

Innovation at the space of *dissensus*: negotiating knowledge in health care

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Abstract

This paper takes a critical perspective on innovation discourse that focuses on knowledge transfer practices. We argue that whilst a ‘services approach’ to innovation can be useful in understanding elements of the complex and multi-layered healthcare cycle, it fails to account for the power and knowledge dynamics of user-provider relationships. In order to take account of the recent shift towards models of increased patient engagement in the choice and management of care, we adopt a more user-inclusive approach and discuss the importance of the emergent disparities between different actors’ perceptions of care, choice, knowledge and control. In so doing we hope to shed some light on knowledge practices enacted at the ‘space of dissensus’, and hence provide a new vocabulary for improving existing approaches to healthcare innovation.

Keywords: public sector, healthcare, service innovation, dissensus, knowledge legitimacy, Jacques Ranciere

Introduction

In the current economic climate, where health systems of major economies and healthcare providers are undergoing significant shake-ups, discussions of ‘savings’ are increasingly combined with calls for re-evaluating the public sector’s “innovation deficit” (Potts 2009). In the UK, recent public policy discourse emphasizes the growing influential role of innovation, which is illustrated for instance in the debate around the public services ‘innovation imperative’ in tackling today’s economic and social challenges (Harris & Aldbury 2009). However the nature and impact of service innovation in public sector settings remains under-researched (Walker 2007). Crucially, endeavors to address the complexities of innovation impact are further hindered by the lack of effective communication between the organization and policy literatures, and discussion around healthcare-specific issues is being conducted in ways that are not immediately recognizable by external observers.

Innovation research has increasingly emphasized the formal and informal institutional dimensions of the innovation process and has extended the very notion of innovation, by encompassing not only product and process innovation, but also organizational innovation in the wider Schumpeterian sense (Fagerberg 2005). It has moreover highlighted the complex and intrinsically social nature of knowledge practices enacted in innovation. This more holistic approach has led to a phenomenon that Borrás (2010) describes as “innovation widening”, whereby policy is moving beyond research-science and technology policies. In this context, understanding the political context of innovation policy and its perceived legitimacy becomes increasingly important, although it continues to constitute a marginal area in extant studies (Asimakou 2008).

The services approach and its discontents

A strand of services research literature has offered some interesting ontological perspectives on this multi-faceted nature of innovation, although it has been little acknowledged within organization studies. Core to the *services approach* in the management of innovation is the importance of an open systems orientation that explicitly acknowledges the importance of the organizational and institutional environments (Tether 2003). This approach has been increasingly employed in the information technology (Spohrer et al. 2007) and marketing (Gronroos 2008) literatures. Its logic stresses the key role of knowledge transfer in the conduct of services activities, wherein provider and user co-generate the service exchange on the basis of a mutual understanding of each other’s ‘capabilities and experiences’ (Chesbrough and Spohrer 2006).

Services research attempts to rehabilitate the role of the user and considers it central to the innovation process. This logic resonates with recent developments in the system of health service delivery where increased user involvement has been considered as a potential stimulus for innovation, with a potentially significant impact on the illness experience itself (Forster and Gabe 2008). In England, patient and public involvement (PPI) has become key part of a user empowerment strategy both nationally and locally (Lewis 2010). It is linked to a notion of democracy in reform projects that combine neoliberal and welfare objectives (Needham 2007).

Yet there seems to exist considerable ambiguity in extant policy discourse around the role of ‘lay users’ in democratizing public services. Whilst we observe a shift toward a seemingly more “democratic” and “participative” politics (Barnes 1999), an intense symbolic struggle unfolds in the ensuing policy discourses (Canstandriopoulos 2004). The participating actors become part of a negotiation process, which involves different types of knowledge (Dyer 2004), however the roles and types of knowledge that lay users enact are often bracketed out of “formal policy” debates. In spite of its holistic and user-focused logic, the services approach seems to ultimately fail to account for the conflicts and disparities that are embedded in this negotiation process. Instead the services approach tends to adopt a mechanistic concept of “knowledge translation” (Davies et al 2008) from tacit to explicit in the form of “best practices” which in turn serve as benchmarks for service innovation. These concepts assume – and prioritize – agreement and consensual practices, typically engendering ‘agreed upon orthodoxies’ (Rehn 2010) that obscure or mute the complexities of the process leading to them (Asimakou 2009).

Enter politics: rehabilitating dissensus

A services approach has potential to contribute to organization research by affording a more dynamic and bottom-up notion of service innovation. Yet in order to be properly understood, innovation needs to be contextualized, and to this end the organizational researcher should study it as an ongoing – and often uncomfortable – process that resembles a “game of power and politics” (Asimakou 2008). Therefore, as we will aim to argue, the value of the ‘service’ notion can only be leveraged insofar as it is unpacked in a way that attends to the inherently political nature of public sector innovation. Drawing on a case of NHS service restructuring, we suggest that the changing knowledge and power dynamics between service providers and users provides for a fascinating new area for a critical approach to innovation.

We draw on Ranciere’s notion of dissensus and the politics of public policy, in order to address the inherent ‘spatial awkwardness’ of this dynamics in public health services. In his prolific oeuvre, which remains largely unacknowledged in organization literature, Ranciere offers a poignant and innovative critique of conventional ways of conceiving democracy and politics. He draws attention to the overwhelming dominance of the ‘consensus’ that underlies the systems of liberal democracy. He problematizes consensus politics and shows that it places ‘democracy’ in opposition to “a principle of heterogeneity” (Ranciere 2010: 212), that is to say it veils and homogenizes distinction and difference in society, and hence cancels out real politics. For, the essence of politics, he argues, effectively resides in a process of disagreement, “a challenge to the opposition between legitimate and illegitimate speakers” that allows for a re-description and reconfiguration of their common world of experience (Ranciere 2000).

Such a perspective can throw some new light into a point that Wenger (1998) – reluctantly – alludes to when discussing knowledge-in-practice, namely that “peace, happiness, and harmony” are not necessarily properties of “a community of practice”. Moreover, Ranciere’s concept of dissensus points towards the ‘political nature’ of innovation, which Frost and Egri (1991) consider as a product/practice of a power game. However it avoids the pitfalls of institutional and structuralist analyses of politics where power emanates from and is inherent to a system properties, as it views ‘the political’ not in terms of institutions or particular spaces (or the re-ordering of

these), but rather as emergent, interruptive and sporadic action that generates new ways of belonging.

We hence make a case for a conceptual approach that a) considers service innovation as a political process, which does not necessarily presuppose consensus, but rather may be traced at areas of ‘dissensus’ b) interrogates the seemingly unproblematic process of empowerment implied in the “informed patient” discourse and c) accounts for the emergent and disruptive practices enacted by lay-actors in order to enrich our understanding of their ascribed role as ‘innovators’.

Research case

We conducted a 2.5-year in depth case study of stroke care restructuring in London between 2007-2009. Numerous forms of data were collected to enable triangulation of results (Table 1).

Case and context of stroke service reorganisation

| | |
|--|---|
| Interviews (formal 17 and informal 11) | 28 |
| Stakeholder events | 9 |
| Focus groups transcripts | 260 persons attending |
| Meetings | 4 |
| Documents and interim reports | From: Department of Health, London’s regional health authority |
| Website | London’s Regional health authority; specific engagement events; public consultation surveys |
| Further media tools | Second life animations, video clips, emails, powerpoint presentations |

Table 1: Data collected from London UK Stroke Service reorganisation

Strokes are a leading cause of adult disability and the third leading cause of deaths in the UK (Boyle 2006). In 2006, only 3 of the 30 hospitals in London that provided stroke care met the 90% benchmark for designated stroke care delivery (Darzi 2007). Decision making around the reconfiguring services was a complex process that involved a numerous and diverse set of stakeholders, and a series of events aimed at giving public members the opportunity to provide their views and feedback. In addition, stroke survivors, carers and third sector agencies also were solicited for input through formal interviews conducted by the regional health authority. Throughout the reform process, there were several levels of knowledge transfer engaging patients, carers and public (potential patients and carers).

Our findings reveal a process of *knowledge negotiation* between lay members of the public (including patients and carers) and a breadth of service providers. This process included on the one hand practices that are currently formalised and hence explicitly shaping the official policy discourse: “system-based knowledge practices”, and on the other practices that are enacted by lay actors in an interactional and manner at the ground level and which are by and large unaccounted for in formal policy discourse:

“emergent knowledge practices” (Table 2). In our discussion, we focus on a sample of these themes, notably the ones that illustrate the role of conflict in negotiating knowledge in the system, and the enactment of unexpected practices by lay users.

| Service Stage of Knowledge Negotiation | System-based Knowledge Practices \Leftrightarrow <i>Emergent Knowledge Practices</i> | |
|---|---|--|
| Raising public awareness | Media campaigns, IT-supported interaction and public consultation events | Patients draw on their experience and communicate knowledge back to the system independently or in spite of ‘institutionalized empowerment’ |
| Personalized in-hospital and community care | <p>Ensuring dissemination of information across hospital groups</p> <p>Encouraging informed choices and facilitating provision closer to patients’ homes</p> | <p>Trust and openness between multi-disciplinary groups and patient co-exists with tension and mistrust</p> <p>Patient-to-patient interaction may involve ‘users’ enacting roles of ‘providers’</p> |
| Post-discharge follow up services | <p>Supporting smooth community re-entry by establishing communication channels across GP, carers, social services</p> <p>Training the patient for home-care and self-management</p> | <p>Increased fragmentation in post-discharge communication, misunderstandings and feeling of anxiety may create new meanings and rules</p> <p>Patient’s embodied and intuitive knowledge is entangled with the multiplicity of her engagements with health workers</p> |

Discussion and Conclusions

Service managers highlighted that it took a long time to gain agreement across members of the public who held diverse opinions and perspectives. However, the users' participation was seen as important, and the perception that consensus is important for effective patient involvement was dominant among providers. Previous experiences in health service restructuring had demonstrated that public generally oppose 'downgrading' or moving services; yet they are also keen to have new services opened. Thus in conveying their message through media campaigns and public consultation events, service providers sought carefully about how to structure their words in order to avoid conflict. This reflects more generally a tendency of the *system-based knowledge practices* to assume and advocate consensus.

As lay users, stroke survivors often came forward and volunteered to contribute to the care practices. They were often stimulated to do so not by the official policy campaigns but rather by their own experience with the system and the dissatisfaction with the level of the provided care. Despite the lack of trust they often portrayed of the system, they also viewed the contradictions in perspectives as an opportunity to provide alternative types of – experiential, 'non-scientific' – knowledge. These patient volunteers seemed to find themselves in a space that failed to provide their contributions with legitimacy; the expectations raised by formal empowerment policy were often contrasted with a feeling of uncertainty and frustration.

This seemingly unorthodox form of patient engagement in her own care also illustrates that failures of consensual interaction, miscommunication that inhabit 'a space of dissensus' can have a considerable effect on the shaping of *emergent knowledge transfer practices*. Innovation may hence emerge beyond established systems of power/knowledge (Asimakou 2009), as a process of new meanings that sometimes arise from the patients' frustration and the misunderstandings that trigger it. It is in this sense, the result of a type the suspension of rules that govern normal experience and "normal social order" (Ranciere 2010).

As new actors become involved in different stages of the service, new forms of interaction define what we describe as a changing relationship between healthcare provider and user. Patients now increasingly lie at the center of designed organizational change, which places emphasis on empowerment policies, participatory care and informed choice (Le Grand 2005), they are considered as value co-creators. However the still dominant notion of innovation as a sequential, problem-solving activity seems to be inadequate to capture the complexity and multiplicity of the knowledge transfer that occurs in practice. The formal communication channels used in the London Stroke system to raise public awareness, seemed to be overall an effective means to facilitate some aspects of knowledge transfer. Yet knowledge transfer was manifest as a two-way, dynamic process throughout the stages of the service; importantly this was not always captured in the various conduits opened by empowerment policies. "Empowerment" initiatives only partially succeed in describing forms of lay actor involvement.

We therefore highlight service innovation to be an inherently political process not always be based upon agreement and sharing. Following Ranciere (1998, 2000, 2010) and Asimakou (2008, 2009) we have suggested a lens that considers knowledge

transfer practices at the under-explored space of miscommunication, disagreement and dissensus. What is more, unlike most critical studies of empowerment policies and the ensuing knowledge shifts in healthcare, we do not solely focus on structural or institutional constraints in the unraveling of ‘informed patient’ practices. Rather we have argued that in considering the power dynamics of knowledge transfer, lay actor agency can be manifest in a form of disruption, whereby new meanings may be agreed, disagreed on and redefined, wherein “genuine participation is the invention of that unpredictable subject” (Ranciere 1998).

We contribute to approaches that challenge the “illusion of rationality and control” (Asimakou 2009: 87) both in understanding and in talking about innovation. This can make for better policy in public sector settings as it alerts managers and practitioners to emergent knowledge practices; similarly to the way in which lay actors negotiate and re-define meanings of innovation, policy-makers can benefit from a comprehension of the discussed conflicting perspectives to notions of control and choice, and re-articulate innovation policy to address systemic failures. At the organizational level of innovation, our approach points to new ways of conceptualizing the awkward space of discomfort, anxiety and conflict. It offers a platform that integrates embodied and enacted knowledge to the service innovation agenda and opens new avenues in understanding the application of service-centered practice.

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