An exploration of opportunities for health service managers to share information orally: a method of documentary analysis using an electronic room-booking calendar

Jacqueline MacDonald¹, Peter Bath², Andrew Booth³

¹Annapolis Valley Health, South Shore Health and South West Health, Nova Scotia, Canada. Jacqueline.Macdonald@dal.ca
²Information School, University of Sheffield, Sheffield, United Kingdom. P.A.Bath@sheffield.ac.uk
³School of Health and Related Research, University of Sheffield, Sheffield, United Kingdom. A.Booth@sheffield.ac.uk

In an era of increasing emphasis on health research translation for health policy and health practice, there is a need for researchers to understand how service-level health policy and practice decisions are informed and made. This paper describes the documentary analysis methods used in a study to examine an electronic meeting room booking calendar in order to quantify opportunities for health service managers to meet and share information. Study results suggest that managers of the District Health Authority may spend as much time in meetings sharing information than they do in their own departments. A key finding of this calendar study is that scheduled one-time small group meetings may be as important to health service managers as the two types of meetings typically described in the research literature: scheduled, recurring meetings of formally named groups and unscheduled, informal meetings.

Keywords

Documentary analysis, electronic calendars, meetings, health service managers, oral information sharing

1. Introduction

This paper presents findings from the second in a three-part research project conducted between 2005 and 2009 in a publicly funded District Health Authority in Nova Scotia, Canada. The research developed in response to a district committee’s information need; the committee—working to establish population health as a routine consideration in decision-making—wanted to know what sources managers use to inform decisions, what decision-making processes, and at what point would be best to introduce population-health issues.

Health services have been described as the most complex of organizations to manage [1]. However, very little research has been conducted on health-service managers, the decisions they make, or the service-level policies and other outcomes that result from their decisions.

The first part of this research was an exploratory-interview study, which examined the information that health-service managers used to support critical decisions unrelated to individual patient care, such as decisions involved in developing practice guidelines, complying with patient safety standards, and planning chronic-disease-prevention strategies [2-4]. Decisions were examined within a conceptual framework developed from research related to decision complexity. The framework included decision
levels [5], decision modes [6-10], decision types [11], decision structure [12], and decision situations [10].

Participants described using varying combinations of over fifty different information types to inform decision making. Most managers satisfied [2, 12]; they considered enough information to make a “good-enough” decision. Health-service managers appeared to inform critical decisions by bringing co-workers together to consider the incident collectively, as suggested by the following quotations.

So, bring the group together, and it was the group of managers, clinical resource, the usual people, and nurses who supervise students, so probably about 20. (Manager, Group 3-A)

So we brought together a cross section of people from across the district, the various sites, the various services, everybody including housekeeping, maintenance, physicians, nurses, the various departments that … provide services for/within the organization. (Manager, Group 3-D)

So in this whole process, we had the staff involved in the department, we involved the health and safety committee, we brought in the occupational health nurse and I guess she doubles as infection control so we had both sides there. (Manager, Group 3-D)

Before exploring aspects of oral information sharing further, it was necessary to gain an understanding of how frequently these meetings were scheduled. A study was designed using documentary-analysis methods to explore the District’s electronic room-booking calendar. The overall aim of this calendar study was to determine whether, as a means of informing decisions, information sharing in scheduled meetings was sufficiently important in health-service managers’ work to be the focus of further study. The objectives were to determine the number of opportunities for scheduled group information sharing that took place and the number, composition, and frequency of the different groups that met, comparing those that met regularly with those that appeared to meet just once. Study results would be used to develop and focus specific interview questions about oral information sharing in a follow-up study.

This paper will provide insight into health-service managers’ workplace practices. It will be of interest to those designing decision-support and other information systems for health-service managers, and for knowledge-broker and similar services. It will also be of interest to researchers and research funders concerned with how research is used in health services.

1.2 Definitions

The word group has been used generically in this paper to mean “a relatively closed and fixed ensemble of people sharing the same ‘goal’ and engaged in incessant and direct communication” [13]. A group could be a department, a committee, a portfolio, a team, or a number of people called together at least once to address and provide perspective on a specific situation. Not all groups are teams. A team exists and adapts over time [14] with “the capacity to share a common information need and similarly to share in the information activities required to fulfil that need” (p. 4).

For this research, a manager is a member of the District’s Leadership Forum. At the time of this research, sixty-one managers participated in these meetings: these included Senior Executive (the Chief Executive Officer and four Vice Presidents who administered the Acute Care, Community Health, Operations, and Medicine portfolios); Directors who oversaw services of two or more departments; Managers of individual departments; and several Junior Leaders just below the Manager level and responsible for leading programs or services without staff or budgets.

2. Literature Review

The research literature reviewed for this study included information technology; the computer sciences; operations research and the management sciences (OR/MS); medicine and the health professions; medical education; health administration; and the library and information sciences (LIS). Individual databases included MEDLINE; ACM Digital Library; Library Literature; Library and
Terms from database controlled vocabularies and free-text terms were used in search strategies that combined concepts related to meetings, group effectiveness, group leadership, information sharing, and shared decision making with concepts related to information, knowledge, and evidence, as well as information behaviours (such as seeking and searching) and information uses (such as decision making, priority setting, resource allocation, policy development, and project management).

The literature review presented in this paper includes research on health services managers’ meetings, as well as research on meetings of managers in general that provided elements used to classify room bookings. The literature identified on the subject of meeting and group effectiveness and leadership was used in the third part of the research project, a second exploratory interview study. The review was updated in 2010, 2011 and again in 2013 to prepare this paper.

2.1 Documentary Analysis Methods for Calendar Studies

Documentary analysis [15] “involves the study of existing documents, either to understand their substantive content or to illuminate deeper meanings which may be revealed by their style and coverage” (p. 35). Documentary analysis differs from content analysis where “both the content and context of document are analyzed: themes are identified” [16] (p. 200).

Rather than clear-cut methods, a variety of approaches are used in documentary analysis, and any written text may be defined as an artefact for study using documentary-analysis methods, regardless of format, including administrative records, web pages, and diaries [17].

No research was identified that could be used to guide the study or to develop study protocols for this type of calendar analysis.

2.2 Meetings as a Mechanism to Share Information

The role of meetings as mechanisms for information sharing for health service managers has been explored in two studies, one Canadian and one Swedish. The Canadian study [18] used semi-structured interviews, meeting diaries, and a focus group to gather perceptions of meeting effectiveness among 24 senior managers in a British Columbia health region. The study identified three types of meetings, paraphrased as follows: information giving, where information is given from one individual to others, information exchanging, where individuals exchange views on a variety of topics, and information creating, where through dialogue and discussion, decisions are made, problems solved and goals formulated. The health region’s 100 managers and senior executives were estimated to spend, at minimum, an average of 1,500 hours a week in meetings [18].

The Swedish study [19,20] used a series of three interviews and structured observation of ten Swedish nurse managers over 3½ -4 days. On average, 59% of their time was spent in meetings, 40% of which were scheduled and, 19% unscheduled [20].

The literature on meetings among managers in general includes dimensions that may be useful in an information sharing study, including whether scheduled or unscheduled, meeting purpose, meeting type, and length, organizational and individual time spent in meetings, group size and meeting cost [21-23]. Other work that may be useful in an observational study of group information sharing includes research on information interactions at meetings [24,25], on information richness, [26] “the ability of information to change understanding within a time interval” (p. 560), and on teamwork and group collaboration [27,28].

In a study of executive directors, department heads and staff of sixteen social welfare and research agencies [29], the researchers identified two types of organizational meetings or “task communications”: planned interdepartmental communications, labelled scheduled communications; and impromptu, unplanned interdepartmental communications about a new organizational activity, labelled unscheduled communications (p. 864). These categories appear to be similar to Simon’s structured and unstructured decisions [30]. A positive relationship was noted between unscheduled
meetings and organizational diversity with respect to employee and service specialization, diffusion of power, high uncertainty, and non-routine work situations. A negative correlation was observed between unscheduled meetings and organizations with job descriptions [29].

After five weeks of observations of chief executives’ work, Mintzberg [31] identified five basic media used to communicate and exchange information. These included documented communication (mail) and verbal communication (telephone, scheduled and unscheduled meetings, and tours). This study found that what the information managers found most useful was obtained through scheduled and unscheduled meetings. Scheduled and unscheduled meetings were similar in frequency but differed with respect to membership and duration. With respect to frequency of activities, they had about the same number of unscheduled meetings (19%) as scheduled meetings (19%), but spent more time in scheduled meetings (59% vs. 10%). Sudden problems were often addressed by telephone or in unscheduled meetings with smaller groups of people with whom they worked more closely. Scheduled meetings tended to be with larger groups with whom they worked less closely, more frequently away from the organization.

A study of engineers communicating in a dynamic environment characterized by the combined effect of complexity, uncertainty, and speed [32] found that they were successful in “quickly and frequently sharing large and diverse volume of information with a large number of people” (p. 84). The findings included that these construction project managers used verbal communication nearly 80% of the time and spent 60% of their time in meetings, of which 80% were not planned. They also preferred information interaction with no more than one or two other persons.

Most of the research on meetings identified considers differences between scheduled and unscheduled meetings. Research that has differentiated between scheduled meetings into recurring meetings of formally named and structured groups and one-time meetings of informal groups, or that examines the differences between these has not been identified. No theories were indentified that could be used in calendar data analysis.

3. Methods

A systematic research plan was developed to allow the process to be inspected [33] or repeated [34]. Ethics approval was obtained through the District’s Health Research Ethics Committee.

3.1 Data Source

The Calendar Study was undertaken in January 2008 so calendar data for the 2007 year were used. In 2007, each of the District’s six sites had at least two large meeting rooms that can accommodate at least seven and as many as seventy people. Any employee can book these rooms via the Microsoft Outlook™ calendar. Data on meetings in these twenty large meeting rooms were examined for this study.

Most departments have small meeting rooms that accommodate up to six people, and most managers have meeting space within their offices for meetings with one or two others. These spaces are not accessible to any employee and not usually booked through the Microsoft Outlook™ calendar so data on any meetings in them were not included in this study.

Calendar data from January through December 2007 were extracted and analyzed. Data included the meeting organizer’s name, booking subject, location, day of week, time of day (morning, afternoon, evening), meeting duration and meeting frequency (if the booking used Outlook’s recurrence feature). Additional information, including the number and names of invited participants, were linked to the booking record but not part of it and so were examined individually as required to identify aspects that were not clear. Agendas and supporting information were not part of the room booking; therefore, these data were neither extracted nor analyzed.
3.2 Thematic Framework for Meeting Characteristics

Meetings were indexed using dimensions identified as appropriate for typical organizational meetings [21-23] and by meeting aspects important to this study. These included group composition whether homogenous, drawn from a single department, program or portfolio, or heterogeneous, having participants from different departments, programs or portfolios and whether they were recurring meetings of formally named groups or appeared to me one-time meetings of unnamed groups.

3.3 Data Preparation and Analysis

Booking data from each of the 20 large meeting room calendars were downloaded into MS Excel™, grouped and sorted. The separate files were merged into a single Excel™ file with 8,686 records. Strings of time and date data in one field were separated into four fields, one each for date, day of week, start time and end time. Some records included brief messages to participants; these were included in a memo field.

All data were imported into a single MSAccess™ table. Information in the subject line was used to index bookings by activity and participant. Categories developed for activities included meetings, education, self-help, clinics and room maintenance. Categories of participants included employees, volunteers, patients, physicians, community partners, government representatives and vendors. Meeting organizer and participant lists were checked when either of these two dimensions could not be determined from the subject line. Any that remained unclear were excluded from further analysis.

Group names were not standardized within the Calendar. For example, entries for the third Tuesday of each month for a specific meeting room were labelled “Occupational Health and Safety”, “OH&S”, “Occ. Health”, and “Site OH Meeting”. Additional information including meeting organizers, participant names and memos were checked so that group names could be standardized with a common group name. This process identified series of meetings that appeared at first to be single meetings but were found to recur.

Upon inspection of consolidated data, there appeared to be numerous duplicate bookings of two or more meeting rooms for the same, or similarly named groups for the same date and time, not always at the same site. For such bookings, it was not clear whether the extra rooms were used for breakout sessions, adjacent rooms were booked to assure privacy, or calendar booking errors. Bookings for the same participants at the same time but in different sites, and in rooms at the same site but not adjacent (so apparently not booked to assure privacy) or for groups so small as unlikely to need breakout sessions were considered calendar booking errors, amalgamated and allocated to the most central location to avoid double counting.

Meetings attended only by employees (managers and staff) were examined for recurrence, attendance by managers and scrutinized to determine group composition, whether homogenous, with participants coming from a single portfolio or heterogeneous, with participants coming from more than one portfolio.

4. Study Results

This section begins with an overview of the activities in these large meeting rooms, then focuses on meetings that health service managers would be expected to attend.

Data from all bookings for the District’s 20 large meeting rooms for 2007 were summarized by activity, participants and time of day (Table1).
Table 1 Breakdown of 7,359 Room Bookings by participant, activity, time of day and likelihood of health service managers' participation.

<table>
<thead>
<tr>
<th>Activity with Likelihood of Managers Participation</th>
<th>TOTAL</th>
<th>morning</th>
<th>Afternoon</th>
<th>all day</th>
<th>evening</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td><strong>MEETINGS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not clear*</td>
<td>350</td>
<td>4.80%</td>
<td>106</td>
<td>1.44%</td>
<td>190</td>
</tr>
<tr>
<td><strong>External</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients, families, general public</td>
<td>231</td>
<td>3.14%</td>
<td>32</td>
<td>0.43%</td>
<td>97</td>
</tr>
<tr>
<td>Volunteers</td>
<td>263</td>
<td>3.57%</td>
<td>55</td>
<td>0.75%</td>
<td>51</td>
</tr>
<tr>
<td>Physicians</td>
<td>34</td>
<td>0.46%</td>
<td>2</td>
<td>0.03%</td>
<td>3</td>
</tr>
<tr>
<td><strong>Employees &amp; External Partners</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employees &amp; External Partners</td>
<td>172</td>
<td>2.34%</td>
<td>41</td>
<td>0.55%</td>
<td>65</td>
</tr>
<tr>
<td>Employees &amp; Government Reps</td>
<td>29</td>
<td>0.39%</td>
<td>12</td>
<td>0.16%</td>
<td>3</td>
</tr>
<tr>
<td><strong>Employees &amp; Volunteers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employees &amp; Volunteers</td>
<td>46</td>
<td>0.63%</td>
<td>3</td>
<td>0.04%</td>
<td>13</td>
</tr>
<tr>
<td>Employees</td>
<td>4708</td>
<td>63.96%</td>
<td>2261</td>
<td>30.72%</td>
<td>1445</td>
</tr>
<tr>
<td><strong>Subtotal Meetings</strong></td>
<td>5973</td>
<td>81.17%</td>
<td>2926</td>
<td>34.33%</td>
<td>1894</td>
</tr>
<tr>
<td><strong>EDUCATION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not clear*</td>
<td>47</td>
<td>0.64%</td>
<td>8</td>
<td>0.11%</td>
<td>9</td>
</tr>
<tr>
<td><strong>External, including Government</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients, families, general public</td>
<td>729</td>
<td>9.91%</td>
<td>159</td>
<td>2.16%</td>
<td>145</td>
</tr>
<tr>
<td>Physicians</td>
<td>117</td>
<td>1.59%</td>
<td>27</td>
<td>0.37%</td>
<td>42</td>
</tr>
<tr>
<td>Volunteers</td>
<td>8</td>
<td>0.11%</td>
<td>2</td>
<td>0.03%</td>
<td>2</td>
</tr>
<tr>
<td><strong>Employee-only</strong></td>
<td>272</td>
<td>3.70%</td>
<td>75</td>
<td>1.02%</td>
<td>119</td>
</tr>
<tr>
<td><strong>Subtotal Education</strong></td>
<td>1174</td>
<td>15.95%</td>
<td>274</td>
<td>3.68%</td>
<td>318</td>
</tr>
<tr>
<td><strong>SELF HELP &amp; SUPPORT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not clear*</td>
<td>1</td>
<td>0.01%</td>
<td>0</td>
<td>0.00%</td>
<td>0</td>
</tr>
<tr>
<td><strong>Patients, families, general public</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients, families, general public</td>
<td>171</td>
<td>2.32%</td>
<td>7</td>
<td>0.10%</td>
<td>1</td>
</tr>
<tr>
<td><strong>Subtotal Self help &amp; support</strong></td>
<td>172</td>
<td>2.34%</td>
<td>7</td>
<td>0.10%</td>
<td>1</td>
</tr>
<tr>
<td><strong>OTHER</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employees &amp; Patients</td>
<td>20</td>
<td>0.41%</td>
<td>9</td>
<td>0.12%</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total Bookings for Meetings, etc.</strong></td>
<td>7349</td>
<td>9.99%</td>
<td>2933</td>
<td>38.38%</td>
<td>2224</td>
</tr>
<tr>
<td><strong>Room Maintenance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employees</td>
<td>10</td>
<td>0.13%</td>
<td>2</td>
<td>0.03%</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>7358</td>
<td>1.00%</td>
<td>2915</td>
<td>38.38%</td>
<td>2226</td>
</tr>
</tbody>
</table>

The three most frequently occurring reasons for the bookings (N= 7,349, 100%) were meetings (N=5975, 81.28%), education (N=1,174, 15.97%), and self-help sessions (N=172, 2.34%) such as Alcoholics Anonymous. Least frequent reasons for bookings were clinics (N=30, 0.41%) such as foot care clinics and room maintenance such as painting or repair (N=10, 0.14%). Activities that started and ended in the morning occurred most frequently (N=2,806, 38.13%), with afternoon-only activities next most common (N=2,226, 30.25%).

Participants in these activities (N=7,349, 100%) included employees (managers and staff), physicians formally associated with the District, patients and clients, volunteers and external partners. Volunteers include members of the governance board, community health boards, fund-raising foundations and women’s auxiliaries, and hospital volunteers. External partners included vendors, government
workers and colleagues from other districts. Bookings likely to include Managers as participants have been marked with a ✓ (a tick mark) in the first column.

4.1 Meeting Cancellations and Updates

Bookings were changed at a rate of 15%. Some cancellations were handled using the Outlook™ delete feature (N=666, 8%) and others by adding notes to the booking label (N=44, 1%). Other bookings were updated (N=594, 6%) by changing the Outlook™ date and time field. It was not possible to determine whether there were more cancellations for one type of activity than another or for one group of participants or another.

4.2 Employee-only Meetings

The three-part research project explored health service managers’ information behaviour during decision making, therefore only the 4,708 meetings involving employees were analyzed further to see if managers were in attendance. Of these, 1,624 bookings were eliminated on closer inspection because they were either duplicate bookings, bookings not cancelled properly or they were routine union meetings attended only by members and not by managers. Most health service staff were members of one of five different unions; managers do not belong to a union so do not attend routine union meetings.

4.3 Analysis of Managers’ Meetings by Date, Month and Weekday

The remaining 3,084 bookings had at least one of the District’s managers on the participation list; attendance by managers was likely but not certain. These were examined by date (Figure 1), by month (Figure 2), and by weekday (Figure 3). The mean number of meetings per month was 257, with peaks in January and October (Figure 1 and Figure 2) and as many as 28 meetings in a single day in October 2007 (Figure 1). There was slight fluctuation by month in spring, autumn and winter and fewer meetings during the summer vacation period and December holiday season (Figure 2).

![Figure 1 Employee-only meetings in large meeting rooms that likely involved managers, by date, in 20 Large Meeting Rooms, 2007](image-url)
The weekday chosen most frequently for meetings was Tuesday, followed by Wednesday (Figure 3). In 2005-2006, the Senior Executive encouraged Managers to try to keep Fridays free of meetings. Consequently, only meetings that could not be scheduled elsewhere in the week were scheduled on “meetingless Fridays”.

The largest number of scheduled meetings in these twenty large meeting rooms that health service managers would be expected to participate in on a single day was 28 (Figure 1), with 12 (11.90) meetings per day the mean, 14 meetings per day the mode, and 13 meetings per day the median. There were 26 weeks in 2007 when 15 or more employee-only meetings were held on a single Tuesday (Figure 4). That there were no Fridays in 2007 with more than 15 scheduled employee-only meetings indicates that encouragement to have “Meetingless Fridays” was effective in 2007.
4.4 Recurring Meetings

The 3,084 bookings with health service managers as likely participants were examined for recurrence; 343 groups were identified with at least two meetings at the same site, the same organizer, a majority of common participants, the same or closely related subject labels, and parallel dates, days of the week, month or quarter. Of these, 84 groups met at least quarterly.

4.5 Departmental and Interdepartmental Meetings

Of the 84 groups that met at least quarterly, 40 were homogenous and 44 were heterogeneous. Only 15 of the 44 heterogeneous groups that appeared to meet regularly did not involve either individual patient care or human resources issues such as staff interviews, performance appraisals, discipline meetings, or meetings with unions.

Several of the 15 heterogeneous groups are likely to have included both managers and staff and may have included members of the public as representatives from the community.

4.6 Small Group Meetings

There were 539 bookings labelled only with first names, for example “Mary, Jane and Susan” that appeared to be one-time meetings. The topic of these meetings was seldom included in calendar data. Surnames other than that of the person who scheduled the meeting were not always included so it was not possible to identify from the calendar record whether participants were from one or more departments.

Research that explores the nature and purpose of managers’ work generally looks at scheduled and unscheduled meetings [31,35]. All of the meetings analyzed for this Calendar Study were scheduled. Scheduled informal, small group meetings accounted for 1/6 of the bookings for these large-group meeting rooms. Reasons why small groups might book a large room to meet could include the need for space to spread out on a table or mount flip charts sheets on the wall.
4.7 Reflections on the Data

As data from the twenty meeting rooms were incorporated and standardized, inconsistencies in calendaring that affect the quality of the data were observed. These included lack of standardization of group names and lack of standard approaches to postponing and cancelling meetings. In addition, many of those who arranged meetings used the calendar to book the meeting room but not to engage participants’ calendars, so it was not possible to determine who participated. Had this content been included, it might have been possible to use topic mapping or social network mapping software to graphically represent the meetings instead of just counts by time and date.

Although it is likely that similar calendaring inconsistencies would occur, the electronic calendars of the managers who participated in the exploratory interview study might have been studied as an alternative to the room booking calendar. Though such a study would not capture unscheduled meetings, it would include meetings in managers’ offices, in departmental meeting rooms, by videoconferencing and by phone, so provide a more complete picture of scheduled meetings to inform decisions.

5. Discussion and Conclusion

This documentary analysis of 2007 meeting room bookings met its original purpose. A mean of twelve scheduled meetings per day for varying combinations of sixty-one managers represents a significant workload. Participation in these meetings was just one of eleven scheduled information-sharing opportunities for managers, as noted by the tick marks in the first column of Table 1. There were up to 28 scheduled employee-only meetings on a single day in 2007 (Figure 1) with a mean of 12 scheduled meetings per day. There were 87 weekdays in 2007 when 15 or more meetings were held (Figure 4).

It was not possible to determine how much time an individual manager spends in meetings from this study as data for scheduled meetings held in managers’ offices, in departmental meeting rooms, by phone and by videoconferencing, and data for unscheduled meetings were not included. Though representing only a small part of oral information sharing in health services, study results suggest managers may spend at least as much of their 7.5 hour day in meetings outside their departments than they do in their own departments. Arising from this part of the calendar analysis, the question “How much of your time at work do you spend in meetings?” was added to interview questions planned for the Second Interview Study.

A key finding of this calendar study concerned the number of small groups meeting in large rooms rather than in offices or smaller departmental meeting rooms. This finding gave rise to questions about the nature of these small group meetings. These related to their purpose, how they differed from larger, more formal meetings, their number and frequency, and whether their actions and decisions were recorded in writing.

This calendar analysis indicates that 84 of 343 named groups that met more than once in 2007 met at least quarterly. Another 539 meetings labelled only with personal names appeared to meet just once. These two findings suggest that not all of the meetings health service managers attend are recurring meetings of formally structured groups. The 84 named groups with more frequent meetings would be expected to have terms of reference, mandates, executive sponsorship, rules of engagement and meeting agendas to guide meetings, and meeting minutes to record decisions and actions. It raises the question of whether, and how, health service managers use meeting minutes of more formally structured groups, how many informal meetings managers attend compared with formally structured meetings, and how decisions and actions of informal groups are recorded.

Arising from this part of the calendar analysis, two additional questions were added to the list of questions planned for the Second Interview Study. These were “How many District committees or working groups do you meet with regularly?” and “When do you tend to refer to meeting records, such as minutes of meetings?”.
There were 539 bookings labelled only with several first names that appeared to be small groups that met only once. These larger more central meeting rooms that typically seat 20 or more people are tightly scheduled. The reason for their use for groups of two or three people was not clear, given availability of smaller departmental rooms that are easier to book and meeting space in most managers’ offices. This gave rise to questions about the frequency and nature of managers’ participation in what appeared to be informal, small group meetings and also whether there are records for less formal group meetings.

Three questions were added to explore these informal meetings. These were “Do you participate in many informal, small group one-time meetings? Can you tell me about these?”, “How many of the meetings you attend would be small group meetings?”, and “How are informal small group meeting actions and decisions recorded?”.

Characteristics of naturalistic decision-makers include multiple conflicting priorities [6]. The rate of cancellation and rescheduling of meetings may suggest sudden changes in plans that may arise out of conflicting priorities. It may also contribute to participants’ satisficing, making decisions before all of the information identified as required might be gathered. There were no immediate implications of this finding for the interview schedule. However, as an area for further exploration the decision complexity framework created for use in the first interview study [5-12] could be used to examine differences between meeting types and critical incident types.

This Calendar study contributed to design of a qualitative follow-up study to explore the information that health service managers need, share and use when they make group decisions, including whether and how they filter oral information sources for relevance, value and credibility and whether and how research reaches them to inform their decisions.

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