to the scope of collaboration. This complex problem is not entirely new, and has already been the object of serious research efforts to date, mostly emphasizing the psychological and technological dimensions of this type of collaboration.

Although psychological and technological research efforts are essential in supporting the Canadian Forces to achieve its mission critical to outcomes, they would greatly benefit from being complemented by research efforts aiming at the institutional dimension of collaboration. Without a sound understanding of the social and institutional conditionings of individual and small group interactions, it is difficult to maximize any research on inter-agency collaboration.

IA provides an analytical framework that can fill an important gap in our understanding of inter-agency collaboration. Formal institutions of the state such as the military, police and security forces, and healthcare agencies largely overlap the social institutions that legitimize their existence. Given this context, it is understood that no sharp distinction can be made between formal institutions, agencies, and social institutions. Furthermore, it is expected that inter-institutional collaboration occurs at the margins of formal and social institutions, where new social space and microsocial orders can be negotiated to ensure that each institution's mandate

and legitimacy are preserved when facing public safety and security challenges requiring multi-agency collaboration. IA is a term used by many disciplines (particularly anthropology, economics, political science, and sociology). For the purpose of this study, IA is considered as an analytical approach aiming at uncovering collective mentalities that affect decision-making, organizational behaviour, and attitudes. Challenges of collaboration, for the purpose of this study, are not considered as matters of individual psychology, but as conflicting institutional realities that transcend individual interactions.

2 The Three Pillars of Institutional Analysis

As Ouellet (2011, in print) observes, within the vast sociological discourse on institutional analysis, Richard Scott's framework is one of relatively few that enables an extensive study of institutions (Ouellet 2011, in print: 3)[1].

Scott's detailed three-pillar conceptual model not only addresses the primary foundations of social order, but takes analyses further. The regulative pillar is concerned with issues of "social predictability" and is comprised of formal and informal rules, regulations, laws, and sanction systems (Ouellet 2011, in print: 3). The other two pillars in Scott's analysis (the normative and cultural-cognitive pillars) are useful in shedding light on the foundations of a "cohesive" social order (Ouellet 2011, in print: 3). Social cohesion is dependent on a variety of unquestioned, commonly-held values and norms about "what is desirable, acceptable and legitimate", thus making the normative components of social cohesion (the second of Scott's pillars) vital to institutional analysis (Ouellet 2011, in print: 3). The cultural-cognitive pillar (the third in Scott's model) focuses on "shared preconceived notions, thought patterns, and worldviews that also contribute to maintaining social cohesiveness" (Ouellet 2011, in print: 3). Combined, the three pillars of institutional analysis enable an all-encompassing study of the actions and decisions of an institution. In the discourse of institutional analysis, the significant decisions that are made by an institution which result in real actions (or inaction) serve as the primary unit of analysis (Ouellet 2011, in print: 3).

Scott's three pillars, as independent variables, can be used to determine why particular actions (or inaction) have the consequences they have (Ouellet 2011, in print: 3). Rules and regulations can restrict what is imaginable (the cultural-cognitive pillar), while at the same time a particular rule can be considered an expression of "underlying norms and values" (Ouellet 2011, in print: 3). To surmount this dilemma of "overlapping dynamics", institutional analysis methodically divides the three pillars, employing specific indicators for each (cited in Ouellet 2011, in print: 3-4)[2]. The indicators for the regulative pillar include formal and informal rules, regulations, laws and sanction systems, as well as rules and sanctions invoked when taking decisions (Ouellet 2011, in print: 4). In terms of the normative pillar, the indicators used are concerned with social expectations about espousing shared norms and standards of action – typically invoking ideas about the "appropriateness" or the "normal" way of "doing business" (Ouellet 2011, in print: 4). Finally, common cultural-cognitive indicators are "specific beliefs, worldviews, thought patterns and the invocation of what is 'right', 'correct' or 'true'" (Ouellet 2011, in print: 4).

However, as with any approach, institutional analysis has its limitations (Ouellet 2011, in print: 4). One of the primary limitations is that making distinctions between the normative and cultural-cognitive pillars can often be challenging (Ouellet 2011, in print: 4). For example, within military institutions the use of organizational charts is common. As Ouellet notes, "this can be both interpreted as a cognitive 'reflex', and a normative commitment to hierarchical constructs. A degree of 'dialogue' is therefore necessary in the analysis between the various types of data" (Ouellet 2011, in print: 4).

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[1] Richard Scott. 2008. *Institutions and Organizations: Ideas and Interest*. Thousand Oaks: Sage.
[2] Marc Scheiberg and Elisabeth Clemens. 2006. "The typical tools for the Job: Research Strategies in Institutional Analysis", *Sociological Theory* 24, 209.

Moreover, institutional analysis is largely a critique of the rational decision-making discourse. Consequently, if taken too far, it can result in unsubstantiated claims and a disregard for "common sense decision-making" in addressing discernable dilemmas (Ouellet 2011, in print: 4). Donaldson has observed (in relation to institutionalists) that structures are neither functional nor rational; they are irrational and of dubious effectiveness[3] (cited in Ouellet 2011, in print: 4). This is at odds with the central ideas of management theory which assert that structural adaptation aimed at improving effectiveness is vital. Therefore, institutionalists risk dismissing contingencies that an organization may face in attempts to increase efficiency (Ouellet 2011, in print: 4). Therefore, it is important to address factors related to effectiveness and efficiency in institutional analyses (even those that include a multi-pillar "dialogue", such as Scott's) (Ouellet 2011, in print: 4).

We turn now to a discussion of the findings of this research beginning with findings related to the regulative pillar of the healthcare sector.

[3] Lex Donaldson. 1995. *American Anti-Management Theories of Organization*. Cambridge: Cambridge University Press.

3 Regulative

As stated above, the regulative pillar is comprised of both formal and informal rules, regulations, laws, and sanctions systems, as well as rules and sanctions used in decision-making processes. In terms of the healthcare sector, laws related to the protection of personal health information and the independence of hospitals and physicians within the health sector, different government jurisdictions related to healthcare and the military, as well as the need for clarity around health-related legislation and governmental/institutional jurisdictions were identified as significant regulative issues that impacted the healthcare sector's ability to collaborate with the police and military sectors.

3.1 Legislation protecting privacy of health information

One of the most significant regulative components identified by respondents who worked in the healthcare sector as influencing collaboration between the health sector and the police and military sectors was the legislation to which healthcare professionals were bound that protected the privacy of personal health information. As one respondent noted:

> That's traditionally been a bit of a problem…I'm not saying it's totally resolved…and of course we have different privacy legislation in every province in Canada too – 'cause healthcare is provincial it's not national – so it may be more of an issue in some provinces than others in terms of the ability of the hospital to disclose information to the police in certain circumstances where people are at risk (Interview 3: 3).

Still another respondent remarked: "I think that certainly within healthcare there's a bit of a reluctance to engage the police and the military, in part because there's often issues around patient confidentiality and issues like that" (Interview 12: 3). Yet another interviewee reported that, "healthcare always has the issue about confidentiality and what they [healthcare professionals] can tell or can't tell anyone who is not directly involved in healthcare" (Interview 4: 4). And another respondent stated:

> [the health sector has] got a huge issue around confidentiality…that are completely at odds with trying to run a big emergency. You know, it's an enormous problem how you…maintain, public order, but don't give out confidential information. It's an enormous issue… I think it's a frustration for them [the police and the military] sometimes because the healthcare people can be phenomenally circumspect about information, and its use, and what they can say (Interview 8: 14-5).

One respondent, however, pointed out that although the legislation protecting the privacy of health information was an issue, it was one that could potentially be addressed if the security sector was bound by similar privacy legislation to which those working in the health sector were bound:

> I don't know what legal impediments, what confidentiality restrictions, the police operate under, but I don't think they're the same as we [the health sector] operate under at all. It could be dealt with [by] some sort of legal mechanism that would…at least legally bind the police or the security forces to be subject to medical type confidentiality when they're asked by us to do something like that. Whether that would work, whether that would be enforceable, I have no idea (Interview 4: 5).

Some respondents, however, disagreed that the legislation protecting the privacy of health-related information was an issue. One observed that in dealing with emergencies such as large-scale flooding or power outages, a massive storm, or an infectious disease pandemic, such legislation would not really be an issue as far as those in the health sector collaborating with those in the security sector because: "…our [health] privacy legislation is about personal health information, so if you're not sharing personal health information – and really, why should you? It's no use to them [the military and police] – it's not an issue, as far as the law is concerned" (Interview 18: 8). Another interviewee concurred and pointed out that,

> …I'm not sure [information technology is] going to help all that much. We're trying to get electronic health records in place across the province, but I can't see the police having access to them because the only people who would have access, under the law, would be people that have a need to know to provide patient care and police don't provide patient care, so…I can't really see that there'd be much exchange of information between the healthcare system and the police force (Interview 3: 5).

Still another interviewee agreed with this perspective, but noted that a reticence to share information was not only an issue in the healthcare sector, but was an issue in the security sector too. They highlighted that the issue of sharing of information went beyond the issue of individual patient records to issues of public health laboratories sharing information (or not) with hospitals, first responders such as paramedics, the MOH, and local Public Health Units. Further, this respondent pointed to confusion around to exactly which information such legislation applied.

> Certainly…on both sides I think there are big issues… On the police/military side whole issues about…security and…sensitivity of information is definitely there. On the healthcare side…a lot of it comes down to legislation around…patient information and consent and privacy. And…it has been hard sometimes for even…the provincial government to get information about patients in hospitals that are having outbreaks and stuff. So…there's lots of legislation within the healthcare sector about patient privacy and things which makes it somewhat difficult to, even though a lot of these things [mass-scale emergencies and public health issues such as infectious disease outbreaks] don't involve individual patients, there's that whole sort of aura around how information is managed in health, and…how do you share that, or what you can or can't share; things like that…They [privacy legislation/restrictions] technically may not be a barrier, but they are perceived to be a barrier (Interview 12: 10-1).

Another respondent also raised the issue of security sector concerns related to the sharing and protection of information and stated:

> We all communicate electronically. That certainly hasn't been much of an issue. We can teleconference… We can videoconference… I do know that…there were some sensitivities with respect to the various police forces in Canada…sharing information during the exercises that took place…this is the type of information that they wouldn't normally share with other [organizations], so…that's the area where there were sensitivities… Obviously [name of organization], as a player in the exercise, was relying on information-sharing from some of [the] security forces, and there was sensitivities about sharing that sort of information…I think understanding who they can share information with, that was an issue that was identified …what could the [police] share with us [the health sector], and what could they share with each other? (Interview 16: 5).

Yet another respondent tied the legal obligations to protect particular information to the issues of trust *within* and *between* particular organizations and sectors pointing out that:

> …We [the healthcare sector] [are] not part of the security domain from a national security perspective, so sometimes they may not think we need to know. There's definitely information that we know we will not get because it's sensitive, which is fine… I don't know what the military thinks of [a particular organization], but what [many in the healthcare sector] tr[y] to tell them is everyday physicians and Medical Officers of Health hold personal information and confidential information, and [they're] able to keep that information secure, so that you can trust [them] with that type of information because [they're] used to handling it. So, I don't know that the trust is 100 percent, but I think it's getting there in terms of realizing that [the healthcare sector] can deal with that (Interview 19: 11).

Still another respondent identified similar issues, and pointed out the need for both the security and health sectors to gain a better understanding of each other's roles, needs, and limitations in order to better understand the areas of "overlap" and the need to collaborate (as well as the benefits of such collaborations) in certain areas. They noted that:

> …in the health world there's often distrust of police…just because we're so protective of personal health information…as they are of their own information, but…I think it's really important for us to take every opportunity – we can't deny that there's an overlap in some situations and that we need each other, and we need to understand what each other's roles are, and the things we can and can't do…They [the police and military] need to understand what the boundaries of [the *Health Act*] are, and [the health sector] need[s] to understand what their concerns are – you know, everything from needing a warrant for certain things. So, the more that we're able to do the day-to-day stuff and understand each

> other, the better off we are when we have either planned or unplanned emergencies where we really need to work together for the good of the public (Interview 3: 15).

This was also corroborated by the *SARS Commission* at which healthcare workers involved in managing the SARS outbreak in 2003 testified that hospitals were often reluctant to share information with the Ministry of Health (the MOH) and local Public Health Units citing their legal obligations as health professionals to protect patient privacy and confidentiality (Campbell 2004: 122-31). Furthermore, it highlighted the issue of the lack of clarity regarding particular health-related legislation and legal obligations to report and/or protect such information, especially in times of emergency. Lawyers, it was revealed, had to deal with two different provincial-level courts around this issue of privacy and other health-related legislation during SARS (Campbell 2005: 213-24).

In addition to health-related privacy legislation, other particular legal barriers were noted as significant issues in terms of the hospital sector and how it related to other parts of the health sector (such as the MOH and Public Health) – never mind sectors beyond health, such as the police and the military.

3.2 Hospitals: Independent Actors within the Healthcare Sector

Further complicating the regulative pillar in terms of legislation related to the health sector (at least in Ontario) was that hospitals were governed by separate legislation from the rest of the healthcare sector. Under the *Public Hospitals Act* (the PHA) in Ontario, hospitals are governed as autonomous corporations by independent boards for each of the 154 hospital corporations in the province. Thus decisions about the operation and administration of a hospital (i.e. emergency planning, preparedness, and response policies) were, by and large, up to the board governing that particular hospital as opposed to the MOH (Campbell 2005: 153). This impacted the way in which hospitals collaborated (or not) with other segments of the healthcare sector, such as Public Health, as well as other sectors such as the police and/or the military. For example, during an infectious disease outbreak such as SARS (or any other mass emergency), a hospital board could make a decision to close a ward (or an entire hospital), and such a decision was beyond the control of the MOH; hence such decisions were not necessarily integrated province-wide, but were individual hospital policies/decisions. On this point, one interviewee explained that during a particular public health incident:

> [Hospitals] had to tell the Ministry what [they] were doing, but it was primarily a hospital decision [to close a ward or entire hospital]. The Ministry obviously didn't like the idea that hospitals were closing themselves down…they were very upset [but]…[some] just didn't have the staff to run [the] department 'cause [they] had to send so many people home…and so [they] just said, "We're going to close it", and the Ministry got all upset 'cause they don't like you closing…departments, but [some hospitals] did it anyways – [They] said, "Too bad, we're going to do it" (Interview 3: 4).

This interviewee further highlighted some of the dilemmas of collaboration even within the healthcare sector in terms of legislation and relations between hospitals and other parts of the healthcare sector such as Public Health or the MOH. Their comments highlighted that because of the independent legal status of hospitals they tended to operate with little sense of the necessity to collaborate with others in the health sector, let alone other sectors such as the police or the military.

> …If hospital staff were put in quarantine [the hospital] made sure [it] enforced that [its] staff remained in quarantine…Now I guess [hospitals] couldn't be sure they stayed at home, but [they] could at least be sure they didn't come to work…And I doubt if [name of organization] had the resources to [monitor compliance to quarantine orders] 'cause…it was a huge number and Public Health has minimal staff…but it wasn't something that was [a hospital] responsibility – it was Public Health's responsibility (Interview 3: 3-4).

This respondent did not discuss if hospitals collaborated with Public Health to ensure its staff abided by quarantine orders; however, according to this respondent, a hospital's responsibility was to make sure that if it had employees under quarantine that those employees did not come to the hospital to work, but beyond that it was Public Health's responsibility to ensure that those under quarantine complied with the order. As a result of (at least in part) legal responsibilities, it seemed "turf" was carved out *within* the health sector such that hospitals considered quarantine solely a public health concern under the law (and therefore, not a hospital issue); hence a culture emerged of hospitals operating independently and without a great sense of the need to collaborate with Public Health on such an important public health issue. Therefore, it should not be surprising that those working in the hospital sector might not have considered it relevant to collaborate with sectors *beyond* healthcare (i.e. the military or the police).

One respondent, when asked to reflect on real or potential collaborations between the police and/or military and the hospital sectors, said:

> I don't think that there's any difficulty [in collaboration]. I think they just have a very different focus. They [the security sector] have a different culture and different focus – different purpose… I think they are trained in crisis management continuously, and [those working in hospitals] are trained in crisis management, but not on a daily basis…[Hospitals] don't have any [collaborations] with the military, really. And the police – [the police and hospitals] don't have integrated systems…The police come to…hospital[s] to see patients, but it's because of something outside of what [hospitals] do… they [the police] bring patients in, and that's about it; or they…they bring patients into emerg, or they…investigate…knife, gunshot wounds or something, or they come to lay warrants on patients, but they don't have anything to do with [a hospital's] operations when they do that. They are protecting the public, and the public happen to be at [a hospital] (Interview 11: 1-2).

Clearly, according to this point of view, there was little, if any, necessity or relevance for those working in the hospital sector to collaborate with the police or the military, as they had different roles and different foci. Consequently, the health, military and police sectors had few (if any) points of intersection. According to this line of thinking, *if* the police were involved with hospitals it was *not* related to the work of hospitals *per se*, but rather was part of the police "law and order" function.

Another respondent noted some challenges experienced by those in the hospital sector related to the demands and expectations placed on them by the MOH and/or Public Health. These challenges had to do with different roles/responsibilities of each within the health sector and the lack of understanding of the constraints under which each was working as a result of silos that existed within the health sector. According to this respondent,

> I would say [during a particular health emergency] the government and the Public Health sector produced more stress to the hospital and use of resources to produce what they wanted. You'd say…"I feel very strongly, I'm here to manage patients not to give you statistics you can go "oo and aah" over, which I know are important, but you have it coming on both ends. And these people up here [in the government and Public Health] live in a world of Nod… They have no relationship at all to reality. And they want these figures, they want them yesterday, and you've got to get this done and make sure that's in place… They're sitting in their little office like this: "Well, I think it would be a good idea to have…everybody get 10 million masks (Interview 7: 8).

However, it was not only legislation related to the hospital sector that was considered an issue. Some respondents identified legislation related to the public health sector as an issue related to the regulative pillar of the health sector.

3.3 Public Health Legislation

In terms of public health legislation, one respondent noted a jurisdictional issue that required collaboration between public health officials and the police, but which made such collaboration challenging when they pointed out that:

> …in terms of enforcement of public health measures…if somebody was on quarantine and decided to not be compliant, then the police would be involved…the Medical Officer of Health would have to issue an order to the local law enforcement that would have to enforce keeping that person in their home, or wherever they're quarantined to (Interview 6: 2-3).

While a Medical Officer of Health had responsibility for issuing public health orders (including quarantine orders), under the law that individual could not enforce such orders, but had to rely on the police to enforce compliance, as that was a police jurisdiction. This issue was also highlighted in the *SARS Commission Report* as a challenge for public health officials, the police, and lawyers

in terms of the time it took to get such orders applied and enforced through the court system since the process involved multiple courts (Campbell 2005: 213-24).

Another significant issue within the regulative pillar of healthcare that emerged from this research was the particular jurisdictional responsibilities and powers of the federal and provincial/territorial governments related to healthcare and law and order as outlined in the Canadian Constitution.

3.4 Governmental Jurisdictions: Silos of Work and Communication

As a result of the constitutional division of powers, healthcare services were a provincial/territorial jurisdiction. Consequently, the way in which healthcare was delivered and governed differed from province/territory to province/territory in terms of the level of autonomy or centralization of decision-making and authority that existed in the healthcare sector provincially/territorially. Such differentiation impacted inter-organizational collaboration in terms of the provincial/territorial management of and response to mass emergencies which were potentially (and in reality often were) operationalized in thirteen different ways.

Although, as one respondent noted, efforts had been made to reduce such silos, these silos would never entirely disappear because they were an inherent part of such organizational and jurisdictional divisions:

> …there are some traditional silos that have been built up in the healthcare delivery system…I mean…there was commentary on how hospitals worked in isolation of public health…and how all these worked in isolation of other healthcare delivery agencies. And [there has been quite a bit] done…to make sure that some of those silos have been broken down. And I think, from my perspective…[we have seen] a lot of cross fertilization across these silos. But they do still exist. I mean, it's an organizational reality when I'm an organization, I have a defined mandate. You're an organization, you have a defined mandate; only in specific circumstances do they intersect…it's just how we operate (Interview 5: 2-3).

The governmental jurisdictions related to healthcare were noted as potential barriers to collaboration because different levels of government were keen to protect their "turf", or argued that particular roles and responsibilities were (or were not) legally or constitutionally theirs to address or manage. As another respondent put it, "…You're often told in advance: 'That something's being done at the federal level. That's not something you're involved with. You're at the provincial level. We'll take care of it'…that sort of thing happens a lot" (Interview 12: 5). Clearly from such a perspective, different levels of government had different jurisdictions and responsibilities. As such it was "inappropriate" (a normative issue) to collaborate with those working in a different level of government; hence they often worked in isolation from one another. Such an understanding of government jurisdictions did not acknowledge the interconnectedness of the roles and responsibilities of different levels of government, or the necessity for interconnected emergency planning. As the respondent quoted above further observed:

> …people…think about their jobs in silos. Trying to get healthcare people to be involved in emergency management and understand that whole issue, and why they need to do it in the first place…is a struggle… And we sort of moved forward a little bit…[in terms of] get[ting] people engaged, and thinking about this is an important way to spend your time, or an important activity to undertake, but once they do that they still think …we have a job to do which is we have to look after patients, and there is …less understanding in terms of how they may relate and how what they do and what they know and information they have access to may be of benefit to somebody else – and vice versa (Interview 12: 6).

Moreover, the *SARS Commission Report* noted that in terms of the 2003 SARS outbreak, the downloading of financial responsibility for particular healthcare roles (ie. public health) was a significant issue for municipalities which had fiduciary responsibilities for local public health units without necessarily the financial means to meet that responsibility since most municipalities depended primarily on a property tax as their financial base, unlike provincial/territorial and federal governments that had additional taxes (such as income tax and sales tax) as financial base on which to draw (Campbell 2004: 183).

Furthermore, while municipalities had the fiduciary responsibility for public health services in Ontario they did not have the accompanying legal powers or responsibilities since the provincial government retained the legal responsibility for the overall management of healthcare. This division of responsibilities presented barriers to collaboration in addressing the SARS outbreak because one level of government (provincial) imposed administrative and fiduciary responsibilities on another level of government (municipal) without the accompanying financial and legal tools to meet those responsibilities. This caused tensions between the provincial and many municipal governments. Moreover, it resulted in different responses to the SARS outbreak regionally within Ontario depending on the priority a particular local government placed on funding the public health units within its jurisdiction (Campbell 2004: 176-84; Campbell 2005: 59-86).

These inter-governmental jurisdictions played a part in determining communications between different levels of government. As was noted by one respondent, communication tended to occur *within* a given level of government (municipal sectors with other municipal sectors, federal with other federal sectors) rather than *amongst* different levels of government.

> …There's interaction that occurs up there [at the federal level]. That's where the connection is…when you're a federal employee…you deal with other federal employees and…all the communications flow, all the stuff sort of connects together at the top of the organization with an organization that's at an equal level…and then things run down sort of through Health, but *The Public Health Agency* and *Health Canada* [don't] really have a lot of active role in delivery of healthcare…on the public health side they're more of an information collector and…[for] the federal level [to] become involved in a provincial or local issue is…very rare because it has to be…beyond two provinces…it has to be a fairly significant issue, and there's all these rules about when they would get

> engaged anyways, and when they would want to be involved. So…you don't have a lot of interaction day-to-day with the agencies at that level in terms of the health sector. So because of that you sort of think about…the military as the same kind of thing; that they are outside of the tier that you operate in. And if you are provincial, if you are a local person you tend to sort of operate with people in your own tier…if you sort of draw health care, there's healthcare all the way down, whereas the military – you sort of have the sense that they stay up there, you don't have a…provincial-level sort of military organization, or a local-level military presence in most places down here…to cross-talk (Interview 12: 7).

According to this respondent, Health Canada and The Public Health Agency of Canada, at the federal level, monitor trends related to public health issues such as infectious disease outbreaks, while the front-line health sector (such as local public health units, hospitals, family physicians, and emergency responders) are under provincial jurisdiction and there is little communication between these two sectors – clearly an issue in planning for and responding to an emergency.

One respondent emphasized that these legal/constitutional jurisdictions presented a barrier to inter-governmental collaboration because such jurisdictions stipulated a legally/constitutionally sanctioned chain of inter-governmental communication. They asserted:

> It should never be the municipality [that requests federal assistance]. The way it's set up it's the province who asks for the assistance, not the city… And actually, should never be done politician to politician because…there are legal consequences to doing it…there are liability issues…and it should always be a province asking the federal government. It may be a municipality that asks the province to ask the federal government, but that's the channel that it has to go through… There's a prescribed sort of method to doing it – and it works (Interview 8: 2-3).

Another respondent agreed, stating:

> …It's not proper for me to go to a different level of government. In fact, I will have my internal processes, but the bigger issue really is you cannot just jump to the federal level…without the province being in the picture… It's only a military barrier…because the military is identified as being the federal level, which is one step removed from the next level… The same would apply to any other federal resource (Interview 9: 11).

This respondent reported that their reservations about collaborating with the military were primarily about respecting jurisdictional boundaries. They pointed out that based on the jurisdictions between different levels of government there were protocols in place that structured the interactions between different levels of government. Such protocols meant that local or municipal levels of government had very little (if any) direct contact with federal government departments or institutions such as the military. Consequently these protocols shaped inter-government collaborations in a particular way. Further this respondent illustrated the connection between the three pillars in terms of the ways in which rules, regulations, and protocols shaped a

sense of a "proper" or "appropriate" chain of communication amongst different tiers of government. As this respondent noted:

> The reservations essentially are whether I'm overstepping my boundaries…meaning there's a hierarchy that we generally have, and maybe we don't understand the military...the common understanding is that if I wanted to access any federal resources, and the military I identify as being federal... So if they are federal, then for me to access anything federal I have to go through the provincial route. So in fact it's unheard of [to go directly to the federal level of government]. It's unheard of for me because I've actually got to go and discuss my needs at the provincial level. If the province is not able to meet those needs then they may consider a number of resources at the federal level, one of which might be the military… Now, if we had direct access to the military…and the province is fine with it, then I can see collaboration with the military expanding dramatically…we [in healthcare] just don't see…[the military's] role locally, and maybe that's a misconception on our part, because we don't see their role locally because we just generally always believe that we have to wait until the provincial resources…are overwhelmed before you engage the military (Interview 9: 10-1).

Still another respondent agreed with this perspective, but highlighted regional differences:

> The other issue is that because health is largely a provincial jurisdiction that most of what happens in hospitals – [name of region] in particular is a little bit of different situation because hospitals are all individual autonomous bodies. We don't have really good regionalization like what has occurred elsewhere in the country. So not only is health itself a provincial issue, but it really gets devolved even further to this group of hospitals throughout the province which are…loosely working together; whereas the military is a federal level organization with…much fewer connections locally, particularly in [name of province]…out West and other parts of the country there are still more local connections between the military and what happens locally, but in [name of region]…there's no sort of presence of the military…nothing that people seem to interact with all the time… It may differ elsewhere in the country where there are better connections between local military establishments and local healthcare people (Interview 12: 4-5).

Furthermore, this respondent noted that the responsibility for managing and responding to emergencies was often split between different ministries of the same level of government, and that much of the communication in managing and responding to a particular emergency tended to happen at the upper level of government ministries, with little input from front-line workers, in spite of the fact that they knew best what the reality "on the ground" was, and they were the ones expected to carry out the particular policies and practices in responding to and managing an emergency. Their exclusion from emergency planning meant that there were few avenues through which front-line workers (who were expected to work together in responding to an emergency)

could interact with each other and forge relationships prior to an emergency; those relationships which so many respondents asserted were critical to emergency preparedness and response. (This will be discussed further later.) This respondent posited that:

> …one of the difficulties is they [health and emergency management] lie within different ministries often. So the Ministry of the Solicitor General…which also has the Emergency Management…EMO – Emergency Management Operations office for the province – as opposed to the EMU which is the health sector specific emergency management branch for the Ministry of Health. So the interactions that occur largely are at the higher levels, and the people that are really doing the work often don't interact probably as much…[or] as effectively as they should (Interview 12: 1-2).

3.5 Legal Clarity Required

Such jurisdictional divisions often created confusion about where such lines were drawn – especially in responding to emergencies. As one respondent noted, one issue was conflicting mandates that led to jurisdictional confusion related to legal roles and responsibilities:

> Conflicting mandates…like the federal government and the federal system where you have different jurisdictions…between the federal government, and the provincial government, and local governments. Certainly…it lends to some confusion when you're in a crisis: Who does what? Where does your jurisdiction end and mine begin? What is your legal authority for doing what you're doing – if you have any? Those barriers, those are more than just organizational barriers. I think those are jurisdictional issues…(Interview 5: 4).

Some respondents recognized that the military bore a jurisdictional responsibility for the provision of healthcare to its personnel. This blurred some of the boundaries between federal and provincial authorities in the minds of many, including those who worked within the military and health sectors. As one respondent reflected:

> I think the military considers itself almost like a separate jurisdiction, if you like, so…they feel that their Medical Officer is like one of the Chief Medical Officers of Health, and I'm not sure that's seen in exactly the same way by all the other Chief Medical Officers of Health... I think everybody recognizes that the military has a separate population that they look after. They do realize that coordination is important so that we all know our roles and responsibilities. I think there is a recognition that the military can't really provide just as much help, as it were. There's not much capacity there. It's not as though, if a province is overwhelmed, that [the health sector] would expect the military to rush in with hospitals or anything, because really their capacity is built with their own population in mind, and there isn't enough to be helping the provinces and

> territories…So really, I think the military is perceived as playing a rather small role within Canada in providing healthcare and health services (Interview 19: 8).

Aside from jurisdictional "grey areas" or points of confusion, it was noted there were also areas in which legal clarity (often connected to these areas of jurisdictional confusion) around roles and responsibilities was important. One respondent raised the issue of clarifying legal "grey areas" around to which health information the privacy legislation applied. The legal confusion created a perception within the health sector of barriers to sharing health-related information that was not necessarily tied to a particular individual.

> So there's a lot of grey around…'cause a lot of this legislation is new…there's questions around…you can't share information about individuals and personal data, but how does that relate to organisms and bacteria you identify or things like that…in lab data? How does that – even though it's linked to a patient, but if you're not reporting about the patient at all, there's a lot of that same stuff which is handled in the same way, even though it probably doesn't fall under that legislation, but no one's looked at that. There haven't been legal decisions about: Does it? Doesn't it? How do you handle it? So for now everyone just, you know, tries to keep everything close to them and not share (Interview 12: 10-1).

Another respondent insisted that roles and responsibilities in responding to and managing emergencies needed clarification.

> These are your boundaries. These are mine [in an emergency]…I think the police should clearly understand their role. Their role is security, and it's at certain breach areas. Like they don't wander around the hospital…playing heavy. They [the hospital administration] say, "This is your area here. Make sure it's secure. And that's it. You have no other authority than that" (Interview 7: 4-5).

Within the regulative pillar, privacy legislation, organization and government jurisdictional divisions, and confusion related to such jurisdictions and legislation were identified as significant barriers to the health sector collaborating with the police and military sectors. These issues have shaped and been shaped by the normative pillar of the healthcare sector, which we turn to now.

4 Normative

Within the normative pillar, notions of "appropriateness", authority, expertise, and social obligation are central. Related to the normative pillar of healthcare, respondents identified notion of appropriateness of chains of communication and collaboration based on certain authority and/or expertise in a given jurisdiction or issue. The independence of hospitals, a sense of cooperation being a "Canadian" value, and the idea that relationships amongst and within these sectors were critical to emergency response were significant issues identified by respondents as impacting inter-organizational collaboration.

4.1 "Appropriateness", Authority, Expertise

As previously stated, the regulative pillar has shaped, and been shaped by, the normative pillar in terms of notions of the "appropriateness" of behaviour and/or binding expectations of the health sector. For instance, the rules and laws that determined government jurisdictions discussed earlier shaped how different levels of government interacted. One respondent expressed that a sense of collaboration was the "norm" within the healthcare sector, and that "appropriate" channels of communication between different tiers of government were determined by the jurisdictional authority/responsibilities held by different levels of government. This respondent stated that:

> With the police absolutely no questions. There is no issue at all. Maybe that's because you're talking to somebody who practices…health. Maybe if I was in a different discipline it might…surprise me. But in [particular sector of health] we're used to these collaborations. The military, on the other hand, is a different ball game because we don't actually have any military bases here, and we don't actually see the military as a local resource. We see the military as a federal resource, and normally we don't go to the federal without going to the provincial levels first. So…there is a little bit of a pecking order in terms of how we communicate. So if we did feel that we…needed something to do with the military…it's unlikely that we'd call them directly. We would probably go to the province first and then the province would call the appropriate folks (Interview 9: 3).

Another respondent identified the role of the military in providing health services to its personnel as a source of friction between the military and the provinces/territories due to a sense that such services were being delivered inappropriately, given that the military had opted to use private health facilities (as opposed to provincially/territorially managed ones) for its personnel's health services. As they remarked:

> The fact that [military health services are] a federally-driven system in a country where the supply of healthcare is under the direct and exclusive jurisdiction of the provinces is clearly a very important barrier. That barrier exists at every level that makes collaboration between the two sectors very difficult… The decision…that has been taken a long time ago, on the

> part of the military to use…private sector providers on a for-profit, fee-for-service, pay-as-you go basis is…a source of…irritation between health services, provincial health services and the Canadian military. This is…a thorn in the flesh of many people that are trying to manage health systems. So when you say nobody should be using private service, but you have the Canadian Forces doing it on a regular basis, it certainly creates pressure (Interview 15: 4).

Yet another respondent remarked that, in their experience, much of the collaboration

> …usually happens inside of government…so it's been government at the provincial and federal levels, but it's been mostly on the bureaucrat side. So, I think it's been less on the subject matter expert side on both sides…those that are doing the work in policing, or those that are doing the work in healthcare and have the subject matter experience versus the bureaucrats at the top that usually are within ministries that don't have content expertise in the field they're working in. They're more experts at governance and process. So that's who I would say has been doing it so far; and that occurs at the federal level as well as the provincial level (Interview 12: 2).

It seemed that this respondent did not deem bureaucrats as the "appropriate" people to be doing the emergency planning work since they lacked either the health or security-related expertise deemed necessary for such planning.

Still another respondent stated that within the health sector (and public service sector broadly) there was a hierarchy of personnel based on "expertise" and senior-level authority which clashed with the culture of the military. In the healthcare and public sectors those with the greatest authority (i.e. those in senior-level positions) were deemed the most appropriate individuals to attend meetings and represent an organization. Within the military, however, seniority and authority associated with rank did not necessarily equate to "expertise" in a given area, and therefore, senior-ranking military personnel were not necessarily considered the most "appropriate" ones to represent the military on a particular issue. According to this respondent this sometimes caused consternation and confusion amongst those in the health sector and required clarification:

> I didn't anticipate any issues, but I also understand rank structure, military structure, and the way that the military speaks. I didn't have an issue with that…There was certainly some…not even concern, some hesitations on the part of people…as to how we were going to work with the military given that they have a very different structure to what we operate with... I think there's not an understanding…for example, [we] had a liaison officer…from [the military] [and]…the concern was that [this person] was sitting in on meetings…[and] they [those in the health sector] didn't understand why the military was sending someone of a lower rank…There's a different feeling within the public service about the appropriateness of positioning, and appropriateness of people who attend

> the meetings. So it was trying to explain that to them. So it's not necessarily that the military should be sending a colonel because it's not the best use of people or assets, but it was just explaining…why they weren't sending a senior officer, and the fact that it wasn't being treated as any less serious by the military, it was just that that was the appropriate person to send because [that person] had the subject matter expertise (Interview 17: 2).

Ideas about "expertise", "appropriateness", or social obligations were also often tied to particular legally sanctioned roles, responsibilities, and/or authority as in the legal autonomy of hospitals.

4.2 Independence of Hospitals

The legal autonomy of hospitals in Ontario shaped notions of the "appropriateness" or obligation of hospitals to collaborate or share information with other parts of the healthcare sector, as well as sectors beyond healthcare. This shaped the behaviour of the hospital sector.

It was noted earlier that under the *Public Hospital Act* hospitals in Ontario operated as 154 independent corporations governed by independent boards of directors. This legislation contributed to shaping a culture of hospitals operating independently. If hospitals were independent entities legally, then it was considered appropriate for them to operate as such, and in fact, *not* appropriate under the law for any entity other than a particular hospital board to make decisions about a given hospital's policies and practices. As one respondent observed:

> We still…in general within the health field…have difficulties even in engaging…with the hospital sector; 'cause most disaster plans in communities or municipalities start with: everyone responds to the disaster scene; we do this at the disaster scene, patients transported to hospital, and their plans stops there. The hospital's plan starts with: patients show up at hospital door and…and then what happens in the hospital. We've been working for years to try and build better communications and, engage what we call the mobile first responders (Police, Fire, EMS – all the municipal sort of side of things) with the non-mobile first responders, or first receivers which are hospitals, both within the emergency department, but also throughout the hospital (things like critical care, and the ORs and stuff like that which are all impacted by disasters). So, you face those struggles…(Interview 12: 5).

Given that hospitals were legally independent entities, it was an individual hospital's responsibility to develop and administer its disaster plan. In addition, it was up to each hospital to forge relationships with local police forces; relationships which were deemed so critical to emergency planning, preparedness, and response (as discussed further in the next section). More broadly, many respondents noted that the health sector had a different focus (i.e. treating individual patients) from the police and the military which were more global in their actions which were based on notions of serving the "common good".

4.3 Individual Patients versus the "Common Good"

Within the normative pillar of healthcare the health sector's "duty" or moral/ethical obligation to treat individual patients versus the security sector's (the police and the military) "duty" or moral/ethical obligation to serve or act in the interests of the "common good" was seen by many respondents as a potential and/or real barrier to inter-organizational collaboration. One respondent noted, "They [healthcare professionals]…tend to be very focused on individuals making decisions, and you can't interfere with those decisions (Interview 8: 15). This focus on individual patients, as one interviewee noted, was contrasted with triage which the military had practiced for decades. While a physician was trained to focus on and treat individual patients, triage was premised on a responsibility to "the greater good". Central to the practice of triage was the understanding that some (i.e. the most critically wounded) might have to be sacrificed in order to save the greatest number of people. Hence, the healthcare sector had a very different focus and perspective (i.e. treating individual patients) from the military and the police sectors which were more global in focus and action. According to this respondent:

> …I say to [medical people]…we had to have the notion of triaging in military battles years ago. We realized that you put your effort where it was going to do some good, and some people you simply didn't treat them. You had to let them die. And…in emergencies you have to think in very broad terms at first, and then you make it more specific…but you've got to save the most people at the beginning as you can. And you don't spend all your resources on one thing (Interview 8: 16).

Such a difference has proved a significant barrier to collaboration amongst the health, military and police sectors. However, this was not only a normative issue in terms of notions of "appropriateness" or social obligations in terms of one's actions related to either an individual patient or the "greater good". It was also a cultural/cognitive issue in terms of common beliefs or shared logic within a group such as medical professionals, military personnel, police officers, or institutions such as the military and/or hospitals (as will be discussed later).

4.4 Spirit of Cooperation

In spite of the different foci mentioned above, several respondents identified a "spirit of cooperation" across the three sectors. As one respondent emphasized:

> We have a spirit in Canada of cooperation…I never had the sense that there was…a sense of competition, or one-upmanship, or 'I'm in charge'... There [were] challenges fixing whatever the problem was, but there weren't challenges getting help, or engaging [the military], or [the military] saying, 'No. We're not doing 110%'" (Interview 8: 11).

Hence, although these sectors had different responsibilities and foci in terms of social obligations, and differed jurisdictionally (as well as culturally), the principle of the "common good" enabled the military, the police and the health sector to overcome such differences when responding to emergencies which necessitated that they collaborate.

Another respondent echoed this, noting that when addressing emergencies these sectors acted in the interests of the "common good", and worked together to tackle a particular issue, even if formal mechanisms for such collaboration (or for sharing necessary information) were not in place. This respondent observed that:

> …What happens in emergencies is that [the different sectors] just trust each other, and we share anyways, so that the health of the population is not compromised as a result of the fact that there's no agreement in place…but we are trying to put in some MOUs. I don't think that the military is considered in those, but it may be just another dimension that we could look at in the future…(Interview 19: 11).

This respondent felt that although there were no formal agreements signed between the health and military sectors in terms of sharing information, and in spite of the obvious reticence on both sides in sharing information (as discussed later), in times of emergency, whatever potential trust issues there might be were overcome by the common goal of acting in the interests of the "greater good" of the health of Canadians. What helped significantly in this cooperation or collaboration were relationships amongst these three sectors.

4.5 Relationships are Critical to Emergency Response

Cross-sectoral relationships generally (and especially at the local level) between healthcare professionals and law enforcement were critical to emergency response and management, according to several respondents. Relationships were critical because they instilled a sense of social or moral obligation to others, and furthered cross-sectoral trust and understanding. As one respondent observed, building networks and mutual understanding through joint planning and projects was important because it fostered inter-organizational familiarity and,

> …familiarity usually breeds…more familiarity, and more understanding… huge understanding of the issues that are faced by law enforcement and the military in terms of safety, in terms of commitment, in terms of levels of intelligence, organizational skills and…idealism that are in the people, certainly that I worked with… (Interview 6: 5).

Another respondent concurred that relationships, particularly local relationships, were crucial in addressing emergencies collaboratively, stating:

> Well, it's all a matter of building relationships at the local level… Hospitals are separate corporations. You've got 154 separate corporations; so it's each hospital establishing a relationship with its own local police force (Interview 3: 4).

Still another respondent echoed the sentiment that establishing local cross-sectoral relationships was key to local resiliency in responding to emergencies pointing out that:

> The whole thing that we aim for is resiliency and local resiliency, which is why those partnerships locally between EMS, and hospitals, and the security sector are so very important, because if something breaks down

> locally we have to get involved, and nobody really likes that (Interview 5: 7).

This respondent emphasized the importance of building networks and relationships and the role inter-organizational emergency planning could play in that process, observing:

> What helps…is that a lot of the work that we do to prepare for these events is – thankfully these events don't happen every day – you do get to network, and you do build networks and relationships. And you know, people who are part of your committee to develop a plan, you always remember that person; you talk to them at lunch-break, or you have coffee with her afterwards, and you remember that. And that helps …because it's the cold calling people – you do know the face, the names of the people that can answer that question... I think it all helps (Interview 5: 7).

Yet another interviewee felt the importance of relationships was increasingly acknowledged:

> …I think people have really realized this is the way to go. Planning and relationships is absolutely the way to go…The plans are important, but the plans actually only work for a few minutes in an emergency. You've really got to know who's in the room…You can't substitute…plans are great, and plans are wonderful, but relationships are very, very important. I spent a lot of time building relationships…I think that's an important part. You can't work in isolation (Interview 8: 12).

According to this respondent the events of September 11, 2001 fostered a broader recognition that collaboration between the security and health sectors was important in emergency planning, response, and management, yet they felt that the focus on such work had waned in the intervening years (and increasingly challenging economic times); never-the-less it remained crucial to emergency planning and response, and therefore, according to this respondent, it should still be a central focus.

> …after 9/11...there was quite a lot of meeting between the medical community and the emergency managers – and…police, and fire, and other groups tended to be involved in that sort of thing as well…but my sense is that it's probably fallen off in activity. And it's probably fallen off in part because it's longer since the event, and in part because everybody's fixing tight budgets. But…we shouldn't let these things slip because when something happens if those relationships and the plans aren't there, and people aren't on the same page that's when you…you don't want to be learning who's in certain positions in the middle of an emergency. You should know that before hand (Interview 8: 13).

Still another respondent, when discussing the importance of relationships to collaborative work, stated:

> I think not engaging the military…is not an active decision. It's more of a default, sort of impassive decision I think because the relationship's not there. If you knew who to call, if you knew who to be involved with, then you'd be more likely to invite them, or to collaborate. So I don't think there's necessarily as much – there's sometimes a little hesitancy from people in healthcare to engage with more the police than the military I think, because they're more concerned about…back to the sort of issues of patient confidentiality…and…our job is to help people, not to do criminal investigations or whatnot (Interview 12: 6).

The lack of inter-organizational relationships then, was a block to collaboration because without them there was little understanding amongst the health, military, and police sectors of who to call, and what the potential points of interaction amongst these sectors might be. As one interviewee observed, their attendance at a cross-sectoral workshop enabled them to educate participants in the workshop from other sectors of their organization's roles, responsibilities, and capabilities. "And at the end of the three days, it was:

> Okay. We had no idea you had that kind of capability'. So I think it's an education piece from both ends: What can you do for us? What can we do for you? How can we do things together? (Interview 17: 7).

In a further illustration of the barrier that a lack of cross-sectoral relationships could be to collaboration, many healthcare professionals from the hospital sector who testified at the *SARS Commission* noted that often those who requested information on behalf of the MOH were unknown to them; hence the role and authority of such people in asking for such information (and the obligation of those working in hospitals to provide or protect that information) was a significant concern for many, and a barrier to collaboration *within* the healthcare sector during the SARS outbreak in 2003 (Campbell 2004: 122-31).

The normative pillar – what is deemed "appropriate", binding expectations, and social obligations has not only shaped or been shaped by the regulative pillar – but also contributed to facets of the cultural-cognitive pillar in terms of common beliefs, shared understandings, orthodoxies, and/or shared logics of action. We turn now to an exploration of this pillar of the healthcare sector.

5 Cultural-Cognitive

The cultural-cognitive pillar of IA is concerned with shared understandings, orthodoxies, common beliefs, and shared logics of action. Respondents identified several issues pertaining to the cultural-cognitive pillar of the healthcare sector. Primary among these was cultural differences between the healthcare sector and security sectors, including the military and the police. Many respondents contrasted the "law and order" culture of the military and police with the "caring" and "compassionate" focus of the healthcare sector. Further, respondents differentiated the autonomous, individualistic, yet collaborative healthcare culture as differentiated from the police and military culture of the "common good" and identified that as an issue in terms of inter-organizational collaboration. Relationships were deemed crucial to emergency response in terms of fostering trust and a mutual understanding amongst organizations about each other's' capabilities and limitations which was seen as helpful in overcoming some of the cultural barriers amongst organizations. The silos that emerged within and between organizations as a result of jurisdictions (as discussed above) was also identified broadly as an issue that impacted inter-organizational collaboration.

One of the most significant cultural-cognitive aspects was differences in culture in terms of the "law and order" focus of the police and the military in contrast to the culture of "care" and "compassion" that was deemed to dominate the healthcare sector.

5.1 "Law and Order" versus "caring" and "compassion"

Several interviewees noted that they felt (or many of their colleagues in the health sector felt) that the primary role of the military and police was "law and order" (in contrast to the "caring" and "compassion" of the health sector; and if there was no perceived law and order aspect to a "health crisis", then little role was seen for either the military or the police during such a crisis by many within the health sector. As one interviewee put it:

> …enforcing the law [was the primary role of the police]…[but]…when people think of hospitals they think of them as places where care is provided and that's the focus… (Interview 3: 3).

Another respondent echoed this and connected the issue of organizational cultures to the silos in which these sectors operated and identified some areas of friction such cultural differences could produce when the healthcare, police, and military sectors collaborated:

> …I think the healthcare sector doesn't think of their work…as being…related to security response. Their job is taking care of people, and there's a whole sort of culture within healthcare which is much more…warm and fuzzy, and…I don't want to say peaceful, but…everything's sort of good intention to it kind of thing – humanitarian, humanistic sort of perspective to it. So…their vision of police and military tends to be more about…catching criminals, preventing crime…dealing with bad guys carrying guns, weapons – that kind of stuff…it takes a lot of

> education on a daily basis just on individual cases if someone comes in from a crime scene, hospitals are notoriously bad for being involved in not destroying evidence…because it's just something that doesn't come to mind, and…police work a lot with emergency departments…to try and get them to think about that, but our first thing we always think about is the patient; we often forget the other side of things. On the opposite side…the police and the military…when they think about intelligence…they often don't think about the rich sources of data that are available from things like public health surveillance and from understanding what happens with the health sector and how that can provide information, 'cause I think they see the health sector as a bunch of people walking around in white coats that are…not really useful in terms of information…but as some people that just take care of people when somebody gets sick. So there's a bit of a black box on both sides as to what really happens in the other's world, and there's not as many opportunities for us to engage each other on a day-to-day basis because we…sort of live in separate ministries. We live in separate silos of what we do (Interview 12: 3).

Still another respondent explained that:

> …during [name of event], there was no particular role for the military… [It] was essentially run by the provinces… There was no particular role for the military at that point in time. We had no issues around…protecting the public…we didn't have any law and order or…worry about the public rioting that would have required military assistance. There [were] no goods or services to move, or anything… They're [the military] very, very good at logistics…if you go across the country, many of the people in the emergency management sections of the provincial governments, and some municipally, are ex-military people. So…one of their important roles, traditionally, has been they're the biggest feeder group for emergency managers… At one time, I would venture to say, across the country it was probably at least 75 or 80 percent of people who were in any emergency management position were former military people (Interview 8: 3, 9).

Another interviewee concurred when they stated:

> …for things like pandemics and outbreak management I think the military has a lot to offer, in terms of – and in any kind of emergency – tremendous logistics capabilities…a tried and true command structure, which is very foreign to health, and tremendous human and hard asset resources that…can be very useful in civilian emergencies. But…there often isn't enough contact for us to access that expertise and that logistical capability (Interview 6: 3).

However, this law and order focus was deemed to be primarily a civilian police force rather than a military role. The military was considered to be "the last resort" on which to draw in an emergency (at least in Canada). According to one interviewee,

> I would think there would have to be a threshold of seriousness before they would be involved…there would have to be a major risk to the welfare of the public. I don't see the army involved…I mean…it would have to be the black plague – literally – to bring them in and bury the dead, or something, you know? I hope I never live to see the army being involved, you know, unless it was…third world or something, that's a whole different discussion entirely. But…I can't envisage, unless it's something really…society threatening (Interview 7: 6).

It would have to be a serious situation for the military to be called in, as the above interviewee insisted, since Canadians were not used to the military patrolling the streets. Yet another interviewee echoed this explaining:

> …they [the military] were very useful…in transporting wire and telephone poles and getting everything set… So the military did a lot of things like that. They did some work with the [police]… [The military] role, then, was to assist the civilian authorities… We had some military people go with [the police]…and check on people. We didn't actually have them policing, but we had them certainly assisting in that role. We didn't use them as civilian police officers because civilians wouldn't be used to that. We didn't need their medical assistance. It was offered, but we didn't need it. We didn't have any real strain on our medical system, so we didn't use any of their medical people. But…we certainly used their logistics, and we used, as I said, the military police to a minor extent (Interview 8: 2).

The military then, was not deemed to have a role in addressing emergencies in Canada – except in extreme emergencies; and even in extreme emergencies such responses, it was felt, should be managed by civil authorities with military assistance – if necessary. The military's role, in terms of emergency response and management, was primarily one that was external to Canada. In the words of one respondent:

> It's just that the way governments break down powers and control and stuff, traditionally they…[the military] had an overseas mission, not an internal to Canada mission. (Interview 8: 9).

Still another respondent echoed this sense positing that,

> …the military, from what I can see, is there in a supporting role. So they are not…in the international arena they are the primary responder. In the domestic arena things have to get pretty bad…for the federal government to be deploying military personnel… And I think they've been clear that if there is a desire or a need to include the military in any sort of deploy ability…context it's got to be pretty bad. So they're gonna be present…in

> terms of security and setting up perimeters…but they're not going to be, as far as I can see, a lead agency; nor are they going to be out and sort of in full gear and garb. So it's largely within purview of policing, with military as a support (Interview 5: 1).

Another interviewee similarly observed that:

> …traditionally in this country, we don't use the military in civil emergencies very often; and we certainly, in terms of law and order, the only time that I know in our history that we did was during the FLQ crisis. That's the only time that the military have played a role in…patrolling Canadian streets. It's not a traditional role for the Canadian military. Now, what's evolved since 9/11…is that Canada Command has been set up, and there is, there's no question that the military are increasing their capacity to assist in civil emergencies… I think they can play a very important role. They still, they will not run… the military should never run a civil emergency. They should never be the ones running it. They should be there assisting civil authorities… We're not a military country. We're not a military dictatorship, so that you shouldn't change the plan and suddenly bring somebody in. The whole perception of the military being brought in and being in control of a situation suggests that you've lost control, and that we're…that civilians can't do something, and...I don't think any government wants to be seen as doing that. I don't think it's a proper role for the military (Interview 8: 7-8).

In part, the reluctance of many in the health sector (noted above) to engage the military had to do with a perception within the health sector that the military was a war resource, part of the "war machine", as opposed to a peacetime resource which contrasted with the predominant "caring" or "humanitarian" notion of the healthcare sector. According to one respondent, this perception was perhaps a barrier to be overcome in terms of healthcare professionals collaborating with the military:

> …They're the guys who go off to fight the wars…[so] people don't see it [the military] as much as a peacetime resource… I think just the…connotation of working with the military that somehow you're working – and again I don't feel this way, but I sometimes perceive it – with the war machine type of thing. (Interview 6: 6-7).

This respondent further asserted that:

> I think in Canada, and particularly in healthcare in Canada, just because people tend to self-select, is kind of a military aversion…if [we] have a military that means we are involved in wars, and wars are no good, and we should have peace…and to work with the military might be counterintuitive to many people within healthcare…who I think are…I think there's a relative aversion to military terminology and military structures in some parts of healthcare, or…many individuals who are

> involved in healthcare. And I think that probably…certainly in my experience [is] a misunderstanding of the military. So, those are…some of the things that mitigate against that kind of cooperation. I guess the third thing, is…geographic. I mean, military people work in military areas, and those generally are set apart from public health agencies, family practice offices, hospitals, long-term care facilities…you don't see military people in those…roles (Interview 6: 4).

This "law and order", "war" culture of the police and the military was contrasted with the healthcare sector's culture of "caring" and "compassion" connected to this was a military and police "command and control" culture which was differentiated from the health sector's concentration on collaborative and autonomous decision-making.

5.2 Independent Healthcare Culture versus Command and Control Military/Police Culture

Another significant difference between the military or police and healthcare cultures identified by respondents was the "command and control" culture of both the police and military sectors which was contrasted with the independent, individualistic, collaborative, consensus-based culture of the healthcare sector. According to one respondent:

> [collaboration] comes easy for us in the healthcare industry because we work in collaborative relationships all the time, so this was not seen as anything new…It's a norm with us, so there was no anxiety, worry (Interview 10: 3).

Several respondents noted that healthcare professionals (particularly physicians) tended to operate independently. This clashed with the command and control structure of the military and police. One respondent noted that:

> …healthcare organizations tend not to be strongly hierarchical. There is a great deal of value in healthcare placed on independent judgement and professional delivery of care and police and military organizations tend to have clearer chains of command and clearer decision-making authorization, and…because…the corporate function is different I think sometimes that makes it harder for both sides see how the other one is functioning. And I think it is not as true…for police as for the military but the hospitals…in general healthcare professionals work on the basis of shared information once you get back past privacy concerns whereas military organizations in crises tend to operate on a need-to-know basis, and that's very different from…that's part of the culture, but I think…those differences would naturally make it more difficult for organizations – there's obviously a range in both groups, but I think there are some natural differences that are harder to get past (Interview 1: 1).

Another respondent echoed this stating:

> Differences in culture between the...organizations…healthcare – particularly doctors – tend to be a little more free-wheeling, a little more independent. There might be…conflict with…police or with military authorities who are…taking a more rigid approach to a problem. So…there are certainly cultural differences…the emergency room doctor who is ultimately responsible for taking care of the patients that are brought there may have a…different view of what needs to be done or, how it needs to be done than the police do, or the military does. So that's a potential conflict (Interview 4: 5).

As still another respondent described:

> I think a lot of it has to do with…organizational cultures, and how they differ. You know…one level is the various ways of operating within each organization. So here, we're a pretty fluid bunch…Other organizations have a very disciplined hierarchy and chain of command where…a person can't speak or provide an answer to another organization without having that answer approved by their immediate superior, or someone else. So you'll have an organization that's used to operating very quickly…and thinking on the spot, and providing answers, and are empowered to do that. And they confront an organization that doesn't operate that way you automatically get conflict, right? With the military, probably they have more of a structured command and control decision-making way of doing things than we do…those are kind of, the kind of barriers that you'd see (Interview 5: 4).

Yet another respondent concurred, characterizing the cultural difference this way:

> …healthcare [in] Canada [is]…very horizontal, very distributed decision-making processes. Every physician is their own [boss], and every hospital…There's no real command structure, and certainly that's difficult to reconfigure during an emergency where everybody agrees, at least conceptually, you have to [know]…who's in charge? Well, the military, you always know who's in charge. So that's one [barrier] – culture (Interview 6: 4).

According to this respondent healthcare professionals were used to operating:

> …as free and independent thinkers, and being accountable for [their] own actions… (Interview 6: 7).

Hence such professionals did not tend to operate well under a command structure since the predominant thinking amongst healthcare professionals was: "You can't tell me what to do..." (Interview 6: 7). As still another respondent observed:

> Well, they [the police] have their way of doing things, and you have to be accommodative and…you have to work things out. They have a particular chain of command. You have to respect that. If you're in emergency mode there is the whole incident management system that you have to fit into. So I think the only challenge is to operate within the norms of policing which is very much command and control… I think it's probably more of a cultural divide than anything…(Interview 14: 2).

The independent decision-based culture of healthcare was further evident in the autonomous nature of hospitals (as discussed earlier) – and independence of physicians that operated within the hospital sector. As some respondents highlighted, physicians had privileges at a given hospital, but were not employees of that hospital. They functioned as independent contractors, working and making decisions independently, and it seemed that many physicians resented the incursion of others (either a hospital administration or the MOH) imposing restrictions via rules and regulations on their ability to operate autonomously. This respondent emphasized that:

> [many in the hospital sector would] like the government to make changes to the *Public Hospital Act*…about the relationship of doctors to hospitals…to try and get…better ways of dealing with doctors because doctors are sort of outsiders in hospitals. They have privileges and we want to tighten up the evaluation of doctors, the monitoring of doctors, and the ease with which a doctor could be removed from a hospital (Interview 3: 3).

One respondent, however, argued that there was a hierarchical structure within the healthcare sector, particularly between physicians and other healthcare professionals.

> I think probably [the barrier to collaboration]…also…relates somewhat to some elements of medical culture where…doctors write orders and people follow out those orders…part of the culture of we'll write it down, and then you do exactly as we say...(Interview 4: 5-6).

Furthermore, this interviewee pointed to the hierarchical approach of the MOH in terms of communicating and managing a particular health crisis explaining that,

> …it did not invite…basically the approach [of the MOH] was we have the "experts", we know what needs to be done – you will do exactly as we say; rather than…we're all working…a little blind here; we're all trying to learn as we go along, here's what we're trying to achieve, and please if you have any insights…or…information that you can supply to us that might be helpful – please, here's an easy way of getting it to us. There was none of that (Interview 4: 6).

Such an approach was not well received by many within the healthcare sector (according to this respondent) because they were used to operating in a more independent, yet often collaborative manner.

This cultural difference was also raised when discussing the particular challenge the health sector had in terms of fitting its emergency-preparedness and response planning into the existing command and control structure that dominated the emergency response sector (including the police and the military). As one respondent noted:

> …In some ways, the healthcare sector is trying to work a little bit more like the firefighters and the police, in that we all have emergency plans now that use, in some way, shape, or form…the incident command system. And the health sector has been trying to figure out how to use it because we are not firefighters or the military; command and control just doesn't quite fit well with healthcare. So we're trying to adapt that kind of system, and take on its advantages and see how we can use it in health. So our responses are based on an instant command structure, and I think that that's another area that we've been trying to leverage the military in helping us, and we have had [military] people sitting in during [the response to a particular event], just as an observer, and noting down how we've been doing…
>
> Obviously, you can think of the military and the police as being pretty much command and control driven, right? They have ranks, and orders are set out, and people do what they are told... We've adapted that system to what we call the incident management system…we don't call it incident command, we call it incident management…we do more coordination than we do command, but we use similar…for instance, during a pandemic [there would be] what they call the emergency manager, or incident commander in the military sense, and [they] would conduct the operation like one of them. And [they] have teams underneath [them] in operations, in planning, in administration, in communication…very much set out like an incident command system, but recognizing that our approval processes, the way that we interact is more coordination than it is command and control, but we use similar structures. We're trying to look at how do we maybe utilize some of that in [a]…setting where we do have to make some decisions that are never going to be command and control, right? I mean it's going to be a collaborative, consensus-building-like process. The provinces have jurisdiction over health, so [name of organization] doesn't command and control anything that's health, but [the health sector is using] similar structures to try and get [its] operations done in a more responsive and rapid way…(Interview 19: 12-3).

However, not all respondents considered this cultural difference to be problematic necessarily, but reflected on it as positive in planning because the security sector brought a different focus, expertise, and knowledge to emergency planning that healthcare professionals generally did not have. According to one respondent, this was a principal benefit of inter-organizational collaboration:

> Law enforcement comes with a perspective that, as a healthcare

> professional, we wouldn't have. So, particularly in looking at an emergency situation where people are anxious, stressed…I think their expertise to be able to look at things about crowd control, bringing a large number of people together, and what are the potential risks and issues? They have that expertise, and that's a benefit to us in our planning and in our collaboration because we don't have that (Interview 10: 4).

And yet another respondent, when reflecting on the different cultures of healthcare (as part of the public service sector) and security sectors as positive in planning noting that:

> It's a different focus. Within certain areas of the public service there's the risk-averse mentality of needing to have all of the information before a decision is made, whereas in your…response services (defence, policing, firefighting) there's the understanding that you're never going to have all of the information you want to make a decision, and the need to support decision-making on best available information at the time. So, whereas we may have people here pushing for more and more and more information, sometimes it's useful to have collaboration with an organization that is saying, "Okay. Given what we currently have, this is what we see as the best direction" (Interview 17: 5).

Some respondents recognized the benefits (and frustrations) of the collaborative structure of healthcare in responding to emergencies and highlighted that some of these challenges posed by such cultural differences between these organizations could be best mitigated through communication and planning which bred mutual understanding. As one respondent noted:

> …I could see how the involvement [with the military or the police] affected some of my colleagues who maybe did not have those interactions, and…sometimes…you get frustrated with the military and the police 'cause they both have very, sort of straightforward attitudes to doing things, right? There's all the command and control sort of way, and in public health we're very much about collaborations and building consensus, so making that transition can sometimes be awkward, or very difficult for public health people. So having them involved early in the planning process helped temper that so people understood why they reacted a certain way, and they had a better understanding of our mechanisms of doing things.
>
> We so like to argue our point in [healthcare]. And that is one of the criticisms of my organization…I absolutely think consensus-building is the best decision-making, if you have the time and are able to do that, but that you have to have a command and control structure to respond to emergencies… That's something that…we learned a lot in [name of event] – about the fact that many people in public health are very uncomfortable with going to rapid-decision-making, taking responsibilities for the decision, and just moving on. And many of…my nursing colleagues…said, "You know, I felt like I was, my opinion was ignored"

> because…we'd have a meeting, we'd have a short discussion, and then we'd say, "Okay, this is what we're doing, and here's what we're doing"; and people weren't used to that. They were used to saying, "Well, no. Why don't we try it this way?", or "We could try this.", and "Why don't we go back and check out this?" And we didn't have the time – the luxury of the time to do that… Making decisions on imperfect information is…a skill…that not everybody has. So it was…a challenge. And I think from a security and policing point of view, when they interact with people in public health the consensus-building process can be seen as wasteful and frustrating and, you know, at the end of the day, what do you get? You just come up with a decision. Why didn't someone just make the decision? So having worked together ahead of time helps us understand these things, and help – and may help people understand why it's difficult for public health people to transition to a command and control model (Interview 13: 10-1).

Another respondent felt that a culture had developed within healthcare and the government sectors which understood that collaboration amongst diverse sectors and amongst different levels of government was imperative for emergency planning precisely because of the interlocking roles and responsibilities different sectors and levels of government had in responding to and managing emergencies; further, they noted that in order for the diverse groups involved in addressing any emergency to meet their roles/responsibilities, they all had to be working on the basis of common assumptions about their respective roles, responsibilities, and approaches to addressing a particular issue. This respondent emphasized:

> …I think we've developed a culture, particularly around pandemic influenza planning, that no one agency can do it themselves. I mean that's a baseline assumption that comes right from the feds…everybody's plan is built on…the provincial plan, the local plan – everybody's plan needs to fit together. So, in pandemic planning there's this perspective of collaborative working because no one's plan can sit off by itself. They all, at some point, need to be based on the same planning assumptions. And so, for this experience with the health care sector and law enforcement that just kind of fed right into basic pandemic assumptions, as well as how we work together here…The expectation is we would work together. The only issue becomes: Do we have enough bodies, and resources, and time to work together? ...but the expectation is we work together (Interview 10: 6).

Still another respondent was of the opinion that cross-sectoral collaborative planning was beneficial because it was more likely to ensure a broad sense of "ownership" of an emergency plan, than a plan that was imposed on organizations or sectors without their input.

> …the more people you can involve in the planning stages, and the planning aspects of any event, the more likely you are to have a successful outcome because it's far easier to involve people in planning than it is to pull them in to an operation because…if you involve [people]

> in the planning at all stages, then they feel like they own part of the plan, and they're far more receptive to change. If you need to amend the plan as you go along, it's far easier to explain an amendment than it is to explain a whole new plan (Interview 17: 1-2).

Another respondent echoed these positive sentiments about collaborations asserting that:

> …it's…[a] good governance principle [to] encourage collaboration and constant exchange of information between [sectors]… (Interview 15: 1).

5.3 Individual Patient versus the "Greater Good" Focus

A further cultural difference amongst the health, police and military sectors was the health sector's focus on individual patients versus the focus of the police and the military on the "greater good". This, as discussed earlier, was a facet of the normative pillar in terms of notions of "duties" and "obligations" of a particular sector. However, it was also a facet cultural-cognitive pillar, in that such ideas of "duty" and "obligation" shaped shared logics of action or shared understandings (and vice versa), such that professionals in the health sector were used to operating relatively autonomously and focusing on individual patients, rather than the broader "common good" with which the police and military were primarily concerned. Hence, healthcare professionals tended to resent the incursion of a "command and control" structure (as was considered to dominate the military and police sectors) impeding their ability to care for individual patients by hierarchical orders taking precedence over their ability to make decisions relatively independently in terms of patient care. As one respondent described,

> They [health professionals]…tend to be very focused on individuals making decisions, and you can't interfere with those decisions. The problem is, you're not [as police of military personnel] trying to look after one person, you're trying to look after…5 million, or 30 million people…and it's a different kind of decision-making than medical decisions. And so in a crisis sort of trying to get that through to people and change the rules can be difficult… It's that kind of thinking away from, "I make all the decisions" to group thinks and approaches that are much more societal-based, need to take place in the medical system because it's completely different than what they normally do (Interview 8: 15).

Hence, this difference in sectoral or organizational culture and focus has meant that at times the health, military, and police sectors could seem to be working at cross purposes in terms of each their *modi operandi*. One important way to address this potential, as several respondents identified, was building relationships amongst these three sectors via disaster planning and exercises. Through such collaborative work, cross-sectoral relationships could be built and maintained.

5.4 Relationships are crucial

Not surprisingly, the development of relationships across sectors, particularly prior to an emergency, was seen as critical to the health, military, and police sectors' ability to work collaboratively, and (as noted above) one important tool in overcoming, or at least minimizing potential barriers resulting from cultural differences through the fostering of a mutual understanding of each sector's roles, responsibilities, capacities, and limitations. Many respondents noted that emergency responses were most effective if they were based on pre-existing relationships. According to one,

> the general truth of managing things in crises is that things function better when relationships are established, when people know each other, when people understand the workings of different organizations…[and] expecting organizations to work together well in a time of crisis is…expecting to establish relationships in a time of crisis is generally not the most functional away to operate (Interview 1: 1).

Another respondent concurred emphasizing that:

> …Relationship building is *so* important, and I think we don't always realize the areas that we can help each other until things happen... And it made a huge difference in…the community seeing us as being, working together on these things. And certainly it wasn't everybody and every policeman who knew what was going on, but…we had the buy-in from the senior leadership, and when I needed help we got it (Interview 13: 4).

In this regard, local relationships were considered paramount by many respondents. When asked to reflect on this issue one respondent stated:

> I know locally, if we had to deal with the police it's very easy to deal with…but if it had to go a route up through the provincial government to the federal government…I have no knowledge of whether there are well defined, efficient channels of communication. No idea (Interview 4: 8).

Still another respondent noted that:

> Policing…has been a municipal service…for many, many years, so…they're known quantities and they behave the way you expect them to behave. So, no, I wouldn't say there were any changes [in how the police were perceived] (Interview 14: 3).

The idea that relationships at the local level, in terms of emergency response, were most critical was highlighted by yet another who declared:

> Even in a regular emergency you manage a regular emergency as much as you can locally. And then what the role of the upper tier governments is to fill in behind them with resources, with expertise, with money. But

> you never…take local control totally away. You always want a degree of local control because…those are the people that are familiar with everybody on the ground, that's where the actual people reside, and the cars, and the snowplows, and all the things that you actually need (Interview 8: 1).

Still another echoed this point of view noting that:

> …Everything about emergency preparedness and everything about disaster management is built on relationships and is all built on relationships that exist before the disaster occurs. So…the importance of doing training, and exercises, and things like that are not really as much from what you learn in the exercise, but the relationships you establish…'cause …as we say, "All disasters are local", and really the response always occurs from the local level, and a lot of it comes down to Joe the Fire Chief meeting Bob the Police Chief and engaging and interacting with each other. We still, in emergency preparedness in general within the health field, we have difficulties even in engaging…with the hospital sector; 'cause most disaster plans in communities or municipalities start with: you know, everyone responds to the disaster scene; we do this at the disaster scene; patients transported to hospital, and their plans stops there. The hospitals' disaster plans start with: patients show up at hospital door and, and then what happens in the hospital (Interview 12: 5).

This respondent not only highlighted the importance of inter-organizational relationships at the local level, but also particular challenges within the health sector as far as the hospital sector operating even in isolation from other parts of the health sector, such as paramedics.

Planning and disaster simulations were seen by many to be fundamental to developing and maintaining such inter-organizational relationships. One respondent noted that disaster simulations were an important avenue through which to build such relationships, to test communications structures, and to ensure clarity in terms of roles and responsibilities when responding to and managing an emergency.

> These kind of disasters need to be simulated and…evaluated as to how well the parties work together – whether they have the processes and systems and – particularly communications systems – to…make sure it works… Relationships would be built [through such simulations], but we'll also understand processes and systems…(Interview 4: 6).

Still another respondent concurred stating:

> [The relationship building is] *so* important… and things like mass gatherings…are opportunities to build those relationships and understandings…There's always a role for security (Interview 13: 4, 7).

Another respondent highlighted the importance of communication, particularly in simulating disaster responses stating that:

> …that kind of communication really facilitates understanding each other's' roles, as well as being able to better carry it out when the event occurs (Interview 2: 3).

Still another agreed asserting that:

> …I *really* think, I *really* think we need to take opportunities of…emergency management exercises to work together to make sure that there's a health component built into those exercises… Scale exercise that most municipalities do periodically. It's table-top exercises…those are the opportunities that you can understand the connectedness between the health sector and the security and policing sector (Interview 13: 11).

This respondent also pointed out that mutual understanding stemming from pre-existing relationships ensured a better response in the event of an emergency:

> …We need to understand each other better, so that in a crisis we can work together more seamlessly…but number one is recognizing, on both sides, the importance of having those links, and…finding the opportunities to build those links (Interview 13: 12).

Yet another respondent put it this way:

> …I think that…leveraging each other's' expertise and scientific capabilities is a big one…when something big happens, you want a coordinated way of responding. So, if you haven't practiced together, you have never seen each other, met each other before the event, it is unlikely that when the event occurs things are going to go smoothly and in a coordinated way. So a constant interaction in peacetime is crucial for the response when the actual event occurs (Interview 19: 6).

Echoing this point of view, another respondent stated,

> …the more you work together in planning, and the more you know what other people can do, the simpler it is, then, to call on them when something happens because you've got a pretty good idea already of what they can do (Interview 8: 11).

However, some respondents not only identified the importance of building collaborative relationships, but some of the challenges too, in terms of concerns around different organizational foci. As one respondent pointed out:

> …Some people were concerned that if we worked too closely with police services we'll be seen to be part of that whole law enforcement side, rather than public health side of things… So there was always that little bit

> of tension about…public health and police services have very different aims, but I think it became very clear how important it was for us to have common understanding, or at least understand each other's roles around specific things, particularly related to emergencies…[and]…so making sure that health and security have an understanding about each other's' roles, and work together around the planning for those [high profile] events are things that help us understand each other better about where we should be interacting, and where we can interact, and how we can help each other in those things (Interview 13: 6).

Effective communication was critical to establishing and maintaining relationships and to disaster response and management, as several of the respondents above alluded to. One respondent observed that communication was critical in any disaster preparedness and response, but that it was something that was difficult to "get right". They asserted:

> …You can't reach [all the people]…that you want to reach. You do your best to try to see – experiment with different patterns of communication…but there's always going to be people who say: I didn't get enough information; I got too much; or what I did get was unclear – whatever. Communication is the most important thing in an emergency, but it's the thing that you can never get perfect…It's a general rule. You try your best but, you know you're going to get criticism for it (Interview 5: 9).

However, as another respondent observed, most of the communication between the health and security sectors tended to be at the upper levels, not the front-line. Emergency planning was useful in building and maintaining relationships, but such planning and discussions needed to filter down from upper levels of the health and government sectors to the local first responders (EMS, fire services and police) because they were the organizations that interacted most closely in the event of an emergency.

> There's not a good connection…at least…below the federal government level, outside of what happens at the Public Health Agency of Canada and at the very senior levels where there's some cross talk that occurs, but it's more information sharing. There doesn't seem to be a lot of connections on the front-line in terms of traditional health, such as public health and the medical sector (Interview 12: 2).

This silo of "cross-talk" within a particular level of government was reflective of physical and institutional silos or separation amongst these sectors, particularly between civilians (such as those in the healthcare sector) and the military or police.

5.5 The military and civilian "silos"

Some respondents raised the physical/geographical separateness of the military from civilians as another barrier. The military tended to be isolated on bases. Consequently, unless civilians lived in a small community with a large military base relative to the civilian population, the military was removed from (and hence an unknown entity in) the lives of most civilian Canadians (including healthcare professionals). One interviewee put it this way:

> ...The military…is a black box to most people…in terms of its relationship to healthcare, is a black box… It's something that we don't know a lot about the internal workings of. Not that we want to avoid it, it's just we just don't know. It's something behind a curtain, and we really don't understand what it is, and what it can do (Interview 6: 3, 6).

The fact that the military was an unknown or little understood quantity for most Canadians impacted potential collaborations since those within the health sector often had little understanding about how the military might be able to collaborate with the health sector in terms of its capabilities or expertise related to the health sector. This was highlighted when a respondent commented:

> The military…and this was a surprise to me anyway, the military does have a lot of expertise in information technology and analysis. What wasn't a surprise to me was the access to resources, but what was a surprise to me was the fact that they were interested in this. Now, of course, I suppose when you think of the security of the nation you can get internal threats, right?...You're not only thinking of missiles coming from outside, but there may actually be something internal that could be…and therefore…it does make a lot of sense, but I guess those things hadn't quite registered before...And I guess it brings me again to this point about where can the military assist is not exactly known very easily. Like we usually associate military assistance with troops coming in and assisting if you've got an area that has suffered an earthquake, and you need to move big equipment and you need to move things et cetera, that's when you need the physical manpower, right? But in fact, the military…can actually assist in advanced scientific areas as well…So, you see, this is kind of new news to us because we've never really associated the military as being advanced in IT, science, or medical applications, but they are obviously quite involved in certain research, and we where we can actually collaborate (Interview 9: 6-7).

As a result of this lack of awareness on the part of the health sector about the military, assumptions were often made that the military did not have a role in particular emergencies because of the military's perceived function, resources, or jurisdiction. For instance, SARS was seen as largely a health emergency that primarily affected hospitals. Thus it was not an emergency in which the military was considered to have a role because the military was seen as a law and order resource, not a health resource. Moreover, given that SARS was considered a health (and primarily hospital) emergency, it fell under the jurisdiction of provinces to manage,

and so the military (since it was a federal resource/jurisdiction) was *not* a resource that hospitals (a provincial jurisdiction) could draw on directly even if they had wanted to, according to the Canadian Constitution that designated particular governmental jurisdictions related to healthcare. On this issue one respondent observed that:

> The military…is a different ball game [to the police] because we don't actually have any military bases here, and we don't actually see the military as a local resource. We see the military as a federal resource, and normally we don't go to the federal without going to the provincial levels first. So, you know, there is a little bit of a pecking order in terms of how we communicate. So if we did feel that…we needed something to do with the military…it's unlikely that we'd call them directly. We would probably go to the province first and then the province would call the appropriate folks… I think [a challenge] with the military…is not having a good handle on what are the contributions they can possibly can make, because generally speaking we would not think of the military first. We would think in terms of the local services being able to respond, and if the local services got overwhelmed we would be appealing to the provincial level. I think the moment the local services got overwhelmed and it was an area that we normally associate with the military could be potentially helpful in, then we would by all means it would be entering our mindset. And so when we talked to the province we would be talking with a view to engaging the military… If you take bioterrorism…[if]…we didn't think that we couldn't cope…[or] a situation like an ice storm where local resources were stretched to the limit, I think at that time were looking for additional resources; and so when you start looking at additional resources, you know, some folks might would be probably be thinking, "Well, what about the military?". And then the question would be: "How do you connect with the military?" So we don't have open access to the military, so we would have to basically go through the province…The province would liaise with the appropriate ADA who manages police areas – and security, and there would have to be some discussions at the Ministry before the request to the military went, because the military request would presumably be a provincial request…I think as a general rule, it would be loathsome to call in the military… to call in the military in any frivolous way. Like we would only call in the military if local resources were…stretched… And also I think the issue of what would you call them [the military] in for, right? Like we don't immediately associate them as setting up hospitals, although they are very capable of doing that; but the province also has it's abilities to be able to set up hospitals. And the province has some arrangements with the federal government some of these may or may not involve the military. So we would actually be operating by going to the provincial level first (Interview 9: 3, 4-5).

However, this lack of understanding on the part of many in the health sector as far as the health-related resources and capabilities of the military meant that other assumptions were also made. As one respondent noted, a common sentiment amongst healthcare professionals was that the

military had the resources (financial and human) to be the "last resort"; that the military could (and would) come in and "save the day" in an emergency. This respondent explained:

> The expectations were…on the healthcare side…we run in to trouble and we need help, the military will just show up and be there to do everything that we need…[The interviewee's colleagues]…would just say: "Well, you know, the military will just fly in and they can move patients…if we need to fly people down from northern Indian communities or…we'll send the military up there to put in field hospitals or doctors and stuff". The anticipation is that the military has this vast capability to do these things… So I think there's a sense from the civilian side that the military will always be the cavalry that shows up at the end to save the day, but from the military side certainly the resources and the necessary to do that aren't there (Interview 12: 4).

This lack of mutual understanding pointed to the importance of building relationships across the three sectors as a way to foster such understanding. What is more, a lack of mutual understanding resulted in a reticence within the health, military, and police sectors to share information with those from the other sectors that might be helpful (even critical) to their emergency planning. Such reticence on the part of many in the health sector was (in part) connected to the legal obligations to protect health and security information, as discussed under the normative pillar, but was also due to a lack of awareness of the ways in which information from a particular sector (the military, police, or healthcare) might be relevant or useful to another sector (as discussed above), as well as issues of trust amongst these sectors.

5.6 Protection of information

Several respondents pointed to a shared cultural "trait" of the health, police, and military sectors to protect information they held. Such guardedness on the part of some in the health sector was primarily tied to jurisdictional issues and privacy legislation related to personal health information (as discussed above). The shared focus on protecting information posed challenges to inter-organizational collaboration in terms of trust (or lack of trust) and sharing (or not) health information with non-health professionals – or in the case of the military sharing military information with "civilians". One respondent noted that it was useful for the military and the police to understand the health sector's limitations related to surge capacity and legal obligations to protect information which was a potential barrier to collaboration since it was at odds with managing or responding to an emergency and concerns regarding "law and order".

> …It's always useful for them [the military and police] to hear…our ability, our surge capacity in the medical system is extremely limited… And it's [the health sector] got a huge issue around confidentiality…that are completely at odds with trying to run a big emergency…It's an enormous problem how you…maintain, public order, but don't give out confidential information…(Interview 8: 14).

As some respondents noted, this mutual culture of protecting information was tied to professional and sector silos – and some even connected these information and trust barriers to physical barriers that sometimes existed amongst these sectors. Reflecting upon one particular experience of collaboration, a respondent stated:

> …it was banging your head against the wall trying to get the security people to really understand that there's a health focus in some of these things…the mentality [was]: "Oh, we can't possibly share this information with you because you'll overreact… (Interview 13: 14).

Another respondent echoed this and observed that:

> I understand the need to be to be confidential. However, it appears that the source of trusted individuals does not extend to…the civilian element... It's very tightly held, as far as I can see within the security circle, and information is shared on sort of a need to know basis, and it's up to them on who needs to know. So [there]…is the need…to balance confidential, sensitive information – and the need to protect that – with the need to ensure civilian organizations (like healthcare) have the information they need to make sure that appropriate plans are in place… So…we're not so much in the secure zone, which…speaks to the earlier issue that I identified that there actually is…if you look at these zones there is an information barrier, as well as a physical barrier, between what these folks know and what [the health sector needs to] know that we need to base our plans on (Interview 5: 1-2).

Organizational structures contributed, to some degree, to these physical and information silos amongst the health, military, and police sectors.

5.7 Organizational Structures

Many respondents noted that one of the most effective ways to break down sectoral silos and build cross-sectoral relationships was establishing structures that facilitated communication.

> ...The thinking post-9/11 was that…we need to do more to break down these traditional silos, and the best way to do it is in an environment that's under clear leadership with disciplined command and control, and where you have…a physical mechanism to break down some of those barriers and to collaborate with other sectors…And it works. I think…there are some traditional boundaries that are very difficult to cross, but…having the structure that applies to any emergency really helps, I think, in terms of engaging because, you know when you're seeing somebody there with a [name of an organization] nametag talking with somebody in military uniform, you just see them as sort of different people with issues of concern that you're sort of dealing with in real time, as opposed to the long process it takes to enter an organization and sort of overcome some

> of those organizational boundaries. That doesn't exist when you're sort of in crisis mode (Interview 5: 3-4).

Different organizational structures emerged as a result of the differing organizational cultures within the military, police, and healthcare sectors. One respondent felt that such structural differences often posed challenges to inter-organizational collaboration, but the actual collaborations on an individual-to-individual basis were not a challenge in terms of personnel from these three sectors working together. This respondent emphasized that:

> …Organizationally, I think…understanding the processes that each system works under, and just appreciating the challenges that each system works under [is important]. [The military]…it [isn't] particularly challenging to work with them [as individuals]…(Interview 17: 4).

This respondent further noted that:

> …You're dealing with a fundamentally different mindset from, certainly senior management. So the challenge is taking – the collaboration at the working level is not particularly difficult. The challenge is when we brief back. And that's learning how to manage that. That doesn't create difficulty in the collaboration. It creates difficulty in what we then do with the information…Collaborating with your guys creates challenges for our organization, but it doesn't create challenges within the collaboration…I think [the military and police are] exceptionally professional. They're very easy to work with (Interview 17: 6).

According to this respondent, it was the organizational structures (as opposed to the individuals in these institutions) which posed significant barriers to inter-organizational collaborations; hence education and awareness about the cultures, structures, capacities, limitations, roles, and responsibilities of each sector were critical to inter-organization collaborations. Other respondents identified clear, formalized structures of communication and roles/responsibilities facilitated inter-organizational collaboration.

6 Conclusion

Institutional Analysis of the health sector has highlighted significant regulative, normative, and cultural-cognitive factors which influenced the nature of collaboration between the healthcare, military, and police sectors. Within the normative pillar of the health sector health legislation related to patient privacy and confidentiality, and different governmental jurisdictions related to various facets healthcare in Ontario were identified as significant factors. Another significant factor was that hospitals (according to the *PHA*) were independent corporations in Ontario. This not only shaped the way in which hospitals operated *within* the health sector, but also how they interacted with sectors *beyond* healthcare. Moreover, legal government jurisdictional silos posed significant challenges to inter-organizational collaboration in terms of the roles and responsibilities and protocol for communication amongst different tiers of government such legislation dictated and/or confusion related to such legislation.

In terms of the normative pillar, respondents noted that differences amongst the health, military, and police sectors in terms of norms of "appropriateness", authority, and "expertise" frequently posed challenges to inter-organizational collaboration. Related to this point, the issue of the independent nature of the way in which the health sector – in particular hospitals and physicians – operated, as well as the health sector's obligation to individual patient care was contrasted with the more global obligation of the police and military sectors to the "common good". In spite of these normative differences, it was deemed by many that the Canadian "value" of cooperation enabled these sectoral barriers to be overcome in times of crisis, in the interests of the "general good" of all Canadians. What is more, inter-sectoral relationships facilitated such collaborations through instilling in all three sectors a sense of moral and social obligation to others, and a sense of binding expectation and "appropriateness" of all three sectors collaborating in the interests of "all Canadians".

In terms of the cultural-cognitive pillar, a culture of independent/individual (yet collaborative) decision-making amongst healthcare professionals generally (and physicians in particular) was considered to be very different from the hierarchical "command and control" culture of the military and police forces. There was a predominant sense amongst healthcare professionals that the primary role of both the police and the military was "law and order", and that they were both hierarchical institutions focused on "catching bad guys" and logistics, rather than health-related issues. As a result, many healthcare professionals did not see a role for either the police or the military in "health" emergencies (unless goods or people needed to be moved around or health facilities set up). Several respondents noted the police and military were focused on the "common good" of national, provincial, or local security. This they contrasted with what they considered to be the health sector's focus on the needs of individual patients. Furthermore, the military was seen by many in the healthcare sector as a "war resource" (as opposed to a "peacetime" or "caring"/"compassionate" resource like the health sector). Moreover, the military was considered by some to be an instrument of Canada's foreign policy. It had a role in other parts of the world (i.e. in emergency management in the Third World), but not in Canada – unless the emergency was dire and local resources were stretched to their limit.

Finally, relationships, particularly those at the local level were deemed central to any emergency response. It was widely regarded that such relationships needed to be developed prior to an emergency. One crucial way to develop and maintain such relationships was through

collaborative emergency planning and disaster scenario exercises. Connected to the importance of relationships was the notion that clear systems of communication and sectoral roles and responsibilities were critical to any emergency response and management. Systems of communication and relationships were shaped by regulative, normative and cognitive-cultural pillars in terms of jurisdictional concerns that structured ideas about which office and/or individuals were deemed "appropriate" to be involved in such collaborations, and the "appropriate" chains of communication, as such work fostered understanding and awareness amongst the three sectors of each sector's capacities, resources, and limitations. Such mutual understanding was crucial to building relationships, overcoming cultural differences and organizational silos, and also to fostering an understanding of the need for and potential areas of collaboration. While it was noted by several respondents that much work had been done in this regard, particularly since 9/11, it was widely believed that more remained to be done.

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This paper reviews the findings of a research project based on a field case study that involved qualitative research of current or former healthcare professionals from middle to upper management who are or were involved in senior decision-making linked to potential collaboration with the Canadian Forces and the police sector. Using Scott's three pillars of Institutional Analysis (IA) as a framework of analysis, the purpose of this research was to explore whether any attitudes or behaviours existed amongst healthcare personnel that would create social or cognitive barriers to institutional collaboration with police and/or military personnel in a public safety context by analysing the regulative, normative and cultural-cognitive pillars of the healthcare sector. The study found that there were significant potential social or cognitive barriers within the healthcare sector which influenced collaboration with the military or the police sectors.

Le présent document passe en revue les conclusions d'un projet de recherche fondé sur une étude de cas sur le terrain portant sur la recherche qualitative de professionnels de la santé passés ou actuels, depuis les cadres intermédiaires jusqu'aux cadres supérieurs, qui participent ou ont participé à la prise de décision de haut niveau associée à une collaboration éventuelle avec les Forces canadiennes et la police. À l'aide des trois piliers d'analyse institutionnelle (AI) de Scott comme cadre d'analyse, la présente recherche vise à vérifier si certaines attitudes ou certains comportements se retrouvaient parmi le personnel médical susceptibles de créer des obstacles cognitifs ou sociaux à la collaboration institutionnelle avec la police et/ou le personnel militaire dans un contexte de sécurité publique, en analysant le pilier culturel cognitif, régulateur et normatif du secteur des soins de santé. L'étude a révélé qu'il existe d'importants obstacles possibles aux plans social et cognitif qui influencent la collaboration avec les secteurs militaire ou de la police

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