Perceptions of Organizational Justice Between Physician Northern Health Medical Advisory Committee Members and Medical Administration

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Abstract

This study investigated physician’s perceptions of organizational justice in the relationship between Medical Advisory Committee members and Medical Administration. Three domains of organizational justice were examined: distributive justice, procedural justice and interactional justice. Thirty four Medical Advisory Committee (MAC) members from three Health Service Delivery Area MACs and the Northern Health MAC participated in this study. Primary data was collected via a telephone interview with 29 Medical Advisory Committee members and 5 Ex-officio Medical Advisory Committee members. The Ex-officio MAC member’s data was treated as a comparison group. An interview format was used to administer a 28 item, 5 point Likert Scale survey tool to interested Medical Advisory Committee members. A series of qualitative questions were asked to further illuminate the data. Data was recorded in writing during the interview process. Raw data was entered into an Excel program and analyzed using a SSPR statistical program. The hypotheses were tested using the ANOVA one way and post hoc tests and group comparisons were made using the Bonferroni testing method. Medical Advisory Committee members across Northern Health reported favourable perceptions of justice in their relationship with Medical Administration across all three domains of organizational justice. However, within the three justice domains there were some areas of concern that require the attention of Medical Administration. It is recommended that Medical Administration address these areas of concern to further strengthen their relationship with MAC members.
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Introduction

Northern Health is a vast geographical area covering almost two-thirds of the province and provides health care to approximately 300,000 people in Northern British Columbia. Northern Health is divided into three operational areas referred to as Health Service Delivery Areas (HSDA’s) and named geographically as the North West, North East and Northern Interior HSDA’s. This structure promotes a greater degree of local operation and decision making control for health care facilities across the Health Authority.

This project is dedicated to understanding physicians’ views regarding their fair treatment by Medical Administration, a team of health care and business professionals tasked with health care service planning and overseeing the day to day operational requirements of Northern Health programs and facilities. The relationship between Medical Administration and medical staff is important because physicians are an integral part of the health care team and are therefore instrumental in providing the best care possible for northern patients.

As a member of the Northern Health Medical Administration team, the writer was interested in learning more about the quality of relationships between Medical Administration and northern doctors with a view to preserve the elements of the relationship that are working well and to dedicate targeted effort to areas of the relationship that require strengthening or development.

The first challenge was to identify the appropriate group of doctors to evaluate for this project. Physicians are not employees of Northern Health and instead, engage with the Health Authority as private contractors. This makes the connection with Northern
Health somewhat remote. For most physicians, the connection with the Authority is established "on paper" through a formal process that ensures physicians are qualified to deliver medical care and are capable of performing specific types of skills and procedures that are needed in a given hospital or facility. With this in mind, the project needed to define a situation where the interface between physicians and Northern Health is more pronounced. The Medical Advisory Committee is the most established and well defined working relationship between Medical Administration and physicians who participate in the regional Northern Health MAC or one of the HSDA Medical Advisory Committees (MACs). Thus, these groups were selected as the focus of this study.

The particular element of the relationship that is of concern to Medical Administration is organizational justice. Organizational justice is a field of study dedicated to understanding people's perceptions of fairness in organizational contexts (Greenberg and Cropanzano, 2001). Ambrose and Harland (1991) maintain that all people make justice assessments in their working relationships and the experience of justice or injustice drives certain attitudes and behaviours in organizational settings that either contribute to, or detract from, feelings of role satisfaction, organizational citizenship, and commitment to organizational goals.

Province-wide, physicians' satisfaction in their working relationships with hospitals is low. According to a three year retrospective assessment of professional satisfaction amongst Canadian physicians (Comeau, 2007), 86% of physicians are satisfied with their patient relationships and almost three-quarters are satisfied with their relationship with other physician and non-physician providers. However, just over half of the physicians surveyed reported satisfaction in their relationship with hospitals. While Medical
Administration maintains that Northern Health enjoys fundamentally good working relationships with northern physicians, there has not been an opportunity to test this hypothesis. Furthermore, even if the assumption of positive physician-administration relationships proves to be accurate, Medical Administration is committed to ensure its continued health.

Because of the aforementioned, inquiry into the elements of organizational justice and the assessment of physicians’ perceptions of justice in their interactions with Medical Administration became the focus of the inquiry. The application of organizational justice theory to the physician-Health Authority context was not without its challenges. This field of study is normally applied to employer-employee relationships where roles and responsibilities are clearly defined and tend to involve an authority gradient where one group is in a position of power and another group is not. Although there is some fiscal and professional incentive to admit and care for patients in hospital, many physicians in Northern Health, such as general practitioners or psychiatrists, do not “need” to work in the hospital setting per se and as private contractors, physicians do not work for Medical Administration. On the other hand, some physicians such as surgeons and other specialists typically require hospital privileges in order to work and are obligated to the Health Authority for those privileges. Thus, the relationship can be characterized as a partnership of mutual benefit, based upon a shared interest in providing safe, quality health care for northern people.

The purpose of this research project is to determine physician MAC member’s perceptions of fairness in their working relationship with Medical Administration and begins with an overview of the evolution of medical committee structures, recognizing
their significance in linking physicians to hospital settings and thus to Medical Administration.

A Brief Overview of Medical Governance

According to the Canadian Medical Association (1992), committees are a key element in medical staff organizations. However, to establish effective committees there must be an understanding of the implications of democracy, authority, responsibility and accountability within these structures. At the same time, there must also be an appreciation of the many problems, interests and needs that are common to larger hospital and health care contexts. The following is a brief overview of the historical development of medical committee structures to explain the evolution of committees and their role in linking physicians to hospital and administrative environments.

Prior to the 16th century, hospitals were primarily founded and funded by religious orders and charities. For the most part, physicians shunned these institutions. However, as the practise of medicine became more complex, physicians were increasingly compelled to associate and become organized within hospital settings. As hospitals grew, the importance of organizational systems and operational mechanisms increased in order to facilitate the ability of physician groups to delegate and divide work. As part of the system, regular meetings were required to promote physicians’ ability to share knowledge, skills and interests in the evolving structure.

During the 18th century, physician meetings gradually evolved into loose committee formats. These committees served as a democratic means to organize large groups of physicians who for the most part were not members of the administrative hierarchy and who were also not system employees. To add to the complexity of having
an atypical status within the hospital setting, the physician's role in committee activities also lacked definition regarding their authority, responsibility and accountability within the committee itself and within the larger hospital milieu. Despite this challenging circumstance, physicians were expected to attend to myriad hospital problems while simultaneously managing the diverse interests of patients, colleagues and other hospital health care workers. Although imperfect, the committee structure provided an organizational framework within which to structure these activities (Read, 1992).

According to Dr. D. Matheson, significant changes in the health care environment occurred between the 1940's and the 1980's to further shape the relationship between physicians and hospitals. In the 1940's and 1950's a Chief Nurse and Chief Doctor worked in partnership to "run" the hospital and this arrangement persisted for a considerable period of time. Then, in the 1970's and 1980's the approach to hospital management became more "business-like" and involved many non-clinical administrators. Initially, this was not problematic because money was plentiful and good ideas could be taken to the administrators, who would in turn find the resources required to enact them. During this time, much of the decision making in hospitals was done by administrators with the implied support of physicians. However, as resources became scarce, decision making continued along administrative pathways and medical support began to wane. In response, many administrative groups bolstered the clinical representation of their senior team with Chief Nursing Officer and Chief Physician Officer positions (although it should be noted that in British Columbia, not all Health Authorities have senior medical leaders on their Executive). As a result of the changes that occurred over this 40 year period, a degree of separation between the two parties
emerged and led to different approaches to decision making— the effects of which continue to influence the physician—administration relationship (D.M Matheson, personal communication, April 7, 2007).

**A Remote Affiliation**

The Medical Advisory Committee structure was chosen as the research focus because it represents the greatest point of intersection between Medical Administration and the physician body. Although there are other important Northern Health medical committees, the MAC structure is dedicated to medical issues of interest to both parties, including: patient safety, quality assurance and quality improvement.

As stated earlier, the physician—Medical Administration relationship has features that distinguish it from the conventional organizational justice context. First, physicians do not work for Northern Health and as a result, medical administrators are not in an authoritative role in relation to the practising physician. In fact, the affiliation is typified by an almost neutral authority gradient, making the relationship more “symbiotic”, and with the exception of the Medical Advisory Committee structure, somewhat remote in nature. For example, most physicians are connected to Northern Health via their community hospital (or other type of care facility) where they provide in-patient care services. This connection is formally established via the privileging and credentialing process.

Physicians working in hospitals are subject to credentialing requirements governed by the 1984 Canada Health Act and Medical Staff Bylaws. In 1984, the Canada Health Act clarified standards to which provincial health programs were required to conform in exchange for federal funding contributions. In part, these standards include:
• **Universality** - coverage of the whole population on uniform terms and conditions
• **Comprehensiveness** - provincial health insurance plans must cover all insured health services (hospital, physician, surgical-dental) and, where permitted, services rendered by other health care practitioners.
• **Accessibility** - there is to be reasonable access
• **Portability** - consistent coverage among the provinces
• **Public administration** - health care insurance plans are to be administered and operated on a non-profit basis by a public authority

By defining the comprehensiveness standard as coverage related to medically necessary hospital services, as well as physician and surgical-dental services provided to insured persons, the Act had the important effect of reinforcing the hospital-physician relationship (Hutchison, Abelson & Lavis, 2001).

In addition to undergoing the credentialing process, a physician must also be granted hospital privileges and be appointed to the Medical Staff before rendering clinical services within a hospital (Dykeman, Dewhirst, 2007). Northern Health’s Medical Staff Bylaws provide a description of the relationship between the Board of Directors and the medical staff organization and define the conditions under which medical staffs serve the facilities and programs operated by Northern Health (Northern Health Medical Staff Bylaws, 2004). It is the Board of Directors who grant privileges to appropriately qualified medical staff members. Thus, northern physicians who wish to admit and care for patients in Northern Health facilities and programs must apply to the Health Authority to be credentialed and to be granted specific facility privileges based on a) the physician’s particular skill sets and b) the needs of the facility in which he/she will be practising. A physician who is credentialed and receives privileges within the Health Authority automatically becomes a member of the Medical Staff. It is this relationship that most commonly constitutes the connection between Northern Health and northern physicians.
On the other hand, the Board of Northern Health has the right to not appoint a physician if that individual does not fit the human resource needs of the Health Authority. The Board may also remove privileges from individual physicians upon the recommendation of the MAC if there are concerns regarding the quality of care delivered by that physician.

Although Northern Health's connection with most physicians is somewhat distant, the North is both fortunate and somewhat different from other Health Authorities in that almost 100% of northern physicians provide patient care in the hospital setting. By contrast, in the Lower Mainland, a large percentage of physicians do not care for their patients in hospital settings. There are numerous factors that contribute to this difference. For example, the population density in larger city centres creates a situation where a physician is able to generate enough Medical Service Plan (MSP) billings in private practice without having to supplement earnings with the provision of patient care in the hospital setting, which tends to be less remunerative. Secondly, larger centres frequently require the physician to commute a fair distance from his/her private practice to the hospital. Commuting time poses an opportunity cost dilemma for the physician because time spent commuting translates into lost revenue from services that could have been provided in the office. This situation is exacerbated by the segregation of procedures in the larger centres where separate hospitals specialize in a certain area of care. For example, one hospital might specialize in cardiac care; one might have an orthopaedic focus, while another provides specialized pediatric care. This means that a general practitioner may simultaneously have several patients in several different hospitals. This makes it impractical (if not impossible) for a physician to be involved in the care of all
patients belonging to his/her private practice. Because of the above, many patients upon admission to hospital become separated from their family physician and are said to be “orphaned”. Orphaned or unattached patients necessitated the need for many urban hospitals to employ hospitalists (physicians who are employed to work exclusively in the hospital setting). The unintended consequence of the hospitalist role has been to reinforce the disconnect between the physician and the hospital and to further erode physician satisfaction as it relates to their interest in providing comprehensive and continuous patient care (Sullivan, 2000).

The literature cites another factor that discourages physicians’ inclination to affiliate with hospitals and invest effort in establishing and maintaining good working relationships with administration. Authors Cruess and Cruess (2000) maintain that physicians have lost professional status within hospitals caused, in part, by the influence of public policy on health care governance- policy that tends to infringe upon physician autonomy and diminish the importance of medical influence in the health care system. Cruess, Cruess and Johnston (1999), stress that disenfranchising medical staff in this way does little to protect the interests of patients.

Thus, despite the fact that physicians in Northern Health are more dependent on hospitals for income maximization than their urban counterparts, Medical Administration should feel compelled to prevent and/or overcome any form of disconnection, whether real or perceived, in the physician-hospital relationship. Supporting physicians to attain the greatest degree of professional satisfaction possible by facilitating their ability to provide “complete” medical care for their patients is in the best interest of patients, physicians and administrators alike (Cruess et al., 1999). Sullivan (2000) concurs, noting
that Canadian physicians pride themselves on a system of care where the family physician “quarterbacks” their patients through the complete process of care (from the community, to the hospital when necessary, and facilitates the transition back to the community).

In the end, continuity and quality of patient care is the primary impetus for Medical Administration’s interest in examining its relationships with physicians. Medical Administration is committed to identify possible deficiencies in the relationship, with a view to invest in activities that will promote physician satisfaction and ultimately improve patient care. As a first step, administration must first understand the nature of the problem.

The Scope of the Problem

Much of the literature characterises the physician relationship with hospital administrators as tense, because the two groups are motivated by divergent interests and perspectives (Rowand, 1996). The author also asserts that the “corporatization” of health organizations coupled with the ever-changing roles of Medical Administration serve to exacerbate the problem. This is because the fluid health care environment renders the physician-administration interface unclear. The relationship challenges are further compounded by the fact that the physician-administrator affiliation functions in the absence of the archetypal employer-employee relationship—a connection that tends to be better understood because it is more “clear cut” (Bujak, 2005). Relations between medical and administrative staffs are further strained because physicians view administrators as being inordinately preoccupied with “the bottom line”. This causes physicians to feel as though their medical decisions in hospitals are unnecessarily
encumbered by businesslike considerations (Starr, 1982; Alexander, Morrisey & Shortell, 1986) and directly conflicts with physicians’ motivations to engage in health care governance. Perhaps Bujak (2005) said it best:

“They want to have input into decisions that have a clear impact on their capacity to deliver care and continue to earn a living free of excessive or unfair competition. Moreover, they want to defend themselves from infringements on the free expression of individual physician prerogative”

(Bujak, 2005, p.28).

Although Northern Health Medical Administration believes its relationships with physicians are fundamentally solid, the relationships are nonetheless subject to the forces described above. For example, Regionalization was introduced in December, 2001 and although the Health Authority structure has streamlined a complicated and expensive health care system by merging 52 health authorities, the change has necessitated the establishment of new relationships, caused other relationships to change, and in some instances cannibalized valued relationships altogether. While there is nothing to indicate that regionalization has contributed to physician dissatisfaction, there is evidence that the physician- hospital relationship is less than optimal in our province. According to the Canadian Medical Association Professional Satisfaction Among Canadian Physicians: A Retrospective Look at Survey Results (2007), physicians in British Columbia reported the lowest satisfaction ratings in the ‘relationship with hospital’ category when compared to physicians working in other Canadian provinces.
Figure 1.

**Relationship with Hospitals**

Male and female physicians were almost equally satisfied with their relationship with hospitals; similarly, differences between FPs and specialists were negligible. Physicians in New Brunswick were among those most content with their relationships with hospitals (65%). Ontarians and British Columbians, on the other hand, were among those least likely to express satisfaction with their relationship with hospitals with only 47% and 46% respectively indicating they were satisfied (Graph 2).

Overall, Atlantic physicians were more likely to state they were very satisfied with the various variables examined in this study than were the rest of the regions. In fact, 22% of Atlantic physicians say they were very satisfied with their relationship with hospitals.

![Graph 2: Satisfaction with Relationship with Hospitals](source)

(Professional Satisfaction Among Canadian Physicians: A Retrospective Look at Survey Results, 2007, p. 5)

Although the survey revealed greater satisfaction levels between Canadian physicians and hospitals in rural environments versus urban settings (65% versus 51% respectively), there is still room for improvement in both realms. At issue here is the opportunity for Medical Administration to identify possible sources of physician dissatisfaction through the assessment of justice measures in physician-Medical Administration interactions.

Much of the literature in the late 1980's and through the 1990's emphasizes the importance of strengthening the working relationships between physicians and administrators. However, it is concerning to note that many strategies aimed at improving cooperation and promoting integration between administration and physicians appear to
be driven by fiscal concerns. This perpetuates the sense that administrative actions are motivated by the bottom line to the exclusion of all other considerations (Goes & Zhan, 1995).

Although the literature indicates that efforts to improve the physician-administration relationship are motivated by the knowledge that such matters as physician practice styles, resource utilization and patient admission rates significantly impact the hospital’s financial performance, there are many other benefits to improving cooperation between administration and physicians. For example, Blair, Slaton and Savage (1990) assert that when effective relationships between hospital and medical staff are a result of administration’s conscious efforts to legitimize the physician’s role within the organization, physicians bond both psychologically and financially to the hospital. This is important because when the physician-hospital relationship functions optimally, physicians feel that the hospital context adds value to their medical practices and promotes their ability to deliver better care.

Authors Smith, Reid and Piland (1990) assert that physician involvement in governance also increases their sense of fiduciary responsibility. Physician participation in health governance exposes them to tough financial and administrative decisions that are normally invisible to the medical practitioner, but nonetheless routinely impact the health care systems within which they work. This heightened appreciation for the context in which health care is administered helps to align administrative and physician efforts to deliver care within an exceptionally complex and economically constrained health care environment (Bujak, 2005). Having said this, the author cautions administrators to be patient with physicians. The ability to appreciate and understand the complexity and
challenges associated with maximizing the performance of the entire health system is contrary to the clinician’s perspective, which tends to be more myopic in nature.

Finally, proponents of enhanced physician-administration integration assert that cooperative ventures add value for both hospitals and physicians by establishing systems that facilitate the free exchange of ideas, resources and expertise needed to promote the efficient delivery of quality health care (Foreman & Roberts, 1991). For example, while administrators possess important skills, many lack clinical backgrounds and therefore benefit from collaborative efforts that permit administration to incorporate physicians’ clinical input and insights into decision making processes involving quality and improvement, patient safety, privileging and credentialing processes (Goes & Zhan, 1995; Hutchinson et al., 2001).

The Relevance of Organizational Justice Research

Clearly, the administration-physician relationship is valuable. The question becomes how to effectively forge, nurture and protect these important relationships. Greenberg and Cropanzano (2001) maintain that organizational justice is of importance to all organizational members and favourable justice perceptions, cultivated through fair organizational behaviour and treatment, have the important effect of positively influencing the member-entity relationship and optimizing organizational commitment and function.

Working from this premise, Medical Administration must ensure that physicians feel meaningfully involved in organizational decision-making and “fair relationships” are an important vehicle to accomplish this end. This is consistent with a key value articulated in Northern Health’s Strategic Plan that states:
“Achieving the goals of Northern Health requires the active inclusion of the medical staff in organizational decision-making. Northern Health will support professional self governance through the medical staff organization and seek medical staff participation in operational decision-making”. Medical Staff Participation, Northern Health Strategic Plan 2004-2008, p. 8

**Why The Medical Advisory Committee Structure?**

The Northern Health and Health Service Delivery MACs are comprised of approximately 43 physician members out of 437 practising physicians in Northern Health, excluding archived numbers, dental, midwifery, etc. (Northern Health Physician Database, 2007).

**Table 1. Northern Health Physician Database Physician Listing**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Number</th>
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<tbody>
<tr>
<td>Anaesthesia</td>
<td>11</td>
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<tr>
<td>Dentist</td>
<td>55</td>
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<tr>
<td>Dermatology</td>
<td>1</td>
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<tr>
<td>ENT</td>
<td>2</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>314</td>
</tr>
<tr>
<td>General Surgeon</td>
<td>19</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>14</td>
</tr>
<tr>
<td>Medical Health Officer NHA</td>
<td>1</td>
</tr>
<tr>
<td>Midwifery</td>
<td>4</td>
</tr>
<tr>
<td>Nephrologist</td>
<td>2</td>
</tr>
<tr>
<td>Neurology</td>
<td>1</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>7</td>
</tr>
<tr>
<td>Oral Maxillofacial Surgeon</td>
<td>1</td>
</tr>
<tr>
<td>Obstetrics &amp; Gynaecology</td>
<td>11</td>
</tr>
<tr>
<td>Orthopaedic Surgeon</td>
<td>10</td>
</tr>
<tr>
<td>Pathologist</td>
<td>8</td>
</tr>
<tr>
<td>Paediatrician</td>
<td>9</td>
</tr>
<tr>
<td>Plastic Surgeon</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>11</td>
</tr>
<tr>
<td>Radiologist</td>
<td>12</td>
</tr>
<tr>
<td>Urologist</td>
<td>3</td>
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(Total excludes Dentist, Midwife and Oral Maxillofacial Surgeon Categories)
While it can be argued that the Medical Advisory Committee members are hardly representative of medical staff in general, particularly in terms of level of organizational sophistication and degree of engagement with Medical Administration, the MAC governance apparatus inarguably serves as the primary point of contact between Medical Administration and medical staff. Consequently, the Medical Advisory Committee is the most relevant framework to studying terms of evaluating the quality of relationships between physician members and Medical Administration.

This research will generate insights that will improve Medical Administration’s understanding about physicians’ perceptions of justice within the Medical Advisory Committee structure. It is the intention of Northern Health to use this new knowledge to optimize the MAC structure as a vehicle for delivering justice to physicians, to strengthen the relationship between Medical Administration and the physician body, and in doing so, to ultimately enhance medical care for northern populations.

The Medical Advisory Committee

The CMA Guide to Medical Administration in Canadian Hospitals (1992) describes Medical Advisory Committees (MACs) as the “senior cabinet” of the medical staff. Medical Advisory Committees usually consist of medical staff members appointed to medical leadership positions within the organization, peer elected medical staff, a regional Medical Health Officer, a Medical Administration secretariat, the CEO who participates in a non-voting capacity and other senior administration members who also participate in a non-voting capacity. Although the functions of the MAC are numerous, its chief responsibility is to advise on matters pertaining to the quality of medical care.
According to the Interim Northern Health Medical Staff Rules (2006), the purpose of the Northern Health Medical Advisory Committee is five fold and includes: 1) to make recommendations to the Board of Northern Health with respect to the initial granting of privileges to applicants for Northern Health Medical Staff membership, 2) to make recommendations with respect to the cancellation, suspension, restriction, non-renewal, or maintenance of the privileges of all members of the Medical Staff, 3) to advise the CEO and the Board of Northern Health regarding the provision of medical care within Northern Health facilities and programs, 4) to advise on the quality and effectiveness of medical care provided within Northern Health facilities and programs, including advice regarding the adequacy of medical resources, the continuing education of medical staff members and establishing priority goals designed to meet the medical care needs of Northern Health populations, and 5) the MAC is tasked to provide medical input into Northern Health decision making processes and to advise the CEO and Board on professional issues of importance to Northern Health medical staff(s), including operational issues that directly affect the medical care of patients.

Underneath the umbrella of the Health Authority wide Medical Advisory Committee are three subsidiary Medical Advisory Committees structured at the level of the Health Service Delivery Area (HSDA MACs). These MACs are geographically based and described as the North East, North West and Northern Interior Medical Advisory Committees. These HSDA MACs exist to ensure that local medical issues and recommendations are heard and addressed at the Northern Health Medical Advisory Committee level and to ensure that these local matters of concern are appropriately brought forward to the Northern Health Board of Directors. The interface is further
strengthened via two administrative processes. First, by the subsidiary MACs' Terms of Reference which are approved by, and consistent with, the Terms of Reference of the NH MAC. Secondly, the subsidiary MACS report to the NH MAC via the submission of committee meeting minutes. Finally, continuity is further facilitated via some HSDA MAC member's dual participation on the NH MAC.

Figure 2. Overview of the Northern Health MAC Structure

It is also very important to note the existence of facility based MACs whose utility is highly prized by facility physicians and other health care providers within the three HSDA's. Regrettably and despite their importance, the study of facility based MACs falls outside the scope of this research project.
Organizational Justice

According to Colquitt, Greenberg and Zapata-Phelan (2005), interest in organizational justice dates back to the days of Aristotle, who was among the first to analyze what constitutes fairness in the distribution of resources between individuals. This theme was revisited in the 17th century when scholars explored the concepts of human rights and the assessment of valid covenants which served as foundational thinking for J.S. Mill’s 19th century notion of utilitarianism, liberty and responsive government. Although discrepant in some respects, these views conceptualize justice as a normative ideal. While this orientation is evident in current literature, most notably Rawls’ 1999 and 2001 works, the current literature supplements this view with the descriptive works of social scientists who are concerned less with the conceptualization of justice as it should be and more with understanding matters of justice and fairness as they are perceived by individuals. Thus, the inquiry into the field of organizational justice or “fairness” (the terms are used interchangeably in the literature) requires an understanding of what people perceive to be fair. It was not until the last half of the 20th century that considerable effort was invested in applying social and psychological processes to organizational settings. It was at this time that insights into people’s perceptions of fairness in organizations gained widespread attention, particularly in the fields of organizational behaviour and human resources management.
With the conceptual tools necessary to investigate the fundamental matter of justice in the workplace established, the focus shifted to the analysis of how concerns about organizational justice manifested themselves in different facets of employees' lives. For example, Leventhal (1976) noted workers' concerns about the fairness of resource distributions such as pay, rewards and the outcomes of dispute resolutions. These concerns relate to what is known as *distributive justice*. Thibaut and Walker (1975), Leventhal (1980), and Leventhal, Karuza and Fry (1980) assert that people attend to the fairness of the decision making procedures that lead to those outcomes and attempt to understand how and why the outcomes came about. These interests constitute the concept of *procedural justice*. Finally, individuals who are concerned with the nature of interpersonal treatment received from organizational authorities and others in the workplace are dealing with the organizational justice element termed *interactional justice* (Bies & Moag, 1986; Greenberg, 1993). Taken together, distributive, procedural and interactional justice are considered the fundamental elements of *organizational justice*, a
term first used in the late 1980’s by Jerald Greenberg who is arguably the foremost and most prolific scholar in the field.

The literature maintains the three dimensions of organizational justice are important to people in work settings for many reasons. According to Tyler and Lind (1992), fair treatment promotes the perceived and experienced “legitimacy” of organizational authorities and in doing so reinforces a sense of their trustworthiness and reduces concerns of unfair treatment and exploitation (Lind, 2001). The aforementioned, enhances trust and confidence in leadership, discourages various forms of disruptive behaviour, promotes incentive for enhanced collegial cooperation, and promotes acceptance of organizational change (Greenberg & Lind, 1992; Greenberg, 1994; Lind 2001). On an individual level, Thibaut & Walker (1975) and Lind & Tyler (1988) note that fairness also fulfils the important need for control, esteem and a sense of belonging, which serve as critical precursors for the promotion of organizational commitment. This research project measures physician MAC member’s perceptions of organizational justice in their working relationships with Medical Administration and did not test for the outcomes associated with just or unjust relationships. This is an area for future inquiry.

**Distributive Justice**

Distributive justice focuses on the fairness associated with the distribution of resources, recognition and influence and is described in the literature as the first wave of organizational justice spanning from the 1950’s through to the 1970’s. Several theoretical themes inform the distributive justice construct.

The first theme is described as the Relative Deprivation concept and was developed primarily through research conducted during World War II. The most notable
study involved US soldiers who were asked about their perceptions of fair treatment by the US Army using “promotion opportunities” as the primary assessment criterion. In this study, comparisons were made between two groups- the Military Police and the Air Corp, with the latter group receiving 20 percent greater opportunities for promotion over that of the Military Police group. Interestingly, the MP group did not compare their promotional opportunities to that of the other group. Rather, MPs who earned promotions felt rewarded because they were in the top 1/3 of their own peer group. By contrast, the Air Corp group, although more likely to experience a career promotion than the MP group, reported greater levels of frustration about their opportunities for promotion and indicated that they felt less recognized because a promotion merely indicated an achievement equivalent to that of which the majority of their peers had achieved (Stouffer, Suchman, DeVinney, Star & Williams, 1949). This example of the relative deprivation phenomenon highlights the idea that people’s reactions to outcomes depend less on the absolute level of those outcomes and are instead assessed in terms of how they compare to the outcomes of others- the referent individual or group against whom people judge them (Colquitt, Greenberg & Zapata-Phelan, 2005).

This work established the importance of what would later be known as the concept of Social Comparison and how such comparative processes influence an individual or group’s judgement of outcomes. Homans (1961) added to the notion of Relative Deprivation to conceptualize the Social Exchange Theory, a process by which an individual’s behaviour influences the behaviour of at least one other individual’s behaviour. A common example of this social exchange occurs when a person elects to help another person in exchange for his or her social approval (Colquitt, Greenberg &
Zapata-Phelan, 2005). Over time, Homans (1961) noted that people build exchange histories that create normative expectations for future exchanges. The more established this pattern becomes, the more strongly it is perceived as normatively appropriate or as Homans observed “precedents are always turning into rights” (p.73). It is important to note that people involved in exchange relationships are sensitive to the possibility that one individual or group may be getting more from the exchange than another group or that one party is not adhering to normative precedents as has come to be expected based on prior exchanges. From this, Homans contends that participants in an exchange relationship will come to expect a profit that is proportional to their investment and fairness exists whenever this expectation is met. Finally, Homans noted that the parties involved in a social exchange may reach different conclusions about distributive justice because perceptions and the perceptual processes that inform the distributive justice concept are highly subjective. Specifically, the scholar noted that people tend to disagree about the investments relevant to their social exchange relationships and also differ in opinion about the rewards received and the costs incurred when judging ‘profits’. This assessment is contingent upon whom the person or group base their comparison and highlights the integrated nature of relative deprivation.

Many of the themes found in Homans’ (1961) conceptualization of distributive justice are also found in Blau’s (1964) discussion of Exchange Relationships. According to Blau, people’s satisfaction with these relationships is contingent on the benefits received relative to the expectations held by the parties. These expectations are informed by people’s personal experiences as well as an awareness of the benefits received by others. Furthermore, Blau outlined different types of expectations. These include general
expectations, particular expectations, and comparative expectations. Predictably, general expectations are described as expectations informed by the prevailing societal norms and standards of the time. Particular expectations are informed by an individual's beliefs that a specific exchange partner will: 1) conform to acceptable codes of conduct and 2) provide rewards for association that will exceed what could be obtained from other exchange partners. Comparative expectations refer to the profits individuals expect to earn from exchange relationships in general and the subsequent use of this information as a standard by which to compare multiple exchange partners. Jointly, these expectations formulate what Blau described as fair exchange.

Although the work of Romans' (1961) and Blau (1964) is similar, Blau's fair exchange theory is treated in the literature as being different from Romans' (1961) conceptualization of distributive justice. The literature contends that Blau's fair exchange theory takes into account more general societal norms of fair behaviour than Romans' social exchange theory. Blau's (1964) work is also differentiated by a distinction between economic exchanges which are contractual in nature and social exchange relationships which involve favours that create undefined future obligations and are based upon trust that future obligations will eventually be fulfilled. This latter notion became significant in the evolution of the organizational justice field because the development of the theory of social exchange relationships became one of the most common explanations used to describe the effects of justice on work behaviour.

Adams' (1965) equity theory expanded upon Homans' elements of distributive justice and was the dominant approach for analyzing justice issues in the work place for more than twenty years. Working with Homans' notions of profits and investments,
Adams defined distributive justice as a concept where equity is a perceived rationalization of outcomes to inputs. The literature defined outcomes as pay, rewards that are intrinsic to the job, job status and status symbols, as well as various other formally and informally sanctioned perquisites. Inputs include education, intelligence, experience and training, skills, seniority, social status and effort expended on the job. It should be noted that the list of outcomes and inputs provided here do not constitute an exhaustive list.

As an extension of Homans' (1961) theory, Adams described the mental calculus that underpins outcome/input comparisons. For example, Adams' (1965) equity theory contends that individuals compare their outcome/input ratios to the corresponding ratios of a comparison group or to themselves at an earlier point in time. The notion of a comparative group harkens back to the concept of relative deprivation and acknowledges that different frames of reference will yield different fairness judgments (Stouffer et al., 1949). According to Adams' equity theory and consistent with elements of Homans' earlier (1960) social exchange theory, if an individual's outcome/input ratio falls below that of a 'comparison other' he/she will experience underpayment inequity and will experience feelings of anger. If the outcome/input ratio exceeds that of the 'comparison others', the person will experience overpayment inequity characterized by feelings of guilt. According to Colquitt, Greenberg and Zapata-Phelan (2005), the critical contribution of equity theory to the field of organizational justice was its description of what happens after inequity is perceived.

The actual mechanics of equity theory were founded upon Festinger's (1957) cognitive dissonance theory of which Adams (1963) viewed his equity theory as being a
specific manifestation thereof. According to Adams, the emotional and psychological reactions described in equity theory can be traced back to the theory of cognitive dissonance. In a dissonant state an individual’s goal is to restore the balance between outcome/input ratio comparisons as a means to remedy psychological tension created by the inequity (Adams, 1965). Balance restoration can be achieved in several ways. For example, balance can be restored behaviourally by altering one’s own outcomes or inputs, or balance can be achieved by acting on the ‘comparison other’ in an effort to alter his or her outcomes or inputs. Balance may also be achieved by withdrawing from the relationship where withdrawal is achieved cognitively by re-evaluating outcomes and/or inputs, or by attempting to change the comparison group.

The key propositions of equity theory have been validated by numerous empirical studies including investigations conducted by Homans (1953), Adams (1963) and fellow scholar Rosenbaum (1962), and again by Adams (1965) when he reviewed earlier results to validate his theory using laboratory studies as the primary experiment method. While the validation of one’s own theory may be suspect, the literature indicates that organizational justice scholars largely accept the favourable results of this review. Having said this, the theory did come under some criticism in the mid to late 1960s and early 1970’s. Despite these criticisms, equity theory has been regarded as a useful organizational behaviour theory over the last two decades and according to Miner (2003), has recently been included in a list of the organizational behaviour theories noted to have the highest scientific validity.

The late 1960’s to the early 1970’s brought forth a shift in the research. Previously, distributive research focused almost entirely on people’s reactions to
perceived inequity. However, Leventhal, through his allocation norm theory, took a more proactive view by shifting the focus from the reactions of reward recipients to the behaviours of the reward allocators. Specifically, Leventhal and his associates sought to determine whether allocators actually adhered to equity principles (by dividing rewards in proportion to relative inputs) in order to divide rewards fairly. Leventhal’s (1976) research demonstrated that allocators tend to use rewards to direct individual’s efforts toward fulfillment of the group’s goals. These rewards are subject to the influence of an allocation norm, defined by Leventhal as “a social rule that specifies criteria that define certain distributions of rewards and resources as fair and just” (p. 94). It is important to note that in many instances the equity norm is not the appropriate norm to use (Leventhal, 1980). This is primarily because following the equity norm requires one to distinguish between the contributions of the recipients and has the potential to threaten the interpersonal cooperation and socio-emotional relationships between group members.

Adding strength to Leventhal’s assertion, Deutsch (1975) cautioned against the universal application of equity theory, noting that equity standards are particularly inappropriate in the non-economic social relationship context. Both scholars claimed that equality rather than equity is the appropriate allocation norm when the primary goal of an exchange is to promote group solidarity and harmony over the advancement of individual productivity. Both scholars believed a need-based allocation norm is the most appropriate norm in instances where the primary goal is to promote personal welfare and development. By advocating the use of different allocation norms, Leventhal (1976) and Deutsch (1975) importantly broadened the scope and definition of distributive justice. According to the teachings of these scholars, a fair outcome would be achieved whenever the allocation
norm applied to a situation promoted the realization of such key goals as productivity, solidarity or welfare. Both scholars noted that most allocation decisions are best described as compromises among multiple allocation norms. Namely the norms of: equity, equality and need allocations - although equity remains the dominant conceptualization of distributive justice in the workplace.

**Distributive Justice Applied to the Medical Advisory Committee Context**

The distributive justice elements that are relevant to the MAC structure include recognition of the responsibilities, effort and expertise invested in the MAC member role, an appreciation for the rigour of the role, as well as the sense that individual MAC members, and MACs as a collective, have influence with Medical Administration.

The literature suggests that MAC member perceptions about the degree to which Medical Administration recognizes their contributions and the degree of influence they have with Medical Administration will likely be judged in comparison with other groups or to themselves at an earlier point in time (Blau, 1964; Colquitt, Greenberg & Zapata-Phelan; 2005). The readings also suggest there will be sensitivity to the possibility that other individuals or groups may be getting more from the MAC- Administration relationship exchange than they are as individuals or more than the region they represent (Homan's 1960; Blau, 1964). Finally, the literature indicates that MAC members will expect "recognition" and "influence" as the desired outcome of the distributive justice exchange to be proportionate to the degree of investment they have made in the committee's work. If this expectation is met, the relationship will be perceived as fair in the distributive sense (Festinger, 1957; Adams, 1965; Leventhal, 1976).
Having said this, the literature acknowledges that there is a degree of subjectivity to be found in people’s conclusions regarding the presence or absence of distributive justice. This is because: 1) people tend to disagree about what constitutes an appropriate or proportional return for investment, 2) that justice perceptions vary according to which group people choose to base their comparisons, and 3) that the perception of a distributively just dynamic is influenced by the assessment of ‘benefits received’ relative to the group’s expectations regarding what benefits the group believed they were entitled to in the first place. Finally, perceptions regarding what constitutes a distributively just relationship are also influenced by the degree of awareness regarding what benefits have been received by others (Homans, 1961; Colquitt, Greenberg & Zapata-Phelan, 2005).

Northern Health Medical Administration believes it treats all MAC members equally and fairly. Consequently, the following hypotheses are proposed:

**Hypothesis 1a.** The three HSDA MACs and the Ex-officio MAC members will have favourable perceptions with respect to the presence of distributive justice.

**Hypothesis 1b.** Overall and within the individual justice questions, there will be no differences in distributive justice perceptions between the three Health Service Delivery Area MACs.

**Hypothesis 1c.** There will be no differences in distributive justice perceptions between NHMAC and Non NH MAC members.
Procedural Justice

The procedural justice wave began in the mid 1970's and continued through the mid 1990's and shifted the emphasis from the assessment of the fair distribution of resources to an analysis of the procedures used to arrive at such allocation decisions.

In 1975, Thibaut and Walker released a monograph outlining five years of research on fairness perceptions in a legal dispute resolution context. This work contrasted two broad categories of legal procedures. First is the adversary system where the judge makes the final decision but does not control the evidentiary procedure used to arrive at the decision or outcome. The second system is the inquisitorial system where the judge controls both the procedure and the subsequent outcome. Research found people preferred the adversary system regardless of the verdict reached. While the impact of the verdict was observed, and the “innocent” verdict was obviously the preferred outcome, the procedural effect was found to be independent of the outcome effect. According to Thibaut and Walker (1975), the key distinction between the two legal approaches, in terms of the assessment of fairness, could be found in the control afforded the disputants versus the third party judge. Through this, the researchers introduced the concept of procedural justice by stating:

"We suggest that the just procedure for resolving the types of conflict that result in litigation is a procedure that entrusts much control over the process to the disputants themselves and relatively little control to the decision maker. There are many correlated and subsidiary elements of procedural justice, but the key requirement for procedural justice is this optimal distribution of control". The researchers concluded by stating “Our research shows that a procedure that limits third-party control, thus allocating the preponderance of control to the disputants, constitutes a just procedure. It is perhaps the main finding of the body of our research” (Thibaut & Walker, 1975, p. 2 and p. 118 as cited in Greenberg & Colquitt, 2005).

This was a significant finding in the field of organizational justice because it demonstrated that procedures, not just outcomes, drove key organizational attitudes. This finding, inspired additional research where Thibaut and Walker (1978) distinguished
between two forms of control: decision control (the degree to which the disputant is able to unilaterally control the outcome of a dispute) and process control (the degree to which a disputant can determine the development, selection, and presentation of the evidence used to resolve the dispute). The effects of Thibaut and Walker's (1975) work received widespread attention in the field during the late 1970's and early 1980's and inspired Leventhal (1980) to continue to develop his research. Although Leventhal's early work focussed on distributive allocation rules, he acknowledged the importance of procedural rules as a second category of justice. Specifically, Leventhal made the case that these procedural rules satisfy certain criteria that individuals require to support a conclusion that allocative procedures are fair (1980). From this, Leventhal went on to establish seven distinct procedural components:

- The selection of agents
- The setting of ground rules
- The gathering of information
- The outlining of the decision making structure
- The granting of appeals
- The building of safeguards
- The use of change mechanisms

Colquitt, Greenberg and Zapata-Phelan (2005) indicate that the most significant contribution of Leventhal's (1980) work was his identification of specific procedural rules that could be used to evaluate the procedural components outlined above. Although Leventhal himself warned that at the time of his studies the criteria that define his "rules" of fair procedure could not be confirmed, the construct of procedural justice and Leventhal's rules were nonetheless introduced to the organizational sciences by Greenberg and Folger (1983) and the "rules" were later validated by numerous empirical organizational justice studies. Leventhal's six rules for fair procedures are:
Consistency—procedures should be consistent across time and persons.

Bias suppression—procedures should not be impacted by self-interest or blind allegiance to preconceptions.

Accuracy—procedures should be based on valid information and informed opinion wherever possible, with a minimum of error.

Correctability—procedures must contain opportunity to modify or reverse decisions through the permission of appeals and grievances.

Representativeness—procedures must reflect the basic concerns, values and outlooks of individuals and subgroups impacted by the allocation—similar to Thibaut and Walker’s (1975) concept of process control.

Ethicality—procedures must be consistent with the fundamental moral and ethical values held by the individuals involved and should be devoid of deception, trickery, bribery and so forth.

Referring to these procedural rules, Leventhal incorrectly hypothesized that concerns regarding procedural justice would be secondary to concerns about distributive justice because procedures are often complex, invisible, and therefore often not considered when outcomes meet an individual or group’s expectations. This belief was later disproved through rigorous empirical testing of the procedural justice construct—research that sought to establish procedural justice as being entirely distinct from distributive justice. This required researchers to determine whether the two constructs actually differed in the minds of employees. This was partially achieved through performance evaluation research conducted by Jerald Greenberg in the late 1980’s. In Greenberg’s study, a sample of managers was asked to consider a particularly fair and a particularly unfair performance evaluation and to identify the most important factors that contribute to the assessment of fairness in each situation. The strongest importance ratings centred on procedural factors composed of process control, correctability, consistency and accuracy items. A secondary emphasis was placed on a distributive factor that primarily indicated concerns about equity. Not only did this research provide empirical support for Thibaut and Walker’s (1975) and Leventhal’s (1980) procedural justice rules, it also proved that
employees indeed do discriminate between the two justice elements and also assign a degree of importance to each element of justice. This research also disproved Leventhal’s earlier assertion that distributive justice was of greater importance to people than procedural justice, even in case where outcomes achieved met the expectations of the group or individual.

Building on this body of work, Tyler and Caine (1981) and later Alexander and Ruderman (1987) examined the effects of the justice dimensions on satisfaction with leadership. The scholars conducted various studies that first assessed three procedural factors: process control, correctability and global process fairness and secondly assessed three distributive factors: promotion and punishment equity, as well as global distributive fairness. The authors then looked at key outcomes related to these factors. The items used in the analysis were: job satisfaction, turnover intentions, trust, stress, and satisfaction with leadership. The research revealed that procedural justice had unique effects on most of these outcomes and that the procedural justice effects on the outcomes were significantly stronger than the effects of distributive justice. Folger and Konovsky’s (1987) work further illuminated and validated these findings by noting that while distributive justice elements were predictive for satisfaction with ‘rate of remuneration’ as an outcome, procedural justice was the more significant predictor of ‘organizational commitment’ and ‘trust in leadership’ outcomes.

In 1989, Folger and Konovsky concluded their body of work by stating:

"Apart from their desire for fair outcomes, people care a great deal about the justice of decision making procedures. Moreover, as the issue moves from the level of personal satisfaction with present outcomes to higher order issues regarding commitment to a system and trust in its authorities, these procedural concerns begin to loom larger than the distributive ones emphasized by equity theory". (Folger & Konovsky, 1989, p. 125-126 as cited in Greenberg and Colquitt, 2005)
Procedural Justice Applied to the Medical Advisory Committee Context

Based on the work of Thibaut and Walker (1975), satisfaction with procedure is independent of outcome effect and MAC members will experience fairness when they have significant input and control over processes and procedures versus situations where control resides with Medical Administration. Furthermore, procedures will be deemed fair when Leventhal’s procedural components are integral to Medical Administration’s interactions with the MAC as evidenced by processes and procedures that are clear with respect to: 1) who will participate in the process, 2) what ground rules will be in effect, 3) what information will be considered, and 4) what safeguards will be put in place to ensure a properly informed outcome (i.e. the opportunity for appeal and change mechanisms) as evidenced by compliance with Leventhal’s Rules for Fair Procedure (consistency, bias suppression, accuracy, correctability, representativeness and ethicality).

Medical Administration believes that administrative procedures and processes enacted within the Medical Advisory Committee context reflect the necessary elements of Leventhal’s procedural components and adhere to Leventhal’s Rules for Fair Procedure. Therefore, the following hypotheses are proposed:

Hypothesis 2a. The three HSDA MACs and the Ex-officio group will report strong evidence of procedural fairness in the relationship between Medical Administration and MAC members.

Hypothesis 2b. There will be no difference in procedural justice perceptions between the three Health Service Delivery Area MACS and the Ex-officio group.
Hypothesis 2c. There will be no differences in procedural justice perceptions between NHMAC and Non NH MAC members.

Interactional Justice

It was not until the mid 1980’s that organizational justice researchers began to shift their focus from the structural characteristics of formal decision making procedures to examining the importance of the interpersonal nature of those procedures. (Colquitt, Greenberg & Zapata-Phelan, 2005). The seminal work of Bies and Moag (1986) generated a keen interest in the analysis and assessment of fairness in interpersonal communication and generated a wave of interactional justice research towards the latter half of the 1980’s and into the early 1990’s.

Recalling his personal experience of mistreatment as a graduate student, Bies noted that graduate students commonly complained of unfair treatment by faculty members, alleging faculty’s tendency to be rude and/or misleading in their interactions with graduate students. Bies maintained that a common point of contention in these accounts was not specifically related to the formal procedures themselves, but rather how these procedures were enacted. To pursue this matter, Bies collaborated with an academic colleague to explain how interpersonal treatment is conceptually distinct from the actual structuring of procedures. Bies and Moag (1986) diagrammed the idea as:

\[
\text{procedure®- - - interaction® - - - outcome}
\]

Interactional justice, found in the interaction element of the diagram above, is concerned about the fairness of interpersonal communication and maintains that people are sensitive to the quality of interpersonal treatment they receive during the execution of organizational procedures. Determining the antecedents of fair interpersonal treatment
was a critical point of clarification and contribution to the understanding of interactional justice. To identify these antecedents, Bies and Moag (1986) drew upon research where job candidates were asked their opinions regarding how recruiters should treat job applicants. This research identified four rules of fair interpersonal treatment:

- **Truthfulness** - Authorities should communicate in an open, honest and candid manner when implementing decision-making procedures, and should avoid any form of deception.
- **Justification** - Authorities should provide adequate explanations or the outcomes of decision making processes.
- **Respect** - Authorities should treat individuals with dignity and sincerity and should refrain from attacking others or being deliberately rude.
- **Propriety** - Authorities should not make prejudicial statements or ask improper questions, particularly questions that pertain to age, sex, religion or race.

Of these rules, job candidate respondents cited truthfulness as the most important fairness element. Although interactional justice rules are derived from a recruitment context, the literature maintains they are relevant to any decision making setting (Colquitt, Greenberg & Zapata-Phelan, 2005). Importantly, these rules were entirely distinct from the procedural justice criteria such as voice, consistency, accuracy and free from bias, as defined by Thibaut and Walker (1975) and Leventhal (1980).

Understanding of the interactional justice construct continued to evolve through the 1980’s and early 1990s. During this era, Bies and Folger (1989) expanded on Bies and Moag’s (1986) work to identify seven key managerial responsibilities:

- Truthfulness
- Justification
- Respect
- Feedback
- Consideration of employee views
- Consistency
- Bias suppression
Additional research by Tyler and Bies (1990) validated the earlier work done in this area of inquiry as did Greenberg et al. in 1991. Greenberg et al. (1991) identified six considerations for managers interested in promoting fairness in their interactions with staff members. Three of the considerations related to the structural elements of interactions and three were interpersonally oriented:

- Consideration of employee’s viewpoints (structural)
- The appearance of neutrality (structural)
- Consistent application of rules (structural)
- Timely use of feedback (interpersonal)
- Use of adequate explanation (interpersonal)
- Treatment with dignity and respect (interpersonal)

The literature discussed thus far suggests a fair degree of overlap between the work of Folger and Bies (1989), Tyler and Bies (1990) and Greenberg et al. (1991). Taken as a collective, there appears to have been further overlap between these works and the work of Thibaut and Walker’s (1975) procedural criteria and Leventhal’s (1980) rules. Indeed, this overlap reportedly created confusion in the field at the time (Greenberg & Colquitt, 2005).

Because there was a fair degree of overlap in this area of inquiry, and although it was clear that “how” procedures were enacted was of importance to people in the workplace, scholars questioned if this concern constituted an entirely different justice domain or if this was simply just another facet of procedural justice. A great deal of research ensued, primarily dealing with the concepts of justification and respect, but the studies did not frame these concepts as ‘interactional justice’ per se until Moorman (1991) conceptualized interactional justice as a separate construct from procedural justice and created the first widely used interactional justice measurement tool. Despite this,
Moorman’s measures espoused the interactional justice conceptualization as it relates to the notion of procedural justice. Therefore, the Moorman’s interactional justice measure actually assesses what is understood to be both procedural and interactional justice elements and as a result, the responses to Moorman’s procedural and interactional justice scales tend to be highly correlated. This led to the common practice of combining the two constructs into a single variable.

The latter half of the 1990’s and the early 2000’s have been dedicated to resolve some of the inconsistent treatment of procedural and interactive justice constructs, to debate the merits of splitting interactional justice into subtypes (interpersonal and informational components), and to clarify the importance of differentiating justice content and justice source in organizational justice measurement practices (Colquitt, Greenberg, Zapata-Phelan, 2005). This body of research dealt with procedural justice and interactional justice as separate constructs but did not attempt to break the interactional dimension down into its interpersonal and informational components as was (and is today) sometimes the practice of some scholars in the field.

The most current literature deals with an integrative approach to the three dimensions of organizational justice. Because the concept of integrative organization justice research is still quite new and the approaches to validating this new construct are inconsistent, even in the traditional context of the employee-employer relationship, attempting to test this dimension of organizational justice within the Physician-Medical Administration domain is outside the scope of this project.
Interactional Justice Applied to the Medical Advisory Committee Context

According to Bies and Moag (1986) and Moorman (1991), Medical Advisory Committee members will be sensitive to the quality of interpersonal treatment they receive as part of procedural processes. In order to arrive at the conclusion that their interpersonal treatment is fair, the interactions between Medical Administration and Medical Advisory Committee members must be characterized by truthfulness, the provision of adequate explanations, respect, and should also be free from bias, improper treatment and tone (Bies and Moag, 1986). Further to this, Medical Administration should structure interactions with MAC members in a manner that considers the MAC member’s viewpoints and applies rules in a consistent and neutral fashion. Additionally, in order to enact procedures using an interactionally fair approach, Medical Administrations must provide MAC members with timely feedback, clearly explain decision making processes, and treat all MAC members with dignity and respect.

Medical Administration believes it’s interactions with MAC members reflect the rules of fair interpersonal treatment as described by Bies and Moag (1986). Therefore, the Hypotheses are:

**Hypothesis 3a.** All three HSDA MACs and the ex-officio group will report strong evidence of interactional personal justice in their interactions with Medical Administration.

**Hypothesis 3b.** Overall and within the individual justice questions there will be no difference in interactional justice perceptions between the three HSDA MACs.

**Hypothesis 3c.** There will be no differences in interactional justice perceptions between NHMAC and Non NH MAC members.
Methodology

Participants

Study participants were interested physician MAC members from either a HSDA MAC or the NH MAC. In some instances participants were members of both a HSDA MAC and the NH MAC. Ex-officio MAC members were also offered the opportunity to participate in the research project. Ex-officio MAC members are organizational leaders who participate in the MAC in a non-voting capacity. Ex-officio MAC members provide physician MAC with information from other parts of the organization and also bring the physician perspective back to their areas of responsibility. Ex-officio members were included in this study as a comparative group against which the physician data could be evaluated. Interested ex-officio members were a mix of physician and non physician members of either a HSDA MAC or the NH MAC. Out of a possible 43 Physician MAC informants, 29 participated in the interview for a response rate of 67%. Out of a possible 11 Ex Officio MAC member informants, where the NH MAC Secretariat and the Director of Medical Administration (as the project researcher) were excluded, 5 participated in the project for a response rate of 45%. Therefore, the aggregate participation rate for this project was 63%.

Research Procedure

With permission from the Chairperson of each MAC, the research project was first introduced to each of the four MACs in December, 2006. Each of the four committees endorsed the research project. Although each MAC endorsed the project it was understood that individual MAC member participation was strictly voluntary.
Furthermore, despite the small sample size, to the greatest extent possible, anonymity and confidentiality was assured by stripping the data of any identifying information.

Primary research was conducted as a second step in the project process. A confidential contact list of NH and HSDA MAC members was used to book interview appointments with prospective participants. Telephone interviews were conducted throughout the month of January and early February, 2007. The Introduction to the Research Project (Appendix 1) letter and the Organizational Justice Questionnaire (Appendix 2) were faxed or emailed to the informant in advance of the interview. The deadline for survey submission for all participants who elected to complete the survey was February 9th, 2007 however this deadline was extended to February 28th, 2007 to provide maximum opportunity for participation.

The Survey

The Organizational Justice Questionnaire was administered to all interested Physician and Ex Officio MAC members using a 28 item, 5 point Likert Scale series of questions of which seven pertained to the distributive justice domain, 14 tested for procedural justice and seven dealt with interactive justice elements. The questionnaire also asked eight open ended qualitative questions designed to add depth to the Likert responses and to illuminate what is working well in the MAC- Medical Administration relationship and what is not working well. Finally, the interview concluded with four basic demographic information questions.

Quantitative Analysis

Quantitative data was analyzed using the SPSS procedure of Oneway Analysis of Variance (ANOVA) with a Bonferroni post hoc test to distinguish differences between
the groups. The groups were identified as the North West, North East, Northern Interior and Ex-Officio. These tests were run for every justice element in each of the three justice domains. The ANOVA was used to detect the presence of statistically significant differences between the groups as well as to ascertain the degree of significance of the variances found between groups. A probability value of .10 or less was used to indicate significance. Although .05 is the normal cut off point to indicate significance for statistical tests and analysis, this value was believed to be too rigorous for this small sample size. Thus, p = <.1 was selected as the cut off point. This value is commonly used in research involving small sample sizes. The elements that produced a statistically significant value were then retested using a Bonferroni post hoc test. The Bonferroni test compares the means of each of the groups to that of the other groups. It indicates the significance of the differences between group means.

Qualitative Analysis

Qualitative analysis involved the transcription of textual data and a grounded theory approach to inductively identify analytical categories as they emerged from the data. Initially, the data were read and reread to identify and index themes and categories centering on key phrases and incidents as described by the informants during the interview process. All the data relevant to each category were identified and examined using a constant comparison process whereby each item was checked and compared with the rest of the data to establish analytical categories. This process was an inclusive process in which as many categories were added to reflect as many of the nuances in the data as possible. Categories were further refined and reduced in number by grouping
them together until key themes emerged. These themes were then used to explain or illuminate the quantitative findings.

Results

Hypotheses la, 2a and 3a state that the three HSDA MACs and the Ex-officio group will report strong evidence of distributive, procedural and interaction justice respectively in their interactions with Medical Administration. These hypotheses were tested by examining the means for each group for each dependent variable. Means of 3.5 or greater are regarded as evidence that the group perceived its relationship with Medical Administration and Medical Administration’s behaviour as being just. A mean of 3.5 was selected as the threshold number because the survey asked respondents to rank their perceptions using a scale that ranged from Strongly Disagree which was assigned a numeric value of 1, Disagree which was assigned a value of 2, Neutral which was assigned a value of 3 (indicating the respondent had no feelings one way or another with respect to the question asked), Agree which was assigned a numeric value of 4 and Strongly Agree which was assigned a value of 5. Using this 5-point scale, a mean value of 3.5 has been interpreted as exceeding a “neutral” answer to survey questions to reflect a favourable perception. The means are shown in Tables, 2A, 3A and 4A.

Distributive Justice

Table 2A.
Group Means and One-way Analysis of Variance Statistics for Distributive Justice Variables

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean-NE</th>
<th>Mean-NI</th>
<th>Mean-NW</th>
<th>Mean-EO</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Recognizes me for the responsibilities I have as a MAC member</td>
<td>4.3</td>
<td>4.0</td>
<td>3.7</td>
<td>4.0</td>
<td>.54</td>
<td>.66</td>
</tr>
<tr>
<td>2. Recognizes me for the amount of expertise I bring to the MAC</td>
<td>4.2</td>
<td>3.9</td>
<td>3.0</td>
<td>4.0</td>
<td>3.7</td>
<td>.02</td>
</tr>
</tbody>
</table>
As can be seen in Table 2A, 16 out of 28 distributive justice variable means are at or above 3.5, indicating a satisfactory relationship between Medical Administration and the MAC groups on these variables. The North East reported favourably on all variables with the exception of the variable indicating that Medical Administration recognizes the stresses and stains of the MAC role (mean = 3.3). The Northern Interior reported a less than satisfactory relationship on four variables: recognizes me for the amount of effort put forth as a MAC member (mean 3.3); recognizes work done well as a MAC member (mean 3.4); recognizes the stresses and strains of the MAC role (mean = 2.9) and as a MAC member, I feel I have influence with Medical Administration (mean = 3.4). The North West reported a less than satisfactory relationship on five variables: recognizes me for the expertise I bring to MAC (mean= 3.0); recognizes me for the amount of effort I put forth as a MAC member (mean= 3.4); recognizes the stresses and strains of the MAC role (mean= 3.1); as a MAC member I have influence with Medical Administration (mean= 3.3) and the MAC has influence with Medical Administration (mean= 3.1). The Ex-officio group reported unfavourably with respect to two variables: recognizes the amount of effort I put forward as an MAC member (mean = 3.4) and recognizes work...
done well as a MAC member (mean = 3.4). Based on the above results, hypotheses 1a, is somewhat supported.

Hypotheses 1b, 2b and 3b state that there will be no differences in perceptions of distributive, procedural and interactional justice among the HSDA MACs. These hypotheses were tested using One-way Analysis of Variance with the Bonferroni Post Hoc test to identify differences between groups. The results are shown in Tables 2A and 2B, 3A and 3B and 4A and 4B.

As shown in Table 2A, the One-way ANOVA for the distributive justice variables revealed a significant difference between groups on two questions. The questions where differences occurred were: Medical Administration recognizes me for the amount of expertise I bring to the MAC (F= 3.7, p = .022) and The MAC has influence with Medical Administration (F= 4.2, p = .01). The Bonferroni Post Hoc test confirmed these results. The results are shown in Table 2B. As there was no significant difference between the groups on five of the seven variables, hypothesis 1b is supported.

Table 2B.
Bonferroni Post Hoc Test of Differences Between Groups (Distributive)

<table>
<thead>
<tr>
<th>Question</th>
<th>Groups A</th>
<th>Group B</th>
<th>Mean Difference</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Recognizes me for the amount of expertise I bring to the MAC</td>
<td>NE</td>
<td>NI</td>
<td>.32</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>NE</td>
<td>NW</td>
<td>1.2</td>
<td>.04</td>
</tr>
<tr>
<td></td>
<td>NE</td>
<td>EO</td>
<td>.17</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>NI</td>
<td>NW</td>
<td>.85</td>
<td>.09</td>
</tr>
<tr>
<td></td>
<td>NI</td>
<td>EO</td>
<td>-.15</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>NW</td>
<td>EO</td>
<td>-.1</td>
<td>.16</td>
</tr>
<tr>
<td>7. The MAC has influence with Medical Administration</td>
<td>NE</td>
<td>NI</td>
<td>.47</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>NE</td>
<td>NW</td>
<td>1.0</td>
<td>.07</td>
</tr>
<tr>
<td></td>
<td>NE</td>
<td>EO</td>
<td>-.23</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>NI</td>
<td>NW</td>
<td>.59</td>
<td>.46</td>
</tr>
<tr>
<td></td>
<td>NI</td>
<td>EO</td>
<td>-.71</td>
<td>.54</td>
</tr>
</tbody>
</table>
The Bonferroni test was used to compare the means of each of the groups to that of the other groups. The test indicates the significance of the differences between the group means. This test revealed no significant differences with respect to the variable, Medical Administration recognizes me for the amount of expertise I bring to the MAC between the North East group and the Northern Interior (mean difference = .32, p = 1.0) or the Ex-officio (mean difference = .17, p = 1.0) groups. Comparing the North East and the Northern Interior groups with the North West, the Bonferroni test revealed that these two groups feel their expertise is significantly more recognized by Medical Administration than does the North West MAC (mean differences = 1.17 and .85, p = .04 and .09 respectively). There was no significant difference with respect to this variable between either the Northern Interior or the North West groups and the Ex-officio group (mean differences = -.15 and -1.0, p = 1.0 and .16 respectively).

With respect to the variable, The MAC has influence with Medical Administration there was no statistical difference between the North East and the Northern Interior or the Ex-officio groups (mean difference = .47, -.23, p = 1.0, 1.0 respectively). There was a significant difference in perceptions between the North East and the North West MAC (mean difference = 1.0, p = .07) indicating that as a MAC, the North East feels considerably more influential with Medical Administration than does the North West. There was no significant differences between the Northern Interior MAC and the North West or Ex-officio groups (mean difference = .59, -.71 p = .46, .54 respectively). There was a significant difference in perceptions of influence between the North West and the Ex-officio group (mean difference = -1.3, p = .03), indicating that
while the Ex-officio group believes that MACs are very influential with Medical Administration, the North West group feels its influence with Medical Administration is less.

**Procedural Justice**

**Table 3A.**  
**Group Means and Oneway Analysis of Variance Statistics for Procedural Justice Variables**

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean-NE</th>
<th>Mean-NI</th>
<th>Mean-NW</th>
<th>Mean-EO</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Is honest and ethical in its dealings with us</td>
<td>4.3</td>
<td>3.9</td>
<td>4.0</td>
<td>4.2</td>
<td>.63</td>
<td>.60</td>
</tr>
<tr>
<td>9. Gives us an opportunity to express our views</td>
<td>4.2</td>
<td>3.9</td>
<td>4.2</td>
<td>4.0</td>
<td>.46</td>
<td>.71</td>
</tr>
<tr>
<td>10. Is completely candid and frank with us</td>
<td>4.2</td>
<td>3.3</td>
<td>3.5</td>
<td>3.8</td>
<td>1.8</td>
<td>.18</td>
</tr>
<tr>
<td>11. Shows a real interest in being fair</td>
<td>4.0</td>
<td>3.5</td>
<td>3.7</td>
<td>4.4</td>
<td>2.1</td>
<td>.12</td>
</tr>
<tr>
<td>12. Deals with us in a truthful manner</td>
<td>4.2</td>
<td>3.8</td>
<td>4.1</td>
<td>4.2</td>
<td>1.1</td>
<td>.38</td>
</tr>
<tr>
<td>13. Gets input from us before making a decision or recommendation</td>
<td>3.5</td>
<td>3.3</td>
<td>2.6</td>
<td>3.6</td>
<td>1.8</td>
<td>.17</td>
</tr>
<tr>
<td>14. Asks for ideas on improvement</td>
<td>3.3</td>
<td>3.2</td>
<td>3.7</td>
<td>3.6</td>
<td>.63</td>
<td>.60</td>
</tr>
<tr>
<td>15. Does not allow personal bias to influence its decisions or recommendations</td>
<td>3.0</td>
<td>3.4</td>
<td>3.2</td>
<td>3.8</td>
<td>.84</td>
<td>.48</td>
</tr>
<tr>
<td>16. Does not allow things that should not be considered to influence its decisions or recommendations</td>
<td>3.2</td>
<td>3.2</td>
<td>3.0</td>
<td>3.6</td>
<td>.50</td>
<td>.69</td>
</tr>
<tr>
<td>17. Is consistent in its application of procedures used to inform decisions and recommendations</td>
<td>3.7</td>
<td>3.5</td>
<td>2.7</td>
<td>4.4</td>
<td>5.3</td>
<td>.01</td>
</tr>
<tr>
<td>18. Provides an opportunity for us to appeal or challenge its decisions or recommendations</td>
<td>4.3</td>
<td>3.1</td>
<td>3.1</td>
<td>3.2</td>
<td>3.4</td>
<td>.03</td>
</tr>
<tr>
<td>19. Provides useful feedback to us regarding its decisions or recommendations</td>
<td>3.3</td>
<td>3.2</td>
<td>3.1</td>
<td>3.4</td>
<td>.09</td>
<td>.97</td>
</tr>
<tr>
<td>20. Allows requests for clarification or additional information about its decisions or recommendations</td>
<td>3.8</td>
<td>3.4</td>
<td>3.8</td>
<td>3.8</td>
<td>.65</td>
<td>.59</td>
</tr>
<tr>
<td>21. Treats all member of MACs with dignity and respect</td>
<td>4.2</td>
<td>4.3</td>
<td>4.0</td>
<td>4.2</td>
<td>.20</td>
<td>.89</td>
</tr>
</tbody>
</table>
As Table 3A reveals, 36 out of 56 procedural justice variable means are at or above 3.5, indicating favourable justice perceptions between Medical Administration and the groups on these variables. Thus, hypothesis 2a is supported.

The North East did not report favourably on the following variables: Medical Administration asks for ideas on improvement (mean = 3.3), does not allow personal bias to influence its decisions or recommendations (mean = 3.0), does not allow things that should not be considered to influence its decision or recommendations (mean = 3.2) and Medical Administration provides useful feedback to us regarding its decisions or recommendations (mean = 3.3). The Northern Interior reported a less than satisfactory relationship on seven variables: Medical Administration is completely candid and frank with us (mean = 3.3), gets input from us before making a decision or recommendation (mean = 3.3), asks for ideas on improvement (mean = 3.2), does not allow things that should not be considered to influence its decision or recommendations (mean = 3.2), provides an opportunity for us to appeal or challenge its decisions or recommendations (mean = 3.1), provides useful feedback to us regarding its decisions or recommendation (mean = 3.2) and Medical Administration allows requests for clarification or additional information about its decisions or recommendations. The North West reported unfavourably on five variables: Medical Administration gets input from us before making a decision or recommendation (mean = 2.6), does not allow personal bias to influence its decisions or recommendations (mean = 3.2), is consistent in its application of procedures used to inform decisions and recommendations (mean = 2.7), provides an opportunity for us to appeal or challenge its decisions or recommendations (mean = 3.1) and Medical Administration provides useful feedback to us regarding its decisions or
recommendations (mean = 3.1). The Ex-officio group reported unfavourably on two variables: Medical Administration provides an opportunity to appeal or challenge its decisions (mean = 3.2) and Medical Administration provides useful feedback regarding its decisions or recommendations (mean = 3.4).

As shown in Table 3A, the One-way ANOVA for the procedural justice variables revealed significant differences between groups on questions 17, Medical Administration provides an opportunity for us to appeal or challenge its decisions or recommendations (F=5.3, p=.01) and question 18, Provides an opportunity for us to appeal or challenge its decisions or recommendations (F= 3.4, p=.03). As there was no significant difference between the groups on 12 of the 14 questions, hypothesis 2b is strongly supported. The Bonferroni Post Hoc test confirmed these results. The results are shown in Table 3B.

Table 3B.
Bonferroni Post Hoc Test of Differences Between Groups (Procedural)

<table>
<thead>
<tr>
<th>Question</th>
<th>Groups A</th>
<th>Group B</th>
<th>Mean Difference</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. Is consistent in its application of procedures used to inform decisions and recommendations</td>
<td>NE</td>
<td>NI</td>
<td>.13</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>NE</td>
<td>NW</td>
<td>.97</td>
<td>.17</td>
</tr>
<tr>
<td></td>
<td>NE</td>
<td>EO</td>
<td>-.73</td>
<td>.88</td>
</tr>
<tr>
<td></td>
<td>NI</td>
<td>NW</td>
<td>.84</td>
<td>.12</td>
</tr>
<tr>
<td></td>
<td>NI</td>
<td>EO</td>
<td>-.86</td>
<td>.32</td>
</tr>
<tr>
<td></td>
<td>NW</td>
<td>EO</td>
<td>-1.7</td>
<td>.004</td>
</tr>
<tr>
<td>18. Provide an opportunity for us to appeal or challenge its decisions or recommendations</td>
<td>NE</td>
<td>NI</td>
<td>1.3</td>
<td>.03</td>
</tr>
<tr>
<td></td>
<td>NE</td>
<td>NW</td>
<td>1.2</td>
<td>.05</td>
</tr>
<tr>
<td></td>
<td>NE</td>
<td>EO</td>
<td>1.1</td>
<td>.22</td>
</tr>
<tr>
<td></td>
<td>NI</td>
<td>NW</td>
<td>-.02</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>NI</td>
<td>EO</td>
<td>-.12</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>NW</td>
<td>EO</td>
<td>1.1</td>
<td>1.0</td>
</tr>
</tbody>
</table>

The Bonferroni test revealed no significant differences between the North East and the Northern Interior, North West and Ex-officio groups (mean difference = .13, .97,
.73 \ p = 1.0, .17, 88 \text{ respectively}) with respect to the variable Medical Administration is consistent in its application of procedures used to inform decisions and recommendations. There was also no significant difference between the Northern Interior and the North West and Ex-officio groups (mean difference = .84, -.86, \ p = .12, .32). There was a significant difference between the North West and Ex-officio group (mean difference = -1.7, \ p = .004).

With respect to the variable, Provides an opportunity for us to appeal or challenge its decisions or recommendations, there was a significant difference between the North East and the Northern Interior and North West groups (mean difference = 1.3, 1.2, \ p = .03, .05 \text{ respectively}), indicating that the North East believes more strongly that Medical Administration provides opportunity for MAC members to appeal or challenge its decisions or recommendations than do Northern Interior and North West MAC members. There was no significant difference in perceptions between the North East and the Ex-officio group members (mean difference = 1.1, \ p = .22). Upon comparing the Northern Interior to the North West and Ex-officio groups there was no significant difference in perceptions (mean difference = -.02, -.12, \ p = 1.0, 1.0 \text{ respectively}). In addition, there was no significant difference between the North West and the Ex-officio groups (mean difference = 1.1, \ p = 1.0).

**Interactional Justice**

**Table 4A**

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean-NE</th>
<th>Mean-NI</th>
<th>Mean-NW</th>
<th>Mean-EO</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>22. Seeks input from the MAC</td>
<td>4.0</td>
<td>4.1</td>
<td>3.7</td>
<td>4.0</td>
<td>.51</td>
<td>.68</td>
</tr>
<tr>
<td>23. Provides me with timely feedback about the decisions and its</td>
<td>3.7</td>
<td>3.4</td>
<td>3.2</td>
<td>3.2</td>
<td>.36</td>
<td>.79</td>
</tr>
</tbody>
</table>
implications

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean</th>
<th>Std Dev</th>
</tr>
</thead>
<tbody>
<tr>
<td>24. Explains the processes of decision making clearly</td>
<td>3.8</td>
<td>.88</td>
</tr>
<tr>
<td>24. Communicates the logic behind the final decision</td>
<td>4.2</td>
<td>2.3</td>
</tr>
<tr>
<td>26. (When necessary) explains why a recommendation made by MAC was not accepted by Medical Administration</td>
<td>4.2</td>
<td>3.4</td>
</tr>
<tr>
<td>27. Medical Administration’s explanations regarding procedures are reasonable</td>
<td>3.7</td>
<td>.82</td>
</tr>
<tr>
<td>28. Medical Administration effectively tailors communication to meet individual’s specific needs</td>
<td>3.3</td>
<td>.95</td>
</tr>
</tbody>
</table>

Evident in Table 4A, 15 of the 28 interactional variable means are at or above 3.5 with only one variable below 3.5 for the North East and Ex-officio groups. In contrast, the Northern Interior and the North West groups have five and six variables respectively that are below 3.5. Because of this, hypothesis 3a is somewhat supported.

The North East reported favourably on all variables except Medical Administration effectively tailors communication to meet individual’s specific needs (mean = 3.3). The Northern Interior MAC reported unfavourably on almost all interactional variables with the exception of variable 22, Seeks input from the MAC (mean = 4.1) and variable 27, Medical Administration’s explanations are reasonable (mean= 3.5). Similarly, the North West MAC reported unfavourably on all interactional variables except variable 22, Seeks input from the MAC (mean = 3.7). In contrast, the Ex-officio group reported favourably on all variables except variable 23, Provides me with timely feedback about the decisions and its implications (mean = 3.2).

As shown in Table 4A, the One-way ANOVA for the interactional justice variables revealed significant differences between groups on question 25, Communicates
the logic behind the final decision ($F=2.3$, $p=.10$) and question 26 (When necessary) explains why a recommendation made by MAC was not accepted by Medical Administration ($F=4.3$, $p=.01$). However, as shown below, the Bonferroni test does not indicate a significant difference between groups for variable 25. Therefore, hypothesis 3b is strongly supported. The results of the Bonferroni test are shown in Table 4B.

**Table 4B.**
*Bonferroni Post Hoc Test of Differences Between Groups (Interactional)*

<table>
<thead>
<tr>
<th>Question</th>
<th>Groups A</th>
<th>Group B</th>
<th>Mean Difference</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>25. Communicates the logic behind the final decision.</td>
<td>NE</td>
<td>NI</td>
<td>1.0</td>
<td>.46</td>
</tr>
<tr>
<td></td>
<td>NE</td>
<td>NW</td>
<td>1.3</td>
<td>.22</td>
</tr>
<tr>
<td></td>
<td>NE</td>
<td>EO</td>
<td>.17</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>NI</td>
<td>NW</td>
<td>.25</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>NI</td>
<td>EO</td>
<td>-.85</td>
<td>.96</td>
</tr>
<tr>
<td></td>
<td>NW</td>
<td>EO</td>
<td>-1.1</td>
<td>.49</td>
</tr>
<tr>
<td>26. (When necessary) explains why a recommendation made by MAC was not accepted by Medical Administration</td>
<td>NE</td>
<td>NI</td>
<td>.78</td>
<td>.31</td>
</tr>
<tr>
<td></td>
<td>NE</td>
<td>NW</td>
<td>1.4</td>
<td>.01</td>
</tr>
<tr>
<td></td>
<td>NE</td>
<td>EO</td>
<td>.37</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>NI</td>
<td>NW</td>
<td>.59</td>
<td>.51</td>
</tr>
<tr>
<td></td>
<td>NI</td>
<td>EO</td>
<td>-.42</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>NW</td>
<td>EO</td>
<td>-1.0</td>
<td>.16</td>
</tr>
</tbody>
</table>

The Bonferroni test revealed no significant differences between the groups with respect to the variable, Communicates the logic behind the final decision. The Bonferroni test also revealed no significant differences with respect to the variable (When necessary) explains why a recommendation made by MAC was not accepted by Medical Administration between the North East group and the Northern Interior or Ex-officio groups (mean difference = .78, .37, $p = .31, .10$) respectively. There was a significant difference between the North East and the North West group’s response to this variable.
(mean difference = 1.4, p = .01), indicating that the North East group felt more strongly than the North West group that when necessary, Medical Administration explains why a recommendation made by MAC was not accepted. The test did not reveal a significant difference between the Northern Interior and the North West or Ex-officio groups (mean difference = .59, -.42, p = .51, 1.0). Finally, there was no significant difference between the North West and the Ex-officio groups with respect to this variable (mean difference = -1.0, p = .16).

Hypotheses 1c, 2c and 3c state that there will be no differences between NH MAC and Non NH MAC member's perceptions of justice in the distributive, procedural and interaction domains in the relationship between MACs and Medical Administration. These hypotheses were tested by examining the means for each group for each dependent variable. For the sake of brevity, Table 5 only lists variables that indicated significant differences in perceptions between the two groups.

Total Justice Perceptions- NH MAC Vs Non NH MAC

Table 5.
Oneway Analysis of Variance of Significant Differences Between the Means for NHMAC Members and Non-NHMAC Members

<table>
<thead>
<tr>
<th>Question</th>
<th>NH Mean</th>
<th>Non NH Mean</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Recognizes me for the responsibilities I have as a MAC member</td>
<td>4.2</td>
<td>3.8</td>
<td>2.8</td>
<td>.10</td>
</tr>
<tr>
<td>8. Is honest and ethical in its dealings with us</td>
<td>4.5</td>
<td>3.9</td>
<td>7.9</td>
<td>.01</td>
</tr>
<tr>
<td>9. Gives us an opportunity to express our views</td>
<td>4.4</td>
<td>3.9</td>
<td>5.2</td>
<td>.03</td>
</tr>
<tr>
<td>12. Deals with us in a truthful manner</td>
<td>4.5</td>
<td>3.8</td>
<td>14.</td>
<td>.001</td>
</tr>
<tr>
<td>21. Treats all members with dignity and respect</td>
<td>4.5</td>
<td>4.0</td>
<td>3.9</td>
<td>.06</td>
</tr>
</tbody>
</table>

Although the mean values for all of the variables in Table 5 are greater than 3.5, there are significantly different perceptions between the NH MAC and Non NH MAC groups in 1 of 7 distributive and 4 of 13 procedural justice domains (p = .10, .01, .03, .001).
and .06 respectively). Thus, hypotheses 1c is strongly supported, 2c is supported while hypothesis 3c is very strongly supported.

In addition to the above, it is noted that for questions three and five under the distributive justice domain, the means were somewhat low across all groups. Similarly, questions 13, 14, 15, 16 and 19 under the procedural justice domain produced low means across all groups. Finally, for questions 23 and 28 under the interactional justice domain, the means were also noted as being relatively low. In an effort to better understand the low means reported above and to provide Medical Administration with specific information regarding what elements are working well in the relationship and what areas are not working well, a decision was made to rank all of the organizational justice variables according to the mean. The results are presented in Table 6 below and the findings will be discussed in the subsequent section.

**Total Justice Perceptions All Groups**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Variable</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>21(P) Treats all members of MAC with dignity and respect</td>
<td>4.15</td>
<td>.702</td>
</tr>
<tr>
<td>2</td>
<td>8 (P) Is honest and ethical with us</td>
<td>4.06</td>
<td>.649</td>
</tr>
<tr>
<td>3</td>
<td>9 (P) Gives us an opportunity to express views our views</td>
<td>4.06</td>
<td>.600</td>
</tr>
<tr>
<td>4</td>
<td>12 (P) Deals with us in a truthful manner</td>
<td>4.00</td>
<td>.603</td>
</tr>
<tr>
<td>5</td>
<td>22 (I) Seeks input from the MAC</td>
<td>3.94</td>
<td>.736</td>
</tr>
<tr>
<td>6</td>
<td>1(D) Recognizes me for the responsibilities I have as a MAC member</td>
<td>3.88</td>
<td>.729</td>
</tr>
<tr>
<td>7</td>
<td>11(P) Shows a real interest in being fair</td>
<td>3.79</td>
<td>.729</td>
</tr>
<tr>
<td>8</td>
<td>7(D) The MAC has influence with Medical Administration</td>
<td>3.71</td>
<td>.871</td>
</tr>
<tr>
<td>9</td>
<td>2 (D) Recognizes me for the amount of expertise I bring to the MAC</td>
<td>3.68</td>
<td>.878</td>
</tr>
<tr>
<td>10</td>
<td>20 (P) Allows requests for clarification or additional information about its decisions or recommendations</td>
<td>3.65</td>
<td>.849</td>
</tr>
<tr>
<td>11</td>
<td>10 (P) Is completely candid and frank with us</td>
<td>3.59</td>
<td>.821</td>
</tr>
<tr>
<td>12</td>
<td>27 (I) Medical Administration’s explanations regarding procedures are reasonable</td>
<td>3.53</td>
<td>.961</td>
</tr>
<tr>
<td>13</td>
<td>4 (D) Recognizes me for the work I have done well</td>
<td>3.47</td>
<td>.706</td>
</tr>
</tbody>
</table>
Table

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>As a MAC member I have influence with Medical Administration</td>
<td>3.47</td>
</tr>
<tr>
<td>15</td>
<td>Is consistent in its application of procedures used to inform decisions and recommendations</td>
<td>3.44</td>
</tr>
<tr>
<td>16</td>
<td>Asks for ideas on improvement</td>
<td>3.41</td>
</tr>
<tr>
<td>17</td>
<td>Explains the process of decision making clearly</td>
<td>3.41</td>
</tr>
<tr>
<td>18</td>
<td>(When necessary) explains why a recommendation was not accepted by Medical Administration</td>
<td>3.41</td>
</tr>
<tr>
<td>19</td>
<td>Recognizes the amount of effort I put forth as a MAC member</td>
<td>3.38</td>
</tr>
<tr>
<td>20</td>
<td>Communicates the logic behind the final decision</td>
<td>3.38</td>
</tr>
<tr>
<td>21</td>
<td>Provides me with timely feedback about the decisions and its implications</td>
<td>3.35</td>
</tr>
<tr>
<td>22</td>
<td>Does not allow personal bias to influence its decisions or recommendations</td>
<td>3.32</td>
</tr>
<tr>
<td>23</td>
<td>Provides me with an opportunity for us to appeal or challenge its decisions or recommendations</td>
<td>3.32</td>
</tr>
<tr>
<td>24</td>
<td>Provides useful feedback to us regarding its decisions or recommendations</td>
<td>3.24</td>
</tr>
<tr>
<td>25</td>
<td>Medical Administration effectively tailors communication to meet individuals specific needs</td>
<td>3.24</td>
</tr>
<tr>
<td>26</td>
<td>Does not allow things that should not be considered to influence its decisions and recommendations</td>
<td>3.21</td>
</tr>
<tr>
<td>27</td>
<td>Gets input from us before making a decision or recommendation</td>
<td>3.18</td>
</tr>
<tr>
<td>28</td>
<td>Recognizes the stresses and strains of the MAC role</td>
<td>3.12</td>
</tr>
</tbody>
</table>

Discussion

Distributive Justice

The purpose of this study is to ascertain physician MAC member’s perceptions of justice in their working relationship with Medical Administration. Overall, the 3 HSDA MACs, the NH MAC and the Ex-officio MAC member group, reported favourable perceptions of justice in all three organizational justice domains. This suggests that Medical Administration has achieved a good degree of fairness in its relationship with physician MAC members across the region. The data also reveals areas where justice perceptions varied among the groups and in some cases the justice perceptions were not optimal. These areas will be examined further and discussed below with reference to the
qualitative data gathered to better understand possible reasons for the differences detected.

Medical Administration recognizes me for the amount of expertise I bring to MAC

With respect to the distributive justice dependent variable, Medical Administration recognizes me for the amount of expertise I bring to MAC the North East and the Northern Interior agreed with the Ex-officio group’s belief that MAC members are recognized by Medical Administration for the amount of expertise they bring to the MAC. Evidence of recognition was described by physicians in terms of their belief that their opinions were sought out by Medical Administration and that advice and recommendations were given serious consideration and were not dismissed.

The North East felt the strongest that their expertise was recognized when compared to all groups, including the Ex-officio group, although this difference was not statistically significant. The greatest difference in perceptions appears between the North East and the North West group. It is concerning that the North West reported they felt the least recognized amongst all the MAC groups. The qualitative data and the literature provided the following insights to explain the different perceptions.

First, the North West group appear to equate recognition with action. A theory evident in the qualitative data suggests that NW MAC members feel recognized when Medical Administration acts upon their advice and recommendations. A number of North West respondents indicated that they frequently raise important issues at MAC and also actively participate in MAC sub-committees and working groups as a means of offering their expert opinion to Medical Administration on important medical matters. They also indicated that in many cases their work on committees, or the recommendations put forth
by the committees they worked on, were not acted upon or were otherwise inadequately addressed by Medical Administration. This appeared to result in an assessment that Medical Administration is unjust in distributive justice matters pertaining to recognition of expertise.

The sense of injustice expressed above is consistent with parts of the distributive justice literature. In particular, Homans’ (1961) social exchange theory maintains that people will feel unfairly treated when they participate in an exchange relationship where their investment of time and effort is met with an outcome that is inconsistent with their expectations. These expectations are either implied or are based on historical experience whereby because prior exchanges occurred in a certain manner, a precedent is set and the normative expectation is such that the group believes that current outcomes will (or should) unfold in the same way. Simply stated, participating in a committee with the expectation that the physician’s recommendations and advice invested as part of the committee process will be accepted and acted upon, leads to an assessment that the interaction was unfair when such action does not occur. This is because the expected outcome was not realized. This is concerning because according to Tyler and Lind (1992), an assessment of fair treatment promotes the perceived and experienced legitimacy of leadership and problems occur when trust in organizational leadership is compromised. Furthermore, the experience of unfair treatment fails to fulfill the need for control and belonging, both of which are necessary antecedents for the promotion of organizational commitment (Thibaut & Walker, 1975, Lind & Tyler, 1988).

The quantitative and qualitative data indicate that the North East MAC feels differently. This MAC feels a strong sense of recognition for their expertise. In fact,
many respondents offered suggestions on ways Northern Health could maximize the benefit of their expertise. For example, some respondents made it known that MAC members could provide more informed expert opinions and recommendations to the Health Authority if Medical Administration could provide them with additional information and education.

The North East group also made a distinction between being recognized for the expertise they bring and the action or inaction Medical Administration undertakes as a result of their expert opinions. Specifically, this group did not expect that their advice or input would necessarily always translate into the implementation of their suggestions. Rather, they expected that their advice would be considered and would sometimes be acted upon.

It is interesting to note that both the North West and North East MAC members have engaged with Medical Administration in similar processes and forums and have achieved similar outcomes where the advice of either group is not always acted upon. Yet, the interactions appear to yield different justice perceptions. This phenomenon is partly explained in the distributive justice literature that acknowledges how different frames of reference will produce different fairness judgements (Adams, 1965). In particular, Adams notes the tendency for people to calculate the fairness of their input/outcome ratio to the corresponding ratios of a comparison group or to themselves at an earlier point in time. One of the theories evident in the qualitative data is that the North East MAC members believe the current outcomes they achieve as a result of their contributions to Medical Administration are superior to the outcomes they achieved in years past or could achieve in isolation. By contrast, the North West group appears to
grieve an old way of doing things where historically their contributions to Medical Administration yielded more favourable outcomes than what they are experiencing with the current administrative group. Similar to Adams’ (1965) equity theory and consistent with Homans’ (1960) social exchange theory, both groups appear to evaluate the degree of justice in their relationship with Medical Administration by using an evaluation framework where the justice comparison is made using themselves as “the referent other” at an earlier point in time. A deeper inquiry into the influence of historical experience on current justice perceptions exceeds the scope of this research project but may constitute an issue worthy of future study.

Another interesting theme emerged from the qualitative data upon comparing the North West MAC member’s responses to those of the other groups. There appears to be varied understandings of the role and function of the MAC. Some MAC members understand the MAC to be an advisory arm of a larger medical staff governance structure. Indeed, this is the intended purpose of MAC as outlined in the Northern Health Medical Staff Bylaws and Interim Medical Staff Rules. However, there are others who see the MAC as an entity with physician advocacy potential and this is problematic. According to Read (1996), a fundamental conflict occurs when MACs become involved in advocacy matters. Although it will always be important for physicians to function in their traditional role as advocates for their patients and for the profession of medicine (Rowan, 1996), with advocacy comes the responsibility to safeguard the interests of medical staff which may detract from the primary role of MAC which is quality assurance.

The North West MAC is not the only group that indicated frustration with an inability to advocate for physicians within the MAC structure. This was a pervasive
theme in the Northern Interior MAC member responses as well. The source of friction may be a function of role confusion or inadequate or unavailable channels for medical staff advocacy. In particular, the data suggests physicians view MAC as an advocacy as well as advisory body and in the absence of a clearly established advocacy body within the medical governance structure, the MAC/ Medical Administration interface is the only mechanism currently available to physicians to advocate for their interests and needs. Since there appears to be a need for physician advocacy, in the absence of a proper channel to do so, physicians attempt to use the MAC to fulfill this function. This is problematic because as stated previously, physician advocacy is not a function for which MAC was designed nor intended to fulfill. Hence, when Medical Administration (as the primary support system for MAC) does not deliver on advocacy matters, frustration results and this has the potential to erode the relationship between MAC members and Medical Administration.

Although all MACs expressed views that suggest there is an issue around the function of MAC, this seems to have caused different groups to have different expectations of Medical Administration. The North West expressed the greatest degree of frustration in this regard and answers to why this might be the case were explored through a deeper analysis of the qualitative data. In response to one of the qualitative interview questions, “What do you see as the most important factor(s) for Medical Administration to focus on to achieve greater “fairness” in its relationship with MAC”? the North West physicians recalled a time prior to regionalization where they had direct access to a local Board and an ability to voice concerns and advocate for physician interests via yearly participation in a “face to face” MAC-Board meeting. The face to
face opportunity to engage with a local Board was reported to be a fair arrangement in comparison to the current, more diffuse organizational structure. According to some NW MAC members, the former administrative structure produced more immediate results and thus administration appeared more receptive and responsive to physician feedback. The North West appears to be grieving the loss of the connection they once had with the Board. It is also possible that the degree of meaning attached to this loss is exacerbated for the North West because it is coupled with a strong sense that the current Medical Administration structure, as a communication conduit to the Board, is sub-optimal. Unfortunately, this research project was not designed to sufficiently explore this phenomenon and lead to any valid conclusions.

The Northern Interior’s expression of a need for increased advocacy opportunity can be attributed to beliefs that the system is “bogged down”. Northern Interior MAC members indicated that Medical Administration is “overtaxed” and that rural areas are neglected, because the vast geography that characterizes Northern Health creates a situation where the current communication and administrative structures are inadequate to meet physician needs across the region.

The North East expressed general satisfaction with respect to their ability to connect and be “heard” by Medical Administration and North East respondents did not report a desire for enhanced advocacy opportunities or for greater connection to the Board. However, some respondents from the North East mentioned that after five years, it might prove to be beneficial to evaluate the Medical Advisory Committee structure.
The MAC has influence with Medical Administration

Different perceptions of distributive justice were revealed in a second dependent variable, *The MAC has influence with Medical Administration*. The North East, Northern Interior and Ex-officio MAC members all report that they feel that MAC has influence with Medical Administration. Again, the biggest difference was found between the North East MAC and the North West MAC members.

The majority of North East MAC Members’ responses suggest this group feels very influential with Medical Administration. However, the group reported a concern regarding balancing physician influence with administrative influence. Several North East MAC members commented that some people talk a lot at MAC meetings, making it difficult for others to express their views or present new ideas in committee meetings. Furthermore, it was noted that sometimes discussions go on too long and as a result many issues are not able to be discussed. There was also a fair bit of commentary from all four MACs that Medical Administration needs to be more conscious of its own influence at MAC meetings, whether at the HSDA level or at Northern Health MAC. Concerns were expressed that the Chairperson sometimes influences rather than guides the meetings and that because of their training Medical Administration is better able to get their points across in meetings than are physicians. Finally, there was the sense that Medical Administration may frame issues in ways that ensure they achieve the outcomes they desire and there was a question regarding the appropriateness of using administrative influence in this way.

The qualitative data revealed another important sub-theme regarding physician’s sense of influence. MAC members representing rural communities expressed concern
that rural issues are given little attention at MAC. This sentiment was most evident in the Northern Interior MAC group where physicians from rural communities noted that they feel they have little influence with Prince George Medical Administration or their MAC peers because NIMAC is consumed with PGRH issues. Both rural and non-rural physicians noted an imbalance between the attention devoted to Prince George issues compared to attention given to rural community interests. A large number of Northern Interior respondents acknowledged that more could be done to ensure that rural issues receive greater consideration. One suggestion was for NI MAC to consider dedicating the early part of the NIMAC agenda to rural issues. This would provide rural physicians the opportunity to be heard and would also provide them with the option of staying on for the balance of the MAC meeting or electing to leave the meeting early, in recognition of the fact that most of the physicians who reside outside of the Prince George area tend to return home on the same evening of the NIMAC meeting in Prince George and therefore face long commutes back to their communities.

**Procedural Justice**

*Medical Administration is consistent in its application of procedures used to inform decisions and recommendations.*

The three HSDA MACS all reported similarly with respect to the procedural justice variable, *Medical Administration is consistent in its application of procedures used to inform decisions and recommendations.* The only significant perceptual differences existed between the North West MAC and the Ex-officio MAC members. The North West MAC members believe Medical Administration is less consistent in its application of procedures to inform decision making than the Ex-officio group believes
Medical Administration to be. The qualitative data confirmed this finding and shed light on where the discrepancy rests.

Some MAC members agreed or strongly agreed that Medical Administration is consistent in decision making processes. Decision making around serious disciplinary issues was cited as an example. By contrast, some MAC members do not feel that Medical Administration is consistent in its decision making processes. There was concern that there is too much crisis management on the one hand and procrastination in decision making on the other. There were also comments that some problems lay less with Medical Administration and instead reside within the MAC groups themselves and that Medical Administration brings greater clarity to MAC discussions.

Based on the above, the question becomes, “Are procedures used to inform decision making processes inconsistent or are they just not well understood”? A great deal of data suggests the latter is the case and that the feedback loop is incomplete. Indeed, MAC members from each of the HSDA MACs and the NH MAC noted a distinct lack of timely feedback. Some believe that decision making processes were inconsistent to non-existent but most indicated that the processes existed and were “probably consistent” however, the processes were described as either not visible, or decisions appeared to be based on a different process than what was believed to have been agreed upon.

Although there were differing perceptions with respect to the degree of consistency employed in decision making processes, there was agreement amongst all groups that better communication around decision making processes would enhance the MAC- Medical Administration relationship and an emphasis on reporting back to the
MACs after decisions have been made should be a point of emphasis for Medical Administration.

*Medical Administration provides us with an opportunity to appeal or challenge its decision*

With respect to the variable, *Medical Administration provides us with an opportunity to appeal or challenge its decision*, the North East perceive they have greater opportunity for appeal than the Northern Interior and the North West.

A review of the Northern Interior’s responses reveals that most NIMAC members felt neutral about this variable or felt that there was good opportunity to challenge or appeal decisions. However, others suggest that although Medical Administration is willing to hear challenges or appeals, the administrative team was not amendable to act on this information and make changes. The departmentalization initiative was provided as an example where Medical Administration has been made aware of certain concerns yet has continued to move this agenda forward without apparent regard for the apprehension expressed by medical staff.

Although the overall assessment of procedural justice was deemed fair by all the MACs, the qualitative responses suggest that for the reasons described above, outcomes were not always well accepted or deemed just. There are two possible explanations for this in the literature. First, Leventhal’s six rules for procedural justice (1980) list “consistency” (procedures should be consistent across time and persons) and “correctability” (the opportunity to modify or reverse decisions through the provision of opportunity for appeals and grievances) as integral to the fair procedures necessary to support a conclusion that distributive procedures are fair and appropriate. There is evidence to indicate these two elements of procedural justice are absent in the MAC-
Medical Administration relationship and this might explain the expressed discontent with certain outcomes and actions enacted by Medical Administration.

The second reason may be attributed to a distinct difference between what the organizational justice literature asserts constitutes fair procedure in the employee-employer relationship and what appears to be considered fair by physician MAC members who do not engage with Medical Administration in this way. In the traditional organizational justice context, the literature suggests that procedure (process control) and not just the outcomes (decision control) typically drive key attitudes regarding the assessment of fairness. In the employer-employee relationship, if people are provided meaningful opportunity to participate in decision making processes, the outcomes of those processes, even if they are not the desired outcomes, tend to be well accepted and deemed “fair” (Thibaut and Walker, 1975; Leventhal 1980). This does not appear to be true in the physician world. Physician MAC members seem to express at least a degree of dissatisfaction with outcomes that contravene their wishes, even if they have been instrumental to the process used to arrive at such outcomes. This may be attributed to the fact that, unlike most employees, physicians are used to functioning in a highly autonomous fashion and therefore possess a great degree of decision control in their day to day work.

**Interactional Justice**

*Medical Administration communicates the logic behind the final decision*

The first point to be made with respect to the interactional justice results is to point out an anomaly in the data. It appears that overall the ANOVA test produced a result indicating a difference in perception amongst the groups with respect to the
dependent variable, *Medical Administration communicates the logic behind the final decision.* Despite this, the Bonferroni test cannot detect where this difference exists amongst the groups. This finding is likely attributable to the small sample size, but nonetheless, led to a result indicating there are no statistical differences amongst the groups in terms of their response to this variable.

When necessary, explains why a recommendation by MAC was not accepted by Medical Administration.

There were considerable differences in perceptions amongst the MAC groups with respect to the dependent variable, *When necessary, explains why a recommendation by MAC was not accepted by Medical Administration.* The North East felt very strongly that there was a high degree of explanation when MAC recommendations are not accepted by Medical Administration, whereas the North West MAC did not believe this to be the case. There is a point of concern in the qualitative data that calls this result into question. Many NE MAC respondents could not think of an instance where a MAC recommendation was not accepted by Medical Administration and therefore could not comment. Others commented theoretically, indicating that if there was a situation where recommendations were not accepted, an explanation would be forthcoming. However, the group noted they would have to ask for the explanation- it would not be provided as a matter of course. This response suggests that the NEMAC tends to give Medical Administration “the benefit of the doubt”. By contrast, NW MAC members were of two minds: some respondents assigned a neutral value to this question, indicating they were not sure. Other respondents indicated that they disagreed but did not provide further explanation.
As noted in the results section, two distributive justice questions produced low means across the groups. Questions three and five deals with the physician’s sense that the amount of effort they invest in MAC is recognized by Medical Administration and Medical Administration recognizes the stresses and strains associated with the MAC role. The low means suggest the groups do not feel Medical Administration appreciates the investment or the pressures associated with MAC membership. It will be important for Medical Administration to consider this feedback and formulate strategies to improve distributive justice perceptions in these areas.

Several procedural questions also produced quite low mean responses and may be areas of concern for Medical Administration. Question 13 asks if MAC members believe that Medical Administration seeks input before making decisions, and question 14 asks MAC members to comment on whether Medical Administration asks for ideas on improvement. With respect to question 13, the qualitative data indicates MAC members in the North East believe Medical Administration seeks their input in decision making processes. However, the Northern Interior and the North West do not believe this is the case. The Northern Interior MAC members expressed concern because although they are frequently asked for input, they cannot identify how their input was used to inform key decisions. For example, one Northern Interior MAC member indicated that he had no idea who actually makes the final decisions within Northern Health. He noted that it would be helpful if Medical Administration revealed this information up front and if Medical Administration could also account for why MAC input is needed, how MAC advice will be used (or not used) and commit to reporting back to the MAC on important decisions within a reasonable timeframe.
The North West also expressed concern regarding inadequate opportunity to provide input into decision making. However, the North West MAC concerns were more pronounced than the Northern Interior as evidenced by responses indicating a degree of anger associated with this experience. Anger was not evident in the Northern Interior’s responses.

Question 14 asks if Medical Administration requests ideas on improvement. Interestingly, the North West strongly agreed this was the case. The research data does not offer any explanations why the North West feels strongly that Medical Administration seeks input on improvement matters, yet does not believe that Medical Administration seeks input to inform decision making or recommendations.

The Northern Interior’s mean response for question 14 was the lowest of the three MACS. Upon review of the Northern Interior’s data, NI MAC members indicated they provide input regarding improvement initiatives but believe that Medical Administration has their own agenda and are generally dismissive of their ideas. Others indicated that improvement activities were entirely secondary to the crisis management activities that appear to plague the Prince George Regional Hospital. The Northern Interior’s low group mean result may also be explained by the fact that a fair number of respondents expressed great interest in the Primary Care initiative but also expressed confusion over who is leading this initiative. There is an impression that it is not “a physician led initiative” and this leaves many doctors unsure of their role and how to contribute their expertise.

A review of the North East qualitative data suggests many respondents expressed a neutral opinion of this variable. There was no other qualitative data to further explain this group’s low mean result.
Questions 15 and 16 produced low means across all the groups. These questions ask about the ability of Medical Administration to filter out personal bias or other information irrelevant to the decisions or recommendations at hand. The low means for all groups appear to be attributed to two factors. First, the majority of respondents indicated they could not comment definitively on whether Medical Administration exhibits bias or is unduly influenced by information that has no bearing on the decisions in question. The second reason appears to be related to the poor wording of these particular questions. In some instances, these questions caused confusion and misinterpretation, or caused the respondent to answer the question hastily and perhaps not as carefully as the other questions.

Question 19 under the procedural justice domain also produced low mean results in response to the statement ‘Medical Administration provides useful feedback to us regarding its decisions or recommendations’. The qualitative data suggests that the low means are likely attributed to an incomplete feedback loop where decisions are made at an administrative level. However, the mechanism by which such decisions are made, the timing, and the potential impact of such decisions, are frequently not reported back to MAC.

Finally, under the interaction justice domain, low mean values were reported by the groups for question number 23 and 28. Question 23 deals with the concept of the MAC receiving timely feedback about decisions and its implications, while question 28 speaks to the issue of Medical Administration’s ability to effectively tailor communication to meet individual MAC member’s needs. Once again, the low means regarding timely feedback appears to be a function of an incomplete feedback loop to the
MACs once decisions are reached. Concerns regarding Medical Administration’s ability to tailor communication to meet individual’s needs also appear to be related to MAC member’s discontent with the format of the MAC agenda package. Many physicians described the NH MAC agenda package as “confusing” and noted a tendency for the MAC package to be delivered late to MAC members, leaving them with inadequate time for reading and meeting preparations. No other explanations were evident in the qualitative data.

To add to the understandings generated above and to provide Medical Administration with information regarding the elements of organizational justice that are handled well in the relationship and to determine which elements are handled poorly, a final analysis ranking all justice variables according to their means was conducted (See Table 6). The top four variables taken from Table 6 indicate areas of strength in the relationship and are as follows:

<table>
<thead>
<tr>
<th>Rank</th>
<th>Variable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>21 (P) Treats all members of MAC with dignity and respect</td>
</tr>
<tr>
<td>2</td>
<td>8 (P) Is honest and ethical with us</td>
</tr>
<tr>
<td>3</td>
<td>9 (P) Gives us an opportunity to express our views</td>
</tr>
<tr>
<td>4</td>
<td>12 (P) Deals with us in a truthful manner</td>
</tr>
</tbody>
</table>

These variables suggest MAC members feel Medical Administration enacts procedures in a respectful, honest and ethical manner and provides opportunity for MAC members to express their views. These results speak to the importance people place on “how” procedures are enacted in order to arrive at conclusions that procedures are just. This is consistent with the work of Moorman (1991), who espoused the concept of interactional justice as an integral part of procedural justice.
The bottom four variables taken from Table 6 reveal areas of weakness in the relationship:

**Table 6 B. Organizational Justice Variables Ranked According to Mean (Bottom Four)**

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>19 (P) Provides useful feedback to us regarding its decisions or recommendations</td>
</tr>
<tr>
<td>25</td>
<td>28 (I) Medical Administration effectively tailors communication to meet individuals specific needs</td>
</tr>
<tr>
<td>26</td>
<td>16(P) Does not allow things that should not be considered to influence its decisions and recommendations</td>
</tr>
<tr>
<td>27</td>
<td>13 (P) Gets input from us before making a decision or recommendation</td>
</tr>
<tr>
<td>28</td>
<td>5(D) Recognizes the stresses and strains of the MAC role</td>
</tr>
</tbody>
</table>

Although the variables are sourced in different justice domains, a theme is evident. The low means for these variables suggest Medical Administration needs to communicate decision making processes and outcomes more clearly to MAC members and should place emphasis on seeking input consistently, reporting back to MAC members how input was used to arrive at decisions, and when necessary, explain why MAC advice or recommendations were not accepted or acted upon. Lastly, it is clear that MAC members do not believe that Medical Administration appreciates the stresses and strains associated with the MAC role. This is a concern for Medical Administration because recognition in the relationship exchange with physicians must be perceived as being proportionate to the degree of investment they have made to the MAC in order for the relationship to be perceived as fair in the distributive sense (Leventhal, 1976).

**Limitations**

In some instances, the small sample size made it difficult for the Bonferroni test to detect where the different perceptions amongst the MAC groups existed although the ANOVA One-way and Post Hoc tests indicated that such differences exist.
While efforts were made to limit bias, a degree of bias likely exists because the writer is a member of Northern Health’s administrative team. Examples of measures taken to minimize the influence of bias include the following. Narrative responses to interview questions were read back to the respondent to ensure the accuracy of the recorded information. During the interview process, efforts were made to avoid prompting the respondent and even when responses were unclear, requests for clarification were minimal to avoid “leading” or otherwise influencing the response. As a result, there were times where the meaning of the qualitative responses was ambiguous, or the respondent misunderstood the question. In both cases, the qualitative data had to be discarded.

Finally, as noted in the previous discussion, two questions were poorly worded and were possibly misunderstood by respondents.

**Recommendations**

The following recommendations are informed by the research findings and their employ may improve justice perceptions between MAC members and Medical Administration.

The research suggests that Medical Administration’s efforts to support the MAC structure to achieve its mandate may be enhanced by ensuring a consistent and clear understanding of the purpose and scope of the MAC at the individual MAC member and committee levels. Also, efforts to promote communication between the HSDA MACs and the NH MACs to ensure that local MAC issues are addressed and appropriately forwarded to the Northern Health Board will increase HSDA MAC member’s confidence that Medical Administration is interested and responsive to their issues.
Northern Health Medical Advisory Committees have developed Terms of Reference and this document is available to Medical Staff in the Northern Health Interim Medical Staff Rules (2006). Terms of Reference comprise of a definitive statement that clearly describe the committee’s purpose, membership composition, scope of authority and major areas of responsibility (United Way of Canada, 2007). MAC Terms of Reference should be reviewed with all MAC groups as part of a regular evaluation process. This will enhance role and function clarity for new and existing MAC members.

The research indicates it may be appropriate for Northern Health to consider the development of a physician advocacy governance mechanism to compliment the advisory function of the MAC. Although it may be argued that the MAC structure requires rectification before adding an additional structure to the governance system, the opportunity for direct and ordered communication with the Board may help to minimize the tendency for some physician MAC members to use the MAC for advocacy purposes.

Medical Administration’s ability to complete the feedback loop by reporting back to MAC after decisions have been made is a key concern. According to Livingstone (1996), physicians need timely access to information that promotes a clear understanding of the intent behind the actions and decisions made by senior management, including feedback regarding how physician input was used (or not used) to inform outcomes. This degree of organizational transparency promotes trust within the physician-administration relationship. Accordingly, Medical Administration is urged to introduce greater structure and rigour in communication processes and provide timely feedback regarding decisions made at the administrative and Board levels. Although the NH MAC reports to the Board regularly via the NH MAC Chairperson, this reporting process should be formalized.
using a written report format to be presented to NH MAC members. This report should outline issues brought forth to the Board, provide an overview of Board discussion regarding matters and provide rationale for actions or inaction on matters presented for consideration. Many MAC members expressed aggravation over the length of the MAC Agenda and meetings. Medical Administration feedback reports may be better received as verbal reports and should be included as a standing agenda item to ensure that feedback opportunities are not missed. As a final point, a pervasive source of contention amongst almost all NH MAC members involved frustration with the format of the MAC agenda package and its late dissemination to MAC members. The agenda format and its late distribution make it difficult for MAC members to prepare for NH MAC meetings. Medical Administration is advised to invest effort to ensure that MAC packages are orderly and distributed to NH MAC members in a timely fashion.

There appears to be a need for greater dialogue with the North West MAC and to a certain degree, with the Northern Interior MAC as well. The qualitative data suggests that dialogue in of itself will not be enough. The Medical Administration team and MACs may benefit from a face to face meeting for the express purpose of identifying and discussing the practical implementation of preferred committee and communication processes to help each group achieve satisfying outcomes. During this meeting, an important theme to discuss is the notion of relationship as a reciprocal process. MAC members also have a responsibility to improve the relationship with Medical Administration. Communication is a two way street and physicians are encouraged to be clear and constructive in making necessary inquires to address concerns and information needs. This recommendation is consistent with the following MAC member’s comments.
“If we have questions we should ask them, if we are unsure who is supposed to take the lead on something we should ask, ‘who is taking the lead on this’? If we are waiting on a decision we should ask, ‘when can we expect to hear back on this decision’?"

MAC members also expressed concern that Medical Administration’s agenda is often too ambitious and in efforts to accomplish the impossible, Medical Administration tends to hastily strike working committees or add tasks to an already onerous workload for both MAC and administrative team members. The end result is one where time, energy and financial resources are insufficient to achieve desired results. Senge (1999) recommends strategies that address these concerns and improve group efficacy in situations where resources such as time and capital are scarce. Theses strategies include:

- Stopping something before starting something new to free up the energy and resources necessary to accomplish identified goals.
- Conduct a committee “check” on all proposed action items. Tasks should be discussed as a committee to test identified action items to: 1) determine their feasibility and 2) to provide an opportunity to discuss alternatives or dismiss the item before wasting time and resources.
- Plan to neglect certain activities. A lean organization cannot pursue everything that seems important. While it may be helpful to commit to all desired results, it is important to suspend actions on some items for a period of time. This helps focus energy on priority items and also ensures that timeframes are realistic.

Medical Administration is advised to consider a new format for the Northern Interior MAC to provide a more effective forum to discuss rural issues. All MAC members should consider participating in this forum in efforts to better understand rural issues and to work collaboratively with rural peers to find solutions that frequently require the participation and cooperation of physicians who work in the Prince George Regional Hospital.

The current practice of meeting face to face on a yearly or twice yearly basis was consistently cited as key to promoting the MAC member- Medical Administration
relationship and was reported as a highly valued MAC activity. Although video conferencing capability was cited as a superior option to teleconferencing, video conferencing equipment is not available in some of the smaller communities across the Health Authority and many MAC members reported feeling disadvantaged as a result of this. Given Northern Health’s weather and geographical challenges, as well as the expense and impracticality of regular travel, Medical Administration is advised to advocate for video conferencing equipment in areas that do not currently have this capability.

Lastly, MAC physician members do not feel that the stress and strain associated with the MAC role is sufficiently recognized by Medical Administration. Periodic discussion with physicians about challenges associated with MAC membership with the opportunity to explore options to reduce stress should be considered.

**Conclusion**

The context in which health care is delivered in the north is complex and Medical Administration relies heavily on physicians’ expertise and participation in processes aimed to maximize the health and well being of northern patients. Medical Administration is committed to understanding the dynamic relationship between administration and physician MAC members and is also committed to invest effort to improve justice perceptions. This project was designed to determine MAC member’s perceptions of organizational justice in their working relationship with Medical Administration. The study revealed good justice perceptions in each of the distributive, procedural and interactional justice domains. However, areas of concern were also identified in each justice domain. In today’s political and economically constrained
climate, where provincial physician satisfaction ratings in the physician-hospital relationship category are low (Comeau, 2007), Medical Administration is obliged to address areas where their relationship with physicians appears deficient. Fair relationships promote trust, cooperation and commitment to organizational goals (Greenberg, 1993). As noted by Levac (1992), the success of complex health enterprises can be directly attributed to the spirit of partnership between Medical Administration and medical staff, because these relationships propel an organization forward in pursuit of its health care mission.
Appendix 1.
Research Introduction Letter

An Introduction to the Research Project

Medical Advisory Committee Member's Perceptions of Fairness Between MAC Members and Medical Administration

Thank you for agreeing to participate in this research project. I am conducting this research project as a requirement for the completion of my MBA degree. This project seeks to better understand your perceptions regarding Medical Administration's fair treatment of you as a member of a Northern Medical Advisory Committee.

The purpose of this research is to help Medical Administration to establish a baseline understanding of our strengths and areas of weakness in terms of enacting fair leadership in our relationship with the MACs. Our goal is to use the information to improve organizational justice in processes, decision making and interactions between Medical Administration and MAC members who represent Northern physicians as a whole.

With your permission, a 20 minute telephone interview will be set up for the purpose of administering a questionnaire that seeks to identify your beliefs about the presence and quality of the three distinct elements of fairness. There will also be questions designed to provide basic demographic information and a question that verbally confirms your consent to participate in the interview process.

The telephone survey will be conducted during the month of January, 2007 and will be scheduled at a time that is convenient for you.

Agreement to be interviewed will imply informed consent. Your participation is strictly voluntary and you may withdraw from the research project at any time. Any documentation related to the project will be destroyed immediately upon your decision to withdraw. Your answers are confidential. I will be the only person to see your responses. I will collate the responses and enter them into a secure database that is password protected. Upon completion of the research I will destroy the paper copy of the completed questionnaire and all electronic data stored on computer will be deleted by May 31, 2007.

The questionnaire will be emailed to you in advance of the interview. Please have a copy of the survey question in front of you during the telephone interview.

If you have any questions or concerns, please call me at (250) 649-7543. If you have any questions or concerns related to this study you may report them to the office of Research, UNBC (250) 960-5650. Alternatively you may choose to email Dr. Rick Tallman, Project Supervisor of this research at Tallmanr@unbc.ca

Results of this survey will be available in April, 2007. If you would like a copy of the study results, you may request them by phone or e-mail.

Please keep this letter for future reference.

Thank you,

Kelly Phipps,
Northern Health Director of Medical Administration
Appendix 2.
Organizational Justice Questionnaire

I have received written and verbal information describing this project and expectations regarding my participation in this research. I am aware that my participation is voluntary and confidential. My name or other identifying information, with the exception of regional representation and MAC position, will not be used. I am aware that I may withdraw from the project at any point in the process without penalty and that all information related to my participation will be immediately destroyed.
Consent obtained on (date) ______________

Please indicate your agreement or disagreement with the following questions by circling the appropriate response.

SD- Strongly disagree
D- Disagree
N- Neither agree nor disagree
A- Agree
SA- Strongly agree

Fairness in the following questions means the extent to which the Medical Advisory Committee (MAC) and your personal contributions to medical leadership via the MAC are recognized and influential

Medical Administration

<table>
<thead>
<tr>
<th>Recognition</th>
<th>SD</th>
<th>D</th>
<th>N</th>
<th>A</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognizes me for the responsibilities I have as a MAC member</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recognizes me for the amount of expertise I bring to the MAC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recognizes the amount of effort I put forth as a MAC member</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recognizes me for the work that I have done well as a MAC committee member</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recognizes the stresses and strains of the MAC role</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As a MAC member I have influence with Medical Administration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The MAC has influence with Medical Administration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

With respect to recognition and influence, please give an example of how Medical Administration has handled this:

- Well-
- Poorly-

Medical Administration (in its dealings with the MACs)

<table>
<thead>
<tr>
<th>Is honest and ethical in its dealings with us</th>
<th>SD</th>
<th>D</th>
<th>N</th>
<th>A</th>
<th>SA</th>
</tr>
</thead>
</table>
Give us an opportunity to express our views | SD | D | N | A | SA
---|---|---|---|---|---
Is completely candid and frank with us | SD | D | N | A | SA
Shows a real interest in being fair | SD | D | N | A | SA
Deals with us in a truthful manner | SD | D | N | A | SA
Gets input from us before making a decision or recommendation | SD | D | N | A | SA
Asks for ideas on improvement | SD | D | N | A | SA
Does not allow personal bias to influence its decisions or recommendations | SD | D | N | A | SA
Does not allow things that should not be considered to influence its decisions or recommendations | SD | D | N | A | SA
Is consistent in its application of procedures used to inform decisions and recommendations | SD | D | N | A | SA
Provides an opportunity for us to appeal or challenge its decisions or recommendations | SD | D | N | A | SA
Provides useful feedback to us regarding its decisions or recommendations | SD | D | N | A | SA
Allows requests for clarification or additional information about its decisions or recommendations | SD | D | N | A | SA
Treats all members of MACs with dignity and respect | SD | D | N | A | SA

Please give an example of how the relationship between Medical Administration and the MAC is:

- Well done-
- Poorly done-

Dialogue is important to arrive at good and accepted decisions. With respect to making decisions, and based on the relationship between Medical Administration and the MAC, Medical Administration:

Seeks input from the MAC | SD | D | N | A | SA
---|---|---|---|---|---
Provides me with timely feedback about the decisions and its implications | SD | D | N | A | SA
Explains the processes of decision making clearly | SD | D | N | A | SA
Communicates the logic behind the final decision | SD | D | N | A | SA
(When necessary) explains why a recommendation made by MAC was not accepted by Medical Administration | SD | D | N | A | SA

Please give an example how Medical Administration followed these steps:

- Well-
- Poorly-
The following items refer to Medical Administration:

<table>
<thead>
<tr>
<th>Medical Administration’s explanations regarding procedures are reasonable</th>
<th>SD</th>
<th>D</th>
<th>N</th>
<th>A</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Administration effectively tailors communication to meet individual’s specific needs</td>
<td>SD</td>
<td>D</td>
<td>N</td>
<td>A</td>
<td>SA</td>
</tr>
</tbody>
</table>

- What do you see as the most important factor(s) for Medical Administration to focus on to achieve greater “fairness” in its relationship with the MAC?
- What should the MAC focus on to achieve greater fairness with Medical Administration?

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**Demographics**

- How long have you been a member of the MAC?
- Are you a NH MAC Member, HSDA MAC member, or both?
- What region are you from?
- What position do you hold on the MAC (Chair, Vice Chair, Voting member, Other___________. Please specify)
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