Towards the creation of learning improvement practices:

Studies of pedagogical conditions when change is negotiated in contemporary

healthcare practices

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Abstract

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In the early 2010s, competitive market logic was introduced into healthcare systems so as to achieve rapid improvements. This took place as improvement policies began to emphasize the notion of collaboration as a method of ensuring patient safety across organizational boundaries. This thesis addresses how staff, in their practical improvement work, balance economic values, on the one hand, against meaningful solutions for the patient, on the other. The research interest focuses on the particular interpretations about improvements that emerge in negotiations about change. These interpretations are foundational to the learning that simultaneously takes place. The aim of the thesis is to analyse and explain the pedagogical conditions that take place in improvement practices in a healthcare system in the 2010s.

The thesis takes its theoretical point of departure in a pedagogical theory that describes how contextual conditions influence learning processes in a specific practice where communication is foundational for learning. The thesis uses critical discourse analysis as a methodological point of departure and builds on a model of improvement work, namely, *the clinical microsystem*. The first study consists of a literature review of the microsystem framework. Subsequently, three case studies were conducted at Jönköping county council, Sweden. Discussions of improvements at clinical meetings and improvement coaches' reflections over their pedagogical approaches provide the empirical data for the case studies.

The findings show that market logic gives rise to a number of displacement effects with respect to learning processes. Short-term profits are shown to supersede goals of a more profound development of knowledge. The composition of an improvement practice is of critical importance to the nature of the negotiation that takes place, and thus how the practice comes to successfully challenge things that are taken for granted and the power structures that exist within the practice. Improvement coaches themselves become pedagogical prerequisites under the influence of the prevailing conditions, as they promote different learning organizations. This thesis develops the conceptual framework that is instantiated by the clinical microsystem, and it also contributes to the social constructionist field of improvement science by establishing pedagogical and discursive perspectives on improvement and change.

Keywords: quality improvement, clinical microsystem, healthcare policy, critical discourse analysis, governing mechanism, knowledge management, negotiation

Original papers

Paper I

Norman, A-C., Fritzén, L., & Lindblad Fridh, M. (2013). One lens missing? Clarifying the clinical microsystem framework with learning theories. *Quality Management in Health Care*, *22* (*2*), 126-136

Paper II

Norman, A-C., & Fritzén, L. (2012). "Money talks": En kritisk diskursanalys av samtal om förbättringar i hälso-och sjukvård. *Utbildning & Demokrati*, *21* (*2*), 103-124

Paper III

Norman, A-C., & Johnson, J. Negotiation of change in healthcare: A communicative perspective of healthcare networks vs. individual units (submitted)

Paper IV

Norman, A-C., Fritzén, L., & Andersson Gäre, B. Quality improvement coaching in healthcare: A Swedish case study of how improvement coaches approach learning in a contemporary healthcare system (submitted)

The articles have been reprinted with the kind permission of the respective journals.

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English and Swedish names, concepts and abbreviations

Several of the names and concepts referred to in this thesis have a Swedish origin. When they are mentioned the first time in the thesis they are written in Swedish followed by the English translation in parenthesis. The Swedish terms are then subsequently used throughout the thesis. Abbreviations are used for both Swedish and English names and concepts. They are included in the following table in order to clarify for the reader the connection between different names and concepts, and their respective abbreviations.

Table 1. English and Swedish names, concepts, and abbreviations that are used in this thesis, in alphabetical order

English	Swedish	Abbreviation
Bridging the Gaps		BtG
Care Guarantee	Vårdgaranti	
Clinical microsystem	Kliniskt mikrosystem	CMS
Community of Practice		CoP
Critical discourse analysis	Kritisk diskursanalys	CDA
God Vård Policy	God Vård föreskrift	GV Policy
Jönköping County Council	Landstinget i Jönköpings län	JCC
New Public Management		NPM
Pay for Performance	Prestationsbaserade ersättningar	P4P
Quality Collaborative	Genombrottsmetod	QC
Swedish Association of Local Authorities and Regions	Sveriges Kommuner och Landsting	SKL
Swedish Government Official Reports	Statens offentliga utredningar	SOU
Swedish Statute Book	Svensk författningssamling	SFS
The Health and Medical Services Act	Hälso och sjukvårdslagen	
The National Board of Health and Welfare	Socialstyrelsen	
The Board's administrative provisions and general advice (National Board of Health and Welfare)	Socialstyrelsens föreskrifter och allmänna råd	SOSFS
The Swedish National Audit Office	Riksrevisionsverket	RiR

1 Introduction

> *When the One-Stop Breast Clinic opened its evening clinic in 2004, it was invaded by clients from all over Skåne. However, it was reported that the staff were really happy. It had been a long time coming when specialists had the opportunity to learn from each other. The local economy sighed a sigh of relief. Shift hours were not reduced, and no referrals were needed. In addition to this – and impossible to put a price tag to – millions of hours of female anxiety were saved. The clinic was inundated with awards, and the managers at the county council level were ecstatic: 'The breast clinic that has opened [...] offers a first class journey through the healthcare system', said the director of healthcare services.*
>
> *The journey was short. In 2009, the clinic was closed, despite the staff members' protests. The Skåne region wanted higher 'cost efficiency'. That was what I read in their decision. To achieve cost efficiency, the county council wanted all mammography tests to be conducted at a single unit. This would provide 'increased possibilities, from an overarching perspective, to increase cooperation and to create a more process-directed method of working with a clear demarcation of responsibilities and common performance indicators and guidelines.'*
>
> *I suspect that many readers will recognize this type of language. And so responsibilities were clearly demarcated: mammography testing was on its own, the surgeons were part of a different organization, cytologists in another, and each with their own price lists. It was thus no longer possible to have three specialists in the same room with a patient. Consequently, the previous level of female anxiety in Skåne has returned. Despite this, the healthcare provider strives to provide diagnoses within 21 days. (Zaremba, 2013: 67-68)[1].*

This is how the journalist, Maciej Zaremba, described the difficulties experienced in establishing an alternative solution that both creates value for

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[1] Translated by the author

patients and is also cost-effective for the organization. This initiative for change, as exemplified by the One-Stop Breast Clinic, illustrates exactly what this thesis addresses. My experience of working as a physiotherapist, a manager, and an investigator into the management of the healthcare system has given rise to a number of questions concerning how, in the context of improvement, we are to balance (i) the demand for the creation of value for patients against (ii) system demands. The One-Stop Breast Clinic example shows that it is not a simple task, despite the fact that several interested parties wanted the same thing. The questions that have emerged in this thesis address what is expressed by the staff when they discuss improvement. Is it better solutions for the patients, or is it financial issues that come to the fore in conversations about improvement? Is it possible to balance these perspectives? My thoughts also touch on what the staff discussions actually lead to in terms of *learning*. This includes learning with respect to those who participate in the discussions, but also learning in terms of subsequent improvements, including the adoption of sustainable, long-term work methods which serve both financial restraints and serve the patients. What conditions influence the pedagogical[2] processes in the staff's improvement work in an early 21st century healthcare system, and how do the conditions emerge in the staff's conversations about improvement? If the conditions under which the improvement work's pedagogical processes can be revealed, then they can be dealt with more consciously, so that in the future they can be used to support the healthcare organization's work in creating cost-effective and value-creating solutions for its patients.

1.1   Problems faced by the healthcare system

The problems that improvement work has to deal with are multi-faceted and complex. New, cost-effective solutions are needed to be found because the demographic age-curve is increasing and more patients need to be cared for, despite decreased resources. The healthcare organization is a knowledge-intensive sector, where research makes new medical treatments possible continuously. High-tech medical tests are becoming more and more expensive, and thus these developments place ethical demands on the priorities in the healthcare organization. The healthcare system can perform at a level that is higher than what society can afford. The healthcare system has progressively become more and more specialized, and has consequently been organized in accordance with the different illnesses that are suffered by the

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[2] There is an on-going debate on what the concept 'pedagogy' should encompass. In the present thesis, I use the concept as it has been developed in the Northern European context (emanating from the German tradition) to place emphasis on the conditions (external and internal) that influence learning processes. In section 4.2, I present how I have interpreted 'pedagogy' in the context of quality improvement work in the provision of healthcare.

human body. Thirty years ago, it was common that a patient died with the first organ failure, for example, a cardiac arrest or lung cancer. Today, patients survive with problems in several organs at the same time, which makes coordination between specialists within a hospital all the more important, including coordination between hospitals, care centres, and homecare providers. Coordination, cooperation, and communication across organizational boundaries are necessary if patients are to receive the care that they need. Disease profiles can also rapidly change, given the increased mobility of populations. Global influenza epidemics, the evolution of multi-resistant bacteria, and the spread of Ebola in West Africa are examples of how today's healthcare systems need to be aware of, and be able to deal with, international threats of the spread of illnesses which were not as prevalent when populations were less mobile.

In contemporary healthcare systems, we are also more aware of patient service quality. Previously, it was expected that a patient would be politely thankful for the care that the medical experts provided, but today the patient's position of power has been highlighted, such that service, consent, and the ability to choose are important features that need to be taken into consideration. If our earlier image of the healthcare system was one of a meeting between a professional and a patient, for example, a meeting between a physician and a patient, we now find a whole team consisting of several professional roles and assignments which is tasked with providing the best possible care for the patient. Thus, it is not only the profile of the patients' different illnesses that has become more complex but also how we organize and coordinate the provision of care across different medical professions and specializations.

Improvement work within the healthcare system is consequently tasked to deal with reduced financial resources, increased patient numbers (who suffer from more serious illnesses), a changing medical knowledge base, access to (but not necessarily finances for) expensive technologies and medicines, individual patient's expectations with respect to cures and the reduction of pain, as well as high demands with respect to the delivery of service. Within the context of this thesis, *improvements* should not be interpreted in terms of improved diagnostics and treatment. Instead, it should be interpreted in its broadest sense, in terms of how we can create an evidence-based, safe, patient-centred, effective, accessible, and equitable provision of care for everyone who is in need of such care (cf. *God Vård*, Socialstyrelsen (The National Board of Health and Welfare), 2006).

1.2   Improvement work as pedagogical processes

Improvement work requires that the healthcare system be made more effective so that it is accessible to everyone who needs it, whilst the provision of care is practiced with the available knowledge and in a safe way in accordance with the patients' preferences. This entails that those individuals who are engaged in improvement work need to have professional knowledge about the local healthcare system. Of course, improvement work can be initiated by management or through national directives, but it is only healthcare staff who can translate such initiatives into practical work. To reduce healthcare-related infections, only the staff know which changes in routines need to be made, for example, where to locate the alcohol-gel disinfectant bottle so that it becomes second nature to wash one's hands before making contact with a patient. Since quality demands cover such wide areas within the organization, practitioners of different professions and medical specialists need to meet with each other so as to discuss that which creates added value for the patients from an overarching organizational perspective. During the course of improvement work, different professional perspectives are exchanged, where the participants develop an understanding of the others' work, the practices that they have in common, and one's own individual contribution. Improvement work can thus be understood as a *pedagogical* practice, where the participants develop socially, as well as in terms of their knowledge, via communication, reflection, and action (Johannessen, 1994). When staff members get together for the purpose of reflection over the way in which they work, then their common tacit knowledge can be made explicit, and thereby become foundational to engaging in improvement work that is based on a common understanding. An engagement in quality improvement work that is based on understanding promotes learning, so that practices can develop an autonomous ability to ensure readiness to new situations, whilst time is given for reflection and recovery.

My experience, however, suggests that there exists a somewhat naive attitude towards learning with respect to quality improvement in healthcare organizations. American proponents of improvement work describe learning as 'joyous', where learning is expected to be a positive and enriching experience (Nelson et al., 2007: 47). Critical organizational researchers, however, give warning of the charitable aspects of learning (Contu et al., 2003; Contu & Willmot, 2003). With their provocative article title, 'Against learning', these authors wish to highlight the fact that politicians exploit the positive connotations that are linked to learning in their effort to achieve higher levels of financial growth (Contu et al., 2003). Learning brings to the table something 'nice' which cannot reasonably be resisted:

'Learning' has appealing connotations resonant with motherhood and apple pie that make it difficult to question or refuse. (Grey, cited in Contu & Willmot, 2003: 293).

Of course, there exists a number of positive experiences that are associated with learning, but there also exists a crass economic reality which is often neglected in conversations about the 'joyous' learning experience. Arguments put forward within the area of critical organizational research, in conjunction with the quality improvement movement's naive attitude towards learning, have piqued my interest into studying what the actual situation is in practice: What comes to the fore and receives interpretive dominance in conversations about improvement? My research interest has thus a critical point of departure as I study the pedagogical conditions that exist in the improvement work undertaken within the healthcare system. The goal of this thesis is to reveal the prevailing pedagogical conditions so that they can be consciously modified, and so that a long-term and sustainable development of the healthcare organization can be supported.

1.3 Negotiations about change

The local negotiation about change as a condition with respect to the translation of knowledge in practice is well-documented (Greenhalgh et al., 2004). The local negotiation about change is thus central to all improvement work. This negotiation entails the dismantling of accepted routines so that something new can emerge, which will improve the situation. A change in one's practice is a challenge to the status quo. During a negotiation about change, we find forces that defend or challenge accepted ways of working. These forces can come to the fore for professional reasons, loyalty, organizational reasons, personal reasons, or simply because one sub-consciously holds on to the norms and culture that the working unit represents. These forces come to the surface in the arguments that the staff present in their negotiations about what should be done. In this thesis, these forces are described and classified as *external conditions* and *internal conditions*, respectively. The external conditions, for example, include political and financial management principles, overarching hierarchies that include professionals and specialists, the prevailing organizational culture, and social trends and norms which influence the staff members' discussions about change. The internal conditions are more relational in character and include the staff members' mutual interaction with each other, loyalties, social positioning, and claims to power. A discussion about change during a work meeting can thus be seen as a negotiation of different interests, where both systemic and relational conditions are present. In this thesis, local and

practically-orientated improvement work is studied as it emerges in these negotiations about change.

In the present study, a *discursive[3]* analytical framework has been used to study that which emerges in negotiations about change. This discourse analytical methodology allows one to analyze and explain how pedagogical conditions emerge and are made manifest in practice under the prevailing organizational conditions. During negotiations, a number of different claims and interpretations are made with respect to what needs to be improved. In this thesis, I use the term *interpretive dominance* to describe when a certain claim comes to the fore and receives legitimacy in the negotiation. What is of interest in this thesis and which deserves explanation from a critical perspective are the particular interpretations about improvements which emerge when the external and internal conditions become relevant to a healthcare practice. Using a point of departure that learning is based on communication (Dewey 1916/1997) entails that that which emerges in negotiations for change also becomes foundational for the learning that takes place. The use of a discourse analytical methodology to study learning and change in the context of improvement work in healthcare, is not a common research practice. However, there are studies that have applied this discursive approach to the study of learning and change in the context of education (Rogers, 2011).

1.4   Improvement practices in healthcare systems

In this thesis, the local and practical improvement work that is performed within a healthcare organization is called an *improvement practice*. With this term, I refer to the continual improvement work that takes place in this context, and not to a specific time-limited improvement project, for example. The practical improvement work that takes place within healthcare systems has been previously described as a *clinical microsystem* (Nelson et al, 2007; 2011). This is a description of the smallest functional unit within a healthcare system, where a meeting between the patient, the patient's family, and medical staff takes place and thereby creates value: "*Microsystems, the essential building block of the health-care system*" (Nelson et al., 2002: 474). These authors claim that the key to the future development of a healthcare system lies in the microsystem's ability to drive systematic improvement work forward. This model attempts to capture the complexity of the healthcare system by

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[3] In the present thesis, the term *discourse* refers to a particular way of speaking about and understanding the world around us (Winther-Jørgensen & Phillips, 2000). Discourse includes language (written and spoken), symbols, non-verbal communication (gestures, movements, facial expressions) and visual images (Chouliaraki & Fairclough, 1999: 38). The discourse analytical methodology is presented in detail in Chapter 5.

considering the microsystem as being embedded within additional organizational structures, called *mesosystems* and *macrosystems*. The mesosystem should be understood as an interconnected system of all the microsystems that the patient needs, for example, different units in a hospital. The macrosystem is the system that organizes the different microsystems and mesosystems, for example, a county council. If one applies this model to the One-Stop Breast Clinic, we observe that the healthcare process that existed before the introduction of this clinic consisted of several microsystems which patients had to visit in a linear order. This included visits to the mammography microsystem, then the care centre microsystem, then the oncology microsystem, and so forth, with referral times and waiting times between each visit. The time between a patient's first contact until a decision was given to the patient was 42 days. This delay was primarily due to the waiting times that existed between each visit to the specialists in the healthcare process (Rognes et al., 2011). All of these microsystems, taken together, formed the patient's mesosystem within the framework created by the Skåne healthcare region (the macrosystem). The One-Stop Breast Clinic, where all the specialists were gathered together in the same location, created a new microsystem which contained all of the parts of the previous mesosystem, and thus the patient had to visit the clinic only once. The waiting time between the patient's first contact and the clinic's decision was consequently reduced to 0 days.

The microsystem model is a tool that can be used in practical improvement work, but the model has not been further conceptualized to any great degree, and the pedagogical processes that take place have not been problematized; instead, these pedagogical processes are primarily described as 'joyous'. By studying the external and internal conditions that govern the pedagogical processes that take place in the improvement work, we can qualify the microsystem model in terms of pedagogical theory and empirical research. The external conditions place focus on how the healthcare system's governance principles influence learning in the improvement practice, whilst the internal conditions place focus on the social processes and the collective learning that simultaneously take place. It has been observed, both internationally and in Sweden, that coaching provides good local support for change (Godfrey, 2013). However, coaching, in terms of being a pedagogical support for long-term learning, has not been studied previously. If the conditions for human learning are studied, then the pedagogical foundations of such learning can be made conscious and modified for future development. According to Dewey (1922/2002), people need support if they are to stop their negative habits:

> *We may desire abolition of war, industrial justice, greater equality of opportunity for all. But no amount of preaching good will or the golden rule or cultivation of sentiments of love and equity will accomplish the results. There must be change in objective arrangements and institutions.*

We must work on the environment not merely on the hearts of men. To think otherwise is to suppose that flowers can be raised in a desert or motor cars run in a jungle. Both things can happen and without a miracle. But only by first changing the jungle and the desert. (Dewey, 1922/2002: 21–22).

The present thesis has a practical knowledge interest (Habermas, 1987a), which is directed towards supporting learning in improvement practices, so that the healthcare system can deliver effective care that creates value for its patients. The contribution made by this thesis is that it reveals the pedagogical conditions that improvement practices are subject to, so that these conditions can be later modified and thereby provide support for future long-term and sustainable improvements. The overarching research question in this thesis concerns the particular pedagogical conditions that emerge when one takes the external and internal conditions that are relevant to improvement practices into account.

1.5 Aim and research questions

The main aim of this thesis is to present an analysis and explanation of the pedagogical conditions that take place in improvement practices in a 2010s healthcare system. To achieve this aim, a discursive analytical framework was used by the researcher.

The object of study in this thesis addresses the conditions for learning, and consequently this thesis does not provide any answers with respect to what the staff members and the patients actually learned from the improvement work. Using a practical knowledge interest, my interest lies in revealing the conditions for learning; including external controlling conditions as well as internal social conditions for the improvement practice. If the conditions are made visible and are fed back into the practice, then the conditions can be more consciously dealt with so that habits and things that are taken-for-granted can be questioned and evaluated, instead of being reproduced without reflection. The practical knowledge interest of the thesis has a critical point of departure with respect to making visible that which is foundational to learning in an improvement practice in an early 21st century healthcare system.

To achieve this aim, four studies were designed with the following questions in mind:

- How are pedagogical aspects in the clinical microsystem framework presented?

- How do pedagogical conditions (external and internal) reveal themselves in the negotiation about change that takes place in an improvement practice?
- What identifies coaching as a pedagogical support for learning processes in improvement practices?

The research presented in this thesis was conducted within the framework of an interdisciplinary research project entitled *Bridging the Gaps* (BtG). The project addresses how improvement work can be used to reduce the gap between theory and practice, that is to say, how theoretical knowledge can be translated into practice. The present thesis does this by using a scientific pedagogical perspective, whilst other projects do this by using other scientific perspectives, for example, quality technology, informatics, or medical perspectives. In the BtG project, all of the empirical data collection was linked to the Jönköping's county council. The empirical studies reported on in this thesis are based on observations made at different healthcare units in Jönköping county. For Study II and Study III, observations were made of meetings at an orthopaedic and rheumatology clinic where improvements were discussed. The observations were made of a work meeting on a ward where nurses and assistant nurses primarily participated, and of a process team meeting where representatives from different healthcare units were present to discuss improvements in the care process that was provided to their patients. Specialist physicians, nurses, assistant nurses, physiotherapists, occupational therapists, ward coordinators, and one development manager took part in the process meeting. The empirical material in Study IV is based on the meetings of a group of improvement coaches who work at a development unit for Jönköping's county council. The coaches' reflections over their pedagogical approaches with respect to improvement practice forms the empirical data for Study IV.

1.6 Thesis organization

This thesis consists of eight chapters, followed by the original papers I-IV. The first chapter provides an introduction to what improvement work within the healthcare system comprises of, and an introduction to the research questions that are raised in the thesis. This chapter ends with a presentation of the aim of the thesis and the lines of enquiry that are followed in the thesis, and a summary contextualization of the empirical studies that are reported on in the thesis. Chapter 2 presents the ideas that are used to support improvement work and how financial management principles inform contemporary healthcare organizations. Chapter 3 addresses previous research on learning and change in healthcare systems, as well as how external and internal conditions for improvement work are highlighted. In Chapter 4, I

present the pedagogical theory which forms the basis of an understanding of improvement practices in the healthcare system in the early 21st century. Using the microsystem model as a point of departure, I consider an improvement practice to be a pedagogical practice where communication and negotiation are foundational to the learning that takes place. In Chapter 5, the pedagogical perspective is complemented with a discourse perspective where the improvement practice is also seen to be an instance of a discursive practice. Chapter 5 presents the ontological framework of the thesis, and provides a description of the discursive analytical framework together with the critical point of departure that is used in the thesis. Chapter 6 describes the context under which the thesis was written, as part of the *Bridging the Gaps* research project, and as part of an interactive research effort. In this chapter, I present a critique of the chosen methodology. I also present how I designed and conducted the studies so as to avoid critical pitfalls and to strengthen the validity of the claims that are made in the thesis. Chapter 6 ends with ethical considerations and a presentation of my role as a researcher. Chapter 7 presents the results of each of the individual studies, which are, in turn, discussed in Chapter 8 in terms of (i) how the market logic influences learning in an improvement practice, and (ii) how interpretive dominance takes place in an improvement practice and creates conditions for learning. Chapter 8 presents the theoretical, practical, and methodological implications that the thesis's conclusions give rise to. The thesis ends with a discussion of a number of methodological limitations, recommendations for further research, and some final reflections over the thesis's conclusions.

2 *'God Vård'* in the healthcare system of the early 21ˢᵗ century

The idea that improvement work leads to '*god vård*' ('good care') has entailed (i) an increased focus on the provision of care as a system with specific goals and processes, and (ii) an awareness that the way to achieve 'good care' is a social process which builds on the cooperation of the staff members and their internal motivational forces. Improvement work is being conducted at a time when healthcare organizations are subject to market adjustments and neo-liberal reforms, but also when performance-based financial rewards have been introduced based on the assumption it would make quality improvement work more effective. Such improvement practices also need to take into account governance- (external) and relational (internal) conditions with respect to the improvement work that is being conducted.

2.1 Ideas about improvement work

The multi-faceted problems that the healthcare system has to deal with put demands on an increased organizational capacity for change. There is the belief that improvement work will provide the key to a more flexible and 'self-learning' organization with an increased focus on its customers and greater responsibility for its fiscal management. Research in patient safety is also a motivating force behind the development of improvement work since the majority of the safety lapses in the provision of healthcare can be traced back to organizational failures, and not to the mistake(s) made by an individual (Kohn et al., 2000; Institute of Medicine, 2001).

Taking inspiration from the Institute of Medicine's (2001) parameters regarding quality in the healthcare system, the Swedish *God Vård* (GV) policy was developed (Socialstyrelsen, 2006). The name of this policy also became a collective name for the type of care that creates added value for the patient. The GV policy states that all of the activities that are conducted by the

healthcare system be evidence-based, effective, of a high quality, patient-centred, safe, accessible, and equitable. In 2011 the policy was strengthened with the stipulation that cooperation should not only include cooperation within a particular county council, but should include cooperation with healthcare providers who are located nearby, for example, with municipal care providers (Socialstyrelsen, 2011; SOSFS (The Board's administrative provisions and general advice), 2011:9). The policy emphasizes the fact that, to achieve good care, staff members need to complement their professional knowledge with knowledge of improvement. The policy also refers to Deming's model[4] of 'Profound Knowledge of Improvement' (Socialstyrelsen, 2006: 7). Batalden & Stoltz (1993) transposed Deming's ideas about knowledge of improvement into the context of the provision of healthcare, which is also quoted in the Swedish GV policy, as shown in Figure 1.

Figure 1. Knowledge of improvement complementing professional knowledge
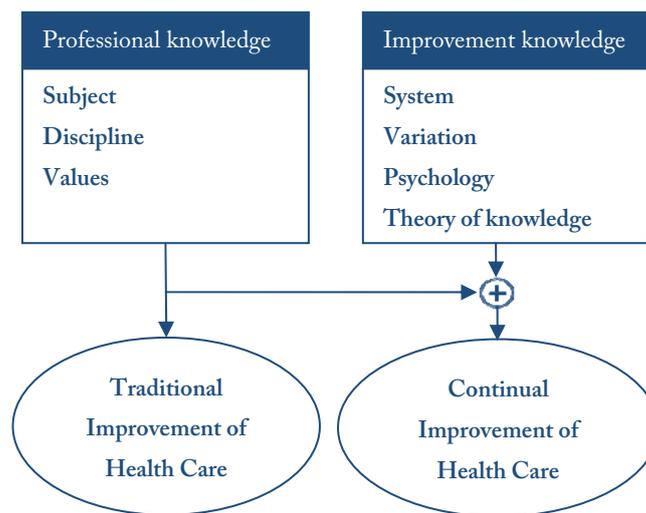
A description of how improvement knowledge needs to be complementary to the professional knowledge found in the healthcare system, so as to create improvements (Batalden & Stoltz, 1993:427, Figure 1).

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[4] W. Edwards Deming developed his ideas about systematic improvement work in the context of the manufacturing industry and service organizations. He has been acknowledged as making a significant contribution to the American economy. He is most famous for having developed the technical industries in Japan and thus contributed to Japan's development during the 1950s and 1960s.

Figure 1 shows that the established professional knowledge, which includes improvements with respect to forming diagnoses, and providing treatment and care, needs to be complemented with new knowledge which will systematically improve the patient's process of care within the healthcare system. This new knowledge includes knowledge of (i) the system, (ii) variation, (iii) psychology, and (iv) the theory of knowledge.

Deming (1994) states that the parts of an organization are mutually dependent on each other, and consequently, management must encourage interaction and cooperation between the different units within the organization. Deming (1994) also claims that *system-thinking* which is directed towards a unified goal creates financial profits and customer satisfaction with a business. So as to focus on the provision of healthcare *as a system*, the staff needs to be clear about why one does what one does (the goal), how one does what one does (mapping of the process), and how one can improve upon what one does (Batalden & Stoltz, 1993). The One-Stop Breast Clinic is an example of how concerned staff members got together and posed these questions and came up with the idea of forming a collective unit which functioned as a solution that created value for the patients from the patients' perspective, and not from the organization's perspective. These changes demanded cooperation between the different medical professions and different specialists, which created a space where learning took place, in addition to the social-economic gains that were enjoyed in terms of reduced waiting times (Rognes et al., 2011).

Figure 1 also shows that one needs to have knowledge of *variation*. This claim is founded on the need to be able to follow up and evaluate whether a change is an improvement (Langely et al, 1996). To show that the One-Stop Breast Clinic provided an overall benefit to the system, they had to measure and follow up on the waiting times in line with the with the costs so as to ensure that reduced waiting times did not cause other effects for the healthcare system as a whole. The motivational factors of the staff, or their *psychology* of change (see Figure 1), are important parts of the puzzle as one pushes forward with improvement work. Deming (1994) emphasizes the fact that improvement work needs to build on the staff's internal motivational factors, including their curiosity and their desire to create solutions that add value, and not on external motivational factors such as performance-related compensation, which is the logic behind 'Pay-for-Performance', for example (see Section 2.2.2). The idea behind systematic improvement work is to test the results of a change on a small scale and then evaluate the effects that this change has before one implements the change across the whole organization (Deming, 1994; Nelson et al., 2007). This is done in improvement work with help from the so-called 'PDSA-cycle' (Plan, Do, Study, Act) which is based both on the areas of action pedagogy (Dewey 1916/1997) and experiential

learning (Kolb, 1984). These points are included in the term *theory of knowledge* that appears in the figure above.

2.1.1   Ideas about improvement challenge traditional structures

By referencing Deming (1994), the GV policy (Socialstyrelsen, 2006) emphasizes both (i) an increased understanding of the healthcare organization as a system and as a business with specific goals, customer processes, and methods of evaluation, and (ii) an increased understanding of the fact that improvement work is a social process which is dependent on the staff's curiosity and willingness to improve in cooperation with each other, instead of competing with each other for rewards. GV thus emphasizes both the external and the internal conditions for improvement practices within the healthcare system. According to Nordgren (2004), the idea behind improvement work goes against the established, expert perspective that exists in the healthcare system which objectifies the patient: "*The physician was described as highly specialized and knowledgeable of the latest technology, whilst the patient was described as sick, ignorant, anxious, irresponsible, helpless, and weak.*" (Parsons, 1951 in Nordgren, 2004: 53). One of the founding fathers of improvement work in healthcare in the USA, Don Berwick[5], challenges this expert perspective by adopting a patient-centred perspective: "*They give me exactly the help I want (and need), exactly when I want (and need) it.*" (Berwick, 2001: 1257). Berwick's statement stands in contrast to the Latin meaning of the word *patior* ('patient') – 'suffer', 'bear', and 'endure'. In Berwick's perspective, it is the patient himself who defines what creates the most value, which is in harmony with early 21st century neo-liberal reforms with respect to the patient's right to choose a care provider and increased influence by the patient.

Improvement work also challenges the assumption that healthcare staff should only be engaged in the provision of care. Staff members are aware that they should work on their own professional development, but not with developing the organization. Critics claim that improvement work should be conducted by managers and administrative staff members, so that the professional medical staff can concentrate on working with their patients (Reinders, 2008). Proponents of quality improvements, however, define improvement work as if it were everyone's responsibility in every part of the system:

> *We propose defining it as the combined and unceasing efforts of everyone – health care professionals, patients and their families, researchers, payers, planners and educators – to make the changes that will lead to better patient outcomes (health), better system performance (care), and better professional development (learning). (Batalden & Davidoff, 2007: 2).*

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[5] Don Berwick and Paul Batalden are pioneers of quality improvement in healthcare and two of the founders of the Institute for Healthcare Improvement in Boston.

Everyone needs to be held responsible if the healthcare system is to be improved. System-thinking is a recurring theme in improvement work (Deming, 1994; Nelson et al., 2007). One goal is to make all of the mutual dependencies within the healthcare system visible and create chains of care provision that create value for the patient (cf. the One-Stop Breast Clinic). An attempt to describe the practical improvement work in relation to the healthcare organization as a whole has been done by the *clinical microsystem* model (Nelson et al., 2007; 2011). In the following section, I will highlight that which is characteristic of the early 21st century's healthcare organization and how certain controlling conditions create the prerequisites for the local and practical improvement work that is being performed.

2.2 New Public Management in correlation with neo-liberal governance

Against the historical background of the expansion of the healthcare system in the 1960s and 1970s, the 1980s were concerned with ideas of rationalization and closer management control with the aim of reducing costs and the size of the public sector (Anell, 2005; Hasselbladh et al., 2008). New Public Management (NPM), which consists mainly of decentralizing budget responsibilities, goal management, and following up on results, was introduced in stages as a management principle with the aim of controlling the costs incurred by the healthcare system. Since the 1980s, the healthcare system has also featured reforms which aim to strengthen the patient's position within the system (Nordgren, 2004). These reforms are based on the resurgence of neo-liberal thinking within society at large, whose fundamental view is that each individual has the ability and the right to decide what is best for that individual. Since 2010, the *Vårdgaranti* (*Care guarantee*)[6] and the right to choose one's care provider have been legal rights (SFS (Swedish Statute Book), 1982:763). The patient's right to choose a care provider is linked to how the care provider is reimbursed in terms of performance-based financing, which is an example of how NPM principles interact with the neo-liberal reforms. A care provision 'market'[7] is created where the patient influences how the care provider is reimbursed. It is thus important that each care provider

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[6] The Vårdgaranti (Care guarantee) states that the patient has the right to make contact with, visit, and a planned course of treatment from a care provider within a specified time-frame. If the county council cannot provide treatment within this time-frame, then the county council is obliged to offer care at a different county council whilst the first county council has to pay for the costs of such treatment.

[7] The Swedish healthcare system is publicly funded and regulated by Hälso- och sjukvårdslagen (The Health and Medical Services Act) and governed by 20 county councils and regions in Sweden. Since the Swedish healthcare system is publicly funded, the 'market' is referred to as an internal market model more than a free competitive market model (Norén & Ranerup, 2013).

attract as many patients to its services as possible. A recent evaluation, made by Riksrevisionsverket (The Swedish National Audit Office, RiR 2014:22), has however found that the reforms of free choice in primary care and the *Vårdgaranti*, has jeopardized the foundational healthcare principles of equal care for all and the priority of the most severely ill. The reforms have increased the contact opportunities with healthcare providers and increased the number of care centres. However, there are mainly patients with less care needs and patients with higher socio-economic status who have benefited from the reforms.

NPM principles has enjoyed great popularity in countries which have a strong public sector controlled healthcare system (for example, in Great Britain, Sweden, and New Zealand) in contrast to countries which do not have a centrally controlled public sector (for example, the USA) (Simonet, 2011). A review of the literature shows that England, but not the USA, has improved clinical results by subjecting care providers to competition (Health Foundation, 2011a). The literature review also showed a number of negative effects caused by NPM; competitive relationships, fragmentation of the healthcare system, reduced access, and resistance from staff members and patients. In Great Britain, the debate over NPM principles between the medical profession and management has been rigorous, especially the debate over the concept of the 'customer' (Harrison & Dowswell, 2008). Nordgren (2004) claims that a similar debate in Sweden took place when physicians, i.e. the profession which enjoys the highest level of autonomy, questioned the concept of the 'customer'. Hasselbladh et al. (2008) claim, however, that the debate in Sweden has not been as vigorous as it has been in Great Britain because of the Swedish population's trust in rationalization and the state's ability to find the best management alternatives. However, in light of the consequences the new healthcare 'market' and NPM have given rise to, the debate has become even more pronounced among Swedish physicians via, for example, 'läkaruppropet' ('physicians' call to arms') (Agerberg, October 2013).

The One-Stop Breast Clinic is an example of an improvement initiative which resulted in reduced waiting times, but without any increase in operating costs. The clinic's management were proud of being able to show these improvements, but when they noticed that other county councils could perform mammography tests at a lower price they decided to close the clinic down to the advantage for a more cost-effective part of that which previously formed a cohesive whole for the patient. NPM, as a financial management principle, gives healthcare companies the ability to decentralize and take control over who is responsible for financing, but we might ask what are the results of this in terms of that which creates value for patients? Or we might ask, as expressed in the introduction by Zaremba (2013), what do these changes result in in terms of 'female anxiety'?

2.2.1 Comparing regulatory frameworks

The patient's position within the system is further strengthened by the *Patientmaktsutredningen* ('Patients' power investigation') (SOU (Swedish Government Official Reports), 2013:2) which gave rise to the passing of a new law for patients in 2015. Besides confirming previously granted rights with respect to access to medical treatment, information, and participation in the care process, this law allows patients to look for healthcare anywhere in the country, instead of the previous restriction of being limited to using healthcare providers within his or her county. The healthcare 'market' has thus been broadened for the benefit of the patient's right to free choice. By increasing the level of patient influence and by applying NPM as a financial governance principle it is expected that the healthcare system will become more cost-effective and more customer-friendly. This will also open up a broader healthcare 'market' where care providers will compete against each other. These changes result in a shift of power over to the patients, who are expected to make some of those choices that were previously made by politicians and experts (Nordgren, 2004).

If one asks the patients what they think important quality aspects of a healthcare system are, they respond by identifying participation in the choice of treatment and continuity of treatment at the same care provider as related to the ability to choose their own care provider (Coulter, 2010). Swedish studies have shown, however, that individuals are interested in their free choice of care provider even though they are not particularly active in searching for information about their possible choices (Glenngård et al., 2011). Individuals tend to choose the care provider that they have had previous dealings with.

The free choice enjoyed by patients creates a new regulatory framework where the patient's individual rights set the norm (Hasselbladh et al., 2008). New national management practices are being developed which will guide, evaluate, and compare the performance of healthcare providers, including, for example, guidelines, performance indicators, and quality registers. These management practices are not compulsory in the sense that a healthcare provider is financially sanctioned if it decides not to participate in these practices, but no county council wants to be reported as being worst in class when the media reports on which county council provides the best healthcare (Blomberg & Waks, 2010). It is also thought that national guidelines, indicators, and quality registers will function as a resource which can be used to make more fact-based decisions in the knowledge-based management of the Swedish healthcare system (Sveriges kommuner och landsting (Swedish Association of Local Authorities and Regions), 2006). This comparative database also serves a purpose in enabling the population's free access to information which they

can use to make well-informed choices with respect to their care provider (Glenngård et al., 2011).

2.2.2   Pay for performance – money for achieving quality goals

To reinforce the county council's participation in the comparative management practices, performance-based payments are linked to the achievement of goals (described as quality indicators) or with registration with the national quality register. One nation-wide governmental initiative is the '*Bättre liv för sjuka äldre*' project ('A better life for the elderly and infirm') which has the purpose of providing a better, more coherent, provision of care for elderly patients who suffer from multiple illnesses (Sveriges kommuner och landsting, 2014). During the mandated period, between 2010 and 2014, the government spent 4.3 billion SEK on improving the provision of healthcare for the elderly. In accordance with NPM principles, the money was distributed to those municipalities and county councils which had achieved a specified number of registrations (within a specified time-frame) in a quality register or had achieved a number of selected quality indicators. In the second study included in this thesis, I report on registrations that were made in the *Senior Alert* register, where ward staff assess the risk of elderly patients falling, their risk of receiving inadequate nutrition, and their risk for pressure ulcers. The risk assessments were registered in the form of standardized reports, which makes it possible to measure, evaluate, and compare performances and thus distribute funding as it is deserved. This management initiative has been successful to the extent that county councils and care providers adapt to the financial incitements (Winblad, 2011). For example, Stockholm county council earned 50 million SEK in 2013 after changing the way it worked according to the national directive described in the 'Bättre liv för sjuka äldre' project.

The improvement project, 'Bättre liv för sjuka äldre', where compensation is controlled by performances that can be measured, is an example of what is called internationally a *Pay for Performance* project (P4P). During the 2010s, P4P has been considered to be an effective method in achieving improvements (de Bruin et al., 2011). Several things can be rewarded, including the performance of a specific work task, (the total number of registrations in a quality register, as in the example above), to more wide-ranging results in terms of reduced mortality figure, better health conditions, or increased patient satisfaction. The performance-based compensation is distributed in the form of a reward or is held back from the budget as punishment if goals are not achieved. In Sweden, we can find both local county council-based initiatives, where compensation is awarded to individual care providers, as well as national initiatives, where compensation is distributed to different county councils, as is deemed justified. In other countries, compensation may also be paid to individual healthcare practitioners.

2.3 An improvement practice in the 2010s healthcare organization

In this thesis, the concept 'improvement practice' is used to study the improvements that are enacted in the healthcare system. The concept has been constructed so as to include what is meant in this thesis by improvement work. An improvement practice should be understood as the local and on-going improvement work which is done by the healthcare staff in a specific practice. An improvement practice thus includes care work improvements in terms of routines and processes, and not the improved support processes, for example, human resources administrative processes, purchasing processes, or management processes. This does not exclude the fact that documentation or communication in terms of IT processes need to be improved upon in the provision of care. Neither does it exclude the fact that the patients are participants within the improvement practice, but the interaction between the healthcare staff and the patients is not the main interest in this thesis. This type of interaction has been studied by others (see Kvarnström, 2011).

The improvements that an improvement practice discusses should also not be interpreted in terms of diagnostics and medical treatments. The ward staff does not meet as a team to make decisions about treatments, instead, they meet together so that they can use their knowledge and areas of responsibility to develop an evidence-based, safe, patient-centred, effective, accessible, and equal care for everyone who needs it (cf. *God Vård*, Socialstyrelsen, 2006).

The concept of 'improvement practice', allows us to study a healthcare practice and its continual improvement work, as it is carried out in an existing organization. Weick (2009) describes the continual improvement work as 'emergent change'. Emergent change does not refer to a great paradigmatic shift, instead, it refers to process-directed and cumulative change where routines are modified step-by-step in a chain of small inconspicuous changes, which, taken together, create a difference. Weick (2009) contrasts 'emergent change' with 'planned change', which is initiated by a project, is episodic, and is a strategic change which is often led by external consultants.

'Improvement practice' includes that which Weick (2009) calls 'emergent change' and not the improvement work that is performed in specific, time-limited projects (planned change). The practical knowledge interest in this thesis attempts to increase our understanding and knowledge of how continual and every-day improvement work can be supported so as to achieve long-term and sustainable improvements in a healthcare organization. Consequently, the empirical cases reported on in this thesis are chosen with respect to the improvement work that is conducted at ordinary wards and established networks in an existing organization.

Weick (2009) claims that emergent change is based on "*innovative sense-making on the frontline*" (2009: 229), where "*people (1) stay in motion, (2) have a direction, (3) look closely and update often, and (4) converse candidly*" (2009: 235). Planned change enjoys an advantage in that it captures one's attention and is focused on a single goal, whilst emergent change creates a self-sustaining ability to adapt to practices which promotes learning and understanding, as well as the ability to mobilize the tacit knowledge that exists within a practice. Communication in improvement work is thus central and a condition for learning and understanding (Weick, 2009), which is also true for improvement practices in a healthcare system. A disadvantage of emergent change is that small changes do not give rise to distinct results, and is limited by its culture (ibid.), thus it is of importance to also study the internal conditions which govern an improvement practice.

2.4   Summary in relation to the aims of the thesis

The healthcare system of the 2010s has been characterized by a shift in power towards the patient, which has been aided by financial management principles. The funding that is given to care providers is dependent on the choices made by patients in a competitive healthcare 'market'. Quality development is accelerated by managing improvement work by using performance-based funding which care providers have to compete for. At the same time, the GV policy argues for the need for cooperation across care providers so as to increase patient safety within the healthcare system (SOSFS 2011:9). These management principles entail that care providers compete *against* each other for performance-related funding, whilst, at the same time, they have to cooperate *with* each other to ensure that the healthcare system remains coordinated. How is this seeming contradiction realized in practice and which values are associated to the concept of 'quality'? Can different values (economic, social, and medical) be balanced against each other and integrated with each other, as suggested by the GV policy, or are certain values pushed to the fore, this resultant suppression of other values? One claim that is made in this thesis is that improvement work should be aimed at long-term and sustainable improvements by developing cost-effective solutions for the healthcare organization as well as meaningful solutions for the patients. This is what the One-Stop Breast Clinic example did. The thesis attempts to analyze and explain the pedagogical conditions that take place in improvement work in the light of the conditions that exist in the 2010s healthcare system. What is in focus in this thesis is how ideas about improvement are realized in practice, in the context of prevailing conditions within the healthcare system. The external conditions include the financial management principles that are currently implemented, and the internal conditions include the coordination

and social interactions that take place during improvement work. The next chapter describes previous studies of the internal and external conditions as they are linked to learning and change in the healthcare organization. This is done to form a point of departure where we can build and elaborate upon previous knowledge but also to identify that which has not been previously studied so that this thesis can contribute with new knowledge about improvement work in a healthcare system.

3 Learning and change in a healthcare organization in the 2010s

Current research on learning and change[8] in healthcare systems touches on several scientific areas of investigation. Consequently, the following presentation is based on a broad literature search of the links between improvement work and its external and internal conditions.[9] The state of current research is organized and presented based on the central questions that are raised in this thesis, irrespective of the particular research area that the knowledge represents.

There exists clear evidence that local, social negotiation is key to the translation of new knowledge and change in practice. The external and internal conditions of improvement work have not been studied much, and neither have the long-term effects of improvement work. Despite the fact that P4P leads to unintended consequences, and that there is no evidence for its effectiveness, the P4P program has been widely adopted. Furthermore, there exists ambiguous evidence for the claim that learning and change is supported by homogenous or heterogeneous groups.

3.1 Knowledge translation and context

Researchers who have implemented evidence-based guidelines, have, over time, come to realize that, besides individual adaptations, organizational

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[8] A literature review was also performed so as to investigate how the thesis's discursive analytical framework has been used previously within the area of healthcare in connection with improvement work. This review is presented in section 6.3.

[9] In February and March of 2012, the following databases were searched: Medline, CINAHL, ERIC, Academic Search Elite, and Business Source Premier. The following keywords were used in the search: 'quality improvement', 'learning theories', 'learning methods', 'workplace learning', 'organizational learning', 'knowledge management', 'negotiation', 'health planning', 'privatization', 'new public management', 'healthcare reform', and 'pay for performance'. In addition to this, a systematic literature review was made using the Health Foundation's research overview (July, 2012). Based on these systematic searches, references were identified and studied in close detail.

change is needed (Grimshaw et al., 2004). The guidelines are locally negotiated where their content is discussed, questioned, and re-formulated in terms of what is most meaningful to the local practice (Ferlie et al., 2001). This negotiation opens up a space for social positioning and power struggles, when the contents of the guidelines are to be adapted to the local context and local priorities. This entails that the contents of the guidelines are stretched and adapted to such an extent that, in the end, the guidelines are in danger of not agreeing with the original, research-based, intention. It is the interaction between the guideline's contents and the context which decides their final use (Greenhalgh et al., 2004).[10] Organizations which have the capacity to create a forum for local negotiations, that is to say, the capacity to integrate guidelines with its own base of tacit knowledge, find it easier to accept new knowledge and innovations. The spread of knowledge throughout an organization is not an objective phenomenon or something granted, it is socially constructed by the participants within the organization (ibid.). The spread of knowledge should be seen as a process which includes continual negotiation and questioning, and not just an isolated event. Organizations which have established inter-professional networks where such negotiation can take place find it easier to exchange knowledge, if social power struggles can be overcome.

The longevity of improvements that are implemented has not been sufficiently studied (Greengalgh et al., 2004). Furthermore, future research should clarify the context better. Most studies consider the context as some kind of parallel phenomenon with respect to the intervention that is under investigation, and not something that is an integrated part of the actual change (ibid.). Improvement studies should focus on describing the intervention and the context as well as possible mechanisms by which an intervention is implemented so that the results of an improvement can be spread to other practices (Øvretveit, 2011). Bate (2014) claims that a distinction between an inner context (the close intra-organizational environment at the micro-level) and the outer context (the social and political macro-level) seems to be sustainable over time.[11] In this thesis, the external and the internal conditions which exist in an improvement work in a healthcare organization in the 2010s

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[10] Two large-scale literature overviews were published in 2004-2005, each with a slightly different focus. Fixsen et al. (2005) focused on research on implementation in businesses, including healthcare organizations, whilst Greenhalgh et al. (2004) focused on the spread of knowledge and innovation within healthcare organizations. I have chosen to use the second study because it specifically concerns healthcare organizations and includes a broader discussion on different views about the spread of knowledge within an organization.

[11] Pettigrew (1985) first made the distinction between the inner and the outer context based on studies within the chemical industry. In a later literature overview of research on improvement work within healthcare organizations, this same distinction with respect to context was found (Damschroder et al., 2009).

are studied. These conditions are what Bate (2014) calls the inner and the outer contexts. This thesis's focus on learning captures the required long-term perspective on improvement work, which is otherwise easily lost when improvement projects prioritize the evaluation of the technical results of a project.

Knowledge management research was studied so as to establish how internal and external conditions influence the spread of knowledge within a healthcare organization. Several studies claim that learning and change is more easily effected within individual units (where the staff members know each other well and work with the same type of patients) than between units where the tension between different groups of professionals and specialists is greater (Ferlie et al., 2005; Tagliaventi & Mattarelli, 2006; Nicolini et al., 2008; Oborn & Dawson, 2010). Purely hypothetically, it is easy to assume that such similarities facilitate learning thanks to fewer conflicts. Similarities most likely cause the staff members to ascribe the same meaning to what is said, that is to say, they interpret things in the same way. However, inter-subjective theories about learning claim that it is by meeting others that one's understanding is tested (Dewey, 1916/2009; Taylor, 1971; Gadamer, 1975/2004). Such theories claim that being confronted with that which is 'different' supports learning. A discourse perspective has been adopted in this thesis (see Chapter 5) with the intent to investigate how 'similarities' and 'differences' are realized in negotiations for change.

Performance-based compensation and budget limits, examples of external conditions, can prevent learning and change in a healthcare organization (Currie & Suhomlinova, 2006; Addicott et al., 2007; 2010). For example, it has been difficult to establish the cancer network in London and to exchange knowledge about its services because of the hospitals' competition for common resources (Addicott et al., 2010). Thus, phenomena which overcome organizational obstacles have been studied. *Individual brokering*, individuals whose professional function is to belong to several organizational units, can work as natural disseminators of knowledge (Tagliaventi & Mattarelli, 2006). Note too that common rules, a common language, or even common professional tools (IT-systems, protocols, checklists) have been shown to facilitate the exchange of knowledge within healthcare organizations. (Oborn & Dawson, 2010). On the other hand, overloading, organizational chaos, a lack of routines, poor communication, and fragmented care providers prevent learning taking place within an organization (Knox et al., 2001). By classifying the prerequisites for improvement practices into external and internal conditions, this thesis provides support for dealing with obstacles and possibilities for learning at the correct level within an organization.

3.2 Social change in quality improvements

Studies on improvement work tend to prioritize the evaluation of the technical interventions that were made, and give scant explanation of the social changes which take place at the same time (Dixon-Woods, 2014). This entails that it is difficult to replicate successful improvement work in different contexts. It is important to collect knowledge of '*what works for whom, in what circumstances, in what respects and how*' (Pawson & Tilly, 2005: 21). The social changes and the interaction between the context and the intervention are just as important, claim Dixon-Woods (2014), who provide an analogy with cancer research:

> *Modern clinical science is now as much concerned with what bodies do to drugs (the impact of context on intervention) as it is with what drugs do to bodies (the impact of interventions on specific contexts). (Dixon-Woods (2014: 92).*

Researchers with backgrounds in the social sciences conducted an 'ex post theory' of a successful quality improvement program once it was completed (Dixon-Woods et al., 2011). An improvement work, *The Michigan Project*, was studied (Pronovost et al., 2006; 2010). This project included over a hundred intensive care units in the state of Michigan. These units were tasked to reduce the number of central venous catheter bloodstream infections (CVC-BSIs) by using evidence-based guidelines.[12] At first glance it may seem that *The Michigan Project* entailed that the staff were to use a checklist for the insertion of a CVC. However, it was *how* the checklist was used that gave rise to the improved results (Dixon-Woods et al., 2011). The researchers showed how the content of the intervention (the checklist) was gradually negotiated by the different intensive care units. The project stuck with the checklist as a principle, but how it was adopted could be modified at the local level. The correct way of administering a CVC was established via research and all of the staff members were educated in its use. All of the necessary equipment was in place and was visible to the staff member. Consequently, it was a failure in the staff members' behaviour and so the problem could be gradually re-formulated as a social problem, and not a technical problem. This allowed for specific preventative measures to be established for the delivery of better treatment. The researchers summarize the social intervention in terms of the time that was given to allow for the re-formulation of social norms, for the benefit of a better practice. This conclusion is in agreement with other research on the translation of knowledge where the effect of local (re-) negotiation is taken into consideration (Greenhalgh et al., 2004). By explaining in detail how the social intervention mentioned above was gradually formulated in their article,

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[12] The average for CVC-BSIs (per 1000 catheter-days) dropped from 7.7 to 2.3 in three months, and to a low of 1.4 after 18 months, which was also the case at the 36-month evaluation.

'Explaining Michigan', Dixon-Woods et al., (2011) have made it possible for other countries to replicate this project (Bion et al., 2013).

3.3 Networks and coaching as support for improvement work

One of the reasons why the Michigan Project was successful was because a number of networks were established between the participants in the intensive care units (Dixon-Woods et al., 2011). The literature shows that there exist different types of network which can support improvement work. For example, we find networks which are formed for the duration of time-limited projects, so-called 'Quality Collaboratives' (Øvretveit et al., 2002; Schouten et al., 2008); formal regional networks which support a particular type of care, for example NHS cancer networks (Addicott et al., 2007; 2010); or more spontaneous networks which are formed for a specific purpose (Bate et al, 2004). The last type of informal network is called a 'social movement' because it relies on the staff members' own motivation instead of a directive from management. This is a type of 'grass-roots' movement, similar to the One-Stop Breast Clinic initiative:

> *Particularly prominent is the recognition that such large scale change in organisations relies not only on the 'external drivers' but on the ability to connect with and mobilise people's own 'internal' energies and drivers for change, thus creating a 'bottom up' locally led 'grass roots' movement for improvement and change. (Bate et al., 2004: 62).*

Within an organization, different tasks and assignments compete for the staff members' attention, which makes problem-solving more difficult within a specific improvement work. Networks thus have a unique ability to support improvement work because the participants can focus on a specific problem (Health Foundation, 2014). Staff members from different organizations and disciplines can get together under more equal conditions where they are relieved from competing work assignments and conflicts which are created by linear hierarchical structures (Health Foundation, 2014: 5). However, other studies have shown that conflicts and competition frequently appear in cooperative networks (Ferlie et al., 2005; Addicott et al., 2010). The current state of research in this area shows ambiguous results. However, the fundamental question, (see section 3.1) with respect to whether *similarity* or *differences* promotes learning, remains. This thesis contributes to this area with a new discourse perspective on the question of whether *similarity* or *differences* promote negotiations about change.

The networks that are most frequently studied are 'Quality Collaboratives' (QC), which are widely spread across different countries (Schouten et al., 2008). In Sweden, such networks are associated with the IHI's[13] 'breakthrough model'. The breakthrough model has been used in several areas, including access to medical services, psychiatry, and patient safety (Sveriges kommuner och landsting, 2014). Despite its widespread use, it has been difficult to evaluate QC because of the different forms that it takes (Schouten et al., 2008; Hulscher et al., 2009). An overview of the literature from 2008 does, however, show that QC has some positive effect despite the fact that its effects within a particular project cannot be predicted (Hulscher et al., 2009). QC builds on the principle that several development teams hold meetings under a project leader so that they can exchange their experiences with each other. The project management has access to a group of experts who know more about the evidence-based content of the proposed change. QC has been criticized for being an expensive way of designing improvement work because it demands a great deal of travelling for the participants to meet with each other and learn from each other. This has given rise to a study of the different forms that QC can take (Gustafson et al., 2013).[14] The hypothesis was that the more support that was provided, the better the results. However, the result showed that only coaching was as effective, and was more cost-effective, than the other forms. Consequently, coaching has become a more considered way of supporting improvement work in the healthcare system (Gustafson et al., 2013; Godfrey, 2013). The most successful feature of coaching is its ability to 'tailor' the content of the proposed change so that it fits the local context (Schneider et al., 2012; Gustafson et al., 2013). One question that arises is whether, in one's pursuit of tailor-making a change, such a change also includes the long-term effects that Greenhalgh et al. (2004) demand. This thesis includes a study of how coaches' pedagogical position is revealed in the context of the external and internal conditions which prevail with respect to their improvement practices.

3.4 Money for quality goals and its unintended consequences

The P4P-program is based on the assumption that external rewards will increase a staff member's level of motivation to change the way that they work (Mehrotra et al., 2010). P4P is not designed to be aimed at a learning organization in any particular way; instead, it is used to achieve a pre-defined pattern of behaviour which is expected to promote better care for the patient.

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[13] Institute for Healthcare Improvement, Boston.
[14] Alternatives included (i) monthly telephone conferences, (ii) coaching, (iii) learning seminars, and (iv) a combination of the above-mentioned forms.

There exist empirical studies that show that the P4P model is effective from a costs and goal-achievement point of view (Kelman & Friedman, 2009). But other studies have shown that is does not have the desired effect because of cultural resistance (McDonald et al., 2009; de Bruin et al., 2011). It is not possible to claim that P4P is generally effective because the structure of the program and the context of its implementation are deciding factors with respect to any eventual outcomes (McDonald et al., 2009; de Bruin et al., 2011). Empirical studies have also shown that the P4P model can bring about a number of unintended consequences (Mannion & Braithwaite, 2012). Performance-based compensation can only be awarded for work performances that are measurable, which may lead to displacement effects with respect to work performances that do not as readily lend themselves to measurement. Furthermore, P4P often excels at providing short-term effects, such that care providers aim at achieving short-term goals so that the measurements themselves become the goal of the operation (ibid.). When care providers compete with each other, the healthcare system becomes fragmented and communication and cooperation between care providers is disrupted (Deming, 1994; Allen, 2009; Shortell & McCurdy, 2009), as shown in the cancer network in London (Addicott et al., 2010). Other unintended consequences are false reporting (Mannion & Braithwaite, 2012), or *cream-skimming* (Winblad, 2011). This can happen when, in a follow-up report, one excludes patients which pull one's results down, or when a care provider markets itself to groups of patients who are not as costly to treat (McMahon et al., 2007; Reinders, 2008). Such 'cheating' is not always intentional. In the context of a particular project, researchers were able to show that the process by which data was measured and collected was subjective and open to interpretation:

> *Variability arose not because of wily workers deliberately concealing, obscuring, or deceiving but because counting was as much a social practice as a technical practice. (Dixon-Woods et al., 2012: 548-549).*

Current research on the P4P model shows no link to learning within improvement practices, despite the fact that other social phenomena have been described. For example, staff members who perform below standard have been bullied (Mannion & Braithwaite, 2012). The staff's morale and trust decreases in the care providers which perform poorly, which entails in worsening provision of care (ibid.). There are also a number of studies on how P4P and NPM have influenced the profession. Critics of P4P claim that P4P removes the staff's professional sense of responsibility (Berwick, 1995; Reinders, 2008; Gorman & Thompson, 2011; Solbrekke & Englund, 2011). Reinders claims that "*professionals who serve economic goals tend to become technicians rather than true professionals*" (2008: 635). One study investigated how the terms *management accounting* and *medical profession* are used and are discussed in the news media and professional journals in Denmark (Malmmose, 2014). The

result of the study showed that there was an absence of the medical profession and that the language of economics and its terms had been admitted to and integrated with the language of medicine. The author argues that this demonstrates a tendency towards commodification of the language of medicine such that medical ethics are pushed to the side. Malmmose (2014) states that this is an example of how NPM principles grant privileges to certain interests, at the cost of other interests, which was not the original intention. Study II shows examples of the same type of displacement effect as shown in Malmmose's results.

The majority of studies which investigate the tension between management incitements and professionalization efforts have focused on physicians (Blomgren, 2003). Blomgren broadens the debate by showing empirically that nurses has a double-edged interest in the new economic principles as shown by their different professional roles. Nurses who are engaged in providing care are threatened by the new economic principles since providing care is not interpreted as something of value when patients are treated as financial incitements. Nurses in the role of administrative managers, however, see the possibility of raising their status with respect to the physicians by organizing and controlling the finances and effectiveness of the ward.

One question that is addressed in this thesis is: How does P4P influence learning? In Study II, I investigate that which is expressed in conversations about change when money is attached to quality goals. In Study IV, I investigate how coaches' pedagogical methods are influenced when money can be potentially paid out for performance results.

3.5 Summary in relation to the aims of the thesis

As a whole, previous research highlights the importance of understanding the interaction between context (outer and inner context), the content of the proposed change, and how the process of change is designed socially and technically (Greenhalgh et al., 2004; Dixon-Woods et al., 2011; Bate, 2014). Previous research also displays different scientific views on how context can be understood. The most traditional way of understanding context emanates from a positivistic tradition that perceives context as the environment of quality improvements: "*Context is everything that is not a quality improvement (QI) – it is the 'environment' within which a quality improvement is carried out.*" (Øvretveit, 2014: 61). An emerging perception, emanating from a social constructionist tradition, apprehends context as a social process where local (re-)negotiations play a central function (Greenhalgh et al., 2004; Bate, 2014; Dixon-Woods, 2014). 'Explaining Michigan' was a ground-breaking study in that it used a sociological point of departure to explain the social processes that

are operative in change. However, none of the studies focused on how the tension between external and internal conditions is realized when local negotiations about change take place. Neither have these studies used a pedagogical point of departure. The issue of learning remains unquestioned, but instead, is taken for granted, even when social processes are in focus. Furthermore, research has identified a number of unintended consequences with the use of P4P (Mannion & Braithwaite, 2012), without specifying these consequences in terms of learning. Finally, the long-term effects of improvement work have not attracted much attention in the literature (Greenhalgh et al., 2004).

Using a pedagogical point of departure, I interpret the wished-for long-term benefits as the potential of an improvement practice to integrate learning in the improvement work. This pedagogical point of departure can support the sociological point of departure by employing Dewey's (1916/1997) view of learning as communication. This thesis bases itself on previous research by claiming that local negotiations are central to all improvement work. Using Dewey's view of learning as communication, this thesis presents an analysis of that which is expressed in negotiations about change. That which comes to the fore during the negotiations forms the basis for the learning that takes place in the improvement practice. How are these negotiations realized in the light of the prevailing external and internal conditions?

The literature primarily related the context to a specific intervention which is to be implemented in the business, for example, Øvretveit (2011). The thesis does not study a specific intervention; instead, it focuses on the continual improvement work which takes place in today's improvement practices. This includes a more continuous and on-going perspective on quality improvement work in contrast with that which has been previously studied, where the context, during a limited time period, is investigated so as to see how it influences a particular intervention. In my study of continuous improvement work, I have used observations to collect data, which, according to Bate (2014) and Baker (2011), provides in-depth explanations of what takes place in practice. Qualitative research which uses such a methodology to explain the interaction between inner and outer organizational conditions is much sought-after (Bate, 2014).

Observing that which is expressed in local negotiations about change and using a discourse analytical methodology to analyze and explain the external and internal conditions for the negotiation, my ambition is to qualify the field of knowledge known as *improvement science*[15] with knowledge about the

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[15] *Improvement science* is a scientific area of study which is currently being established, and, as a consequence of this, there exists not commonly accepted definition of the term, but it refers the

prevailing pedagogical conditions that exist in improvement practices in the healthcare system. This pedagogical point of departure is needed since collective learning is important to the ethical commitment to create better provision of care at a lower cost so as to improve the general health of the population (Marshall et al., 2013). The pedagogical point of departure that is used in this thesis contributes to this project by revealing how learning is expressed and is influenced by prevailing conditions. With increased knowledge of how learning takes place in continual improvement work, we can consciously support this learning from a governance perspective as well as a local, practical perspective, so as to achieve long-term and sustainable improvements in the healthcare system.

The contribution that is made by this thesis to the scientific field of pedagogy is presented within the framework of learning in one's working life. Ellström et al., (2005) claim that pedagogical research in the area of working life can broaden the development of knowledge about learning as a part of people's everyday life in relation to learning that takes place within the framework of formal educational institutes:

> On a general pedagogical and theoretical level, it can contribute to a further development of the general understanding of the human knowledge building and its contextual conditions, and thus even contribute to the development of fundamental theories in the area of pedagogy in general. (Ellström et al., 2013: 174).[16]

The contribution made by this thesis to the field of pedagogy includes a discussion of how learning at the workplace is influenced by prevailing external and internal conditions in the 2010s. The neo-liberal thinking that characterizes today's healthcare system is not unique to healthcare organizations. Analogous to the patient's free right to choice of care provider, we note that financing follows a student's choice of school and university, which also has consequences for the improvement practices that are engaged upon in these institutions (Fanghanel, 2012). The next chapter reports on what characterizes learning and negotiation in an improvement practice in a healthcare system.

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investigation of the methods that are used in improvement work (Marshall et al., 2013: Health Foundation, 2011b). Some common points of departure include: (i) research is influenced by pragmatic thinking, where practical benefits are emphasized (Marshall et al., 2013: Perla et al., 2013); (ii) the production of knowledge is characterized by close cooperation with practices (Marshall et al, 2013); and (iii) the area of study builds on Deming's System of Profound Knowledge model, which claims that the natural sciences and social sciences need to be integrated so as to develop knowledge (Perla et al., 2013).

[16] Translated by the author.

4 A theory of pedagogy as a point of departure for an improvement practice in healthcare

The study of the pedagogical conditions that are relevant to an improvement practice in this thesis is based on pedagogical theory which describes that which characterizes learning in such a practice. The object of study includes practical improvement work in a healthcare system, as described by the microsystem model. At the level of the microsystem, the meeting between the patient, the patient's family, and the staff members creates value. The model places focus on how this meeting is embedded within a larger system as well as the interactions which take place within the microsystem. Pedagogical theory reveals that the microsystem is a practice which is influenced by these individuals, their interaction with each other, and the cultures that the practice is part of, both on a local level and at a more institutional level. In an improvement practice, the staff negotiate with each other whether it is worth changing current routines or whether routines should remain the way they are. The negotiations are thus the communicative foundations for the learning and the social integration that takes place simultaneously.

4.1 The clinical microsystem: a model of practical improvement work in a healthcare system

The *clinical microsystem* (CMS) is an empirically based description of the smallest functional unit within the healthcare system (Nelson et al., 2007; 2011). Proponents of this model claim that the key to development within a healthcare system lies in the microsystem's ability to conduct systematic improvement work: "*Ultimately the outcomes of the macrosystems can be no better*

than the microsystems of which it is composed." (Nelson et al., 2002: 474).[17] In a complex healthcare organization, it is not obvious which system is the most basic system. The patients and their health profiles present a complexity that is difficult to capture in a simple linear process. By using the microsystem model, the medical staff can identify who their patients are, what needs and expectations the patients have, which members of staff are involved in their care, which processes need to be mapped, and what goals they are aiming at. By becoming conscious of the limits of one's microsystem, creates better conditions for the staff members to engage in systematic improvement work. The microsystem model can thus be considered to be a strategy that can be used to apply improvement work in practice.

The following excerpt provides a definition of a microsystem:

> *A health care clinical microsystem is a small group of people (including health professionals and care-receiving patients and their families) who work together in a defined setting on a regular basis (or as needed) to create care for discrete subpopulations of patients. As a functioning unit it has clinical and business aims, linked processes, a shared information and technology environment, and produces care and services that can be measured as performance outcomes. The clinical microsystem evolves over time and is often embedded in larger systems or organizations. As a living, complex, adaptive system, the microsystem has many functions, which include (1) to do the work associated with core aims, (2) to meet member needs, and (3) to maintain itself over time as a functioning clinical unit. (Nelson et al., 2011: 3-4).*

By including the system's patients and family members and its IT-system, processes and goals, the model places focus on the provision of care as a system and not only as performance of an individual work team. The definition also highlights the fact that the microsystem is a healthcare business in miniature, which is governed by *business aims* and *performance outcomes*. The model also emphasizes the staff members' mutual dependencies (Batalden et al., 2003). This entails that the model includes its own position as embedded within a larger governing system. Figure 2 illustrates how one can understand

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[17] These writers were inspired by Brian Quinn's (1992) research on successful service organizations during the 1980s, including Fed-Ex, McDonalds, and SAS. These companies organized themselves into small 'frontline' units where the customer's individual needs and the company's central competencies meet in a continual creation and re-structuring of the services that were provided. Quinn called these units 'the smallest replicable units', which have been translated to 'microsystems' in the clinical microsystem model (Nelson et al., 2007). These authors appropriated this term in the light of their studies of well-performing healthcare systems in the USA. One factor that contributed to the success of these healthcare systems was the small clinical teams which were allowed to take the lead and design care which satisfied their patient's needs in the best possible way.

a microsystem as it relates to the patient and how it is embedded within larger meso- and macrosystems (Nelson et al., 2011).

Figure 2. How the microsystem is embedded within a healthcare system
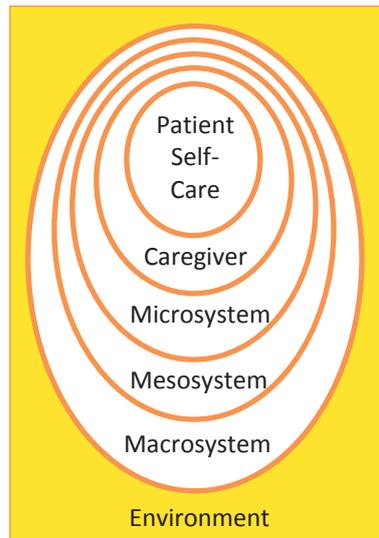
An illustration of how the microsystem relates to the patient and the patient's environment within a healthcare organization (Nelson et al., 2011: 7 (Figure 1.4)).

The mesosystem should be understood as a connected system which consists of all the microsystems that a patient is in need of, for example, different units in a hospital. The macrosystem is the system that organizes the different micro- and mesosystems together, for example, a county council.

4.1.1 The lack of pedagogical perspective in the microsystem model

The microsystem model is an empirically based model and is a way of engaging in practical improvement work in a healthcare system. The model has not undergone any significant conceptualization, but researchers do describe how different scientific areas of enquiry can explain the microsystem's function (Batalden et al., 2005). The metaphor of a lens has been invoked to describe the microsystem's function, including sociological, political, economic, biological, anthropological, psychological, mechanical/physical, and informative 'lenses'. These authors have not mentioned a pedagogical lens, despite the fact that learning is often mentioned, as a particularly pleasant part

of the improvement work: "*Making the work experience for staff meaningful and joyous through their learning to work in an interdisciplinary manner to design and provide patient-centered care*" (Nelson et al., 2007: 47). Learning processes are not problematized. Instead, they are taken for granted, as a pleasant way to socialize with one's colleagues. The microsystem model primarily emphasizes the need to identify and delimit one's microsystem as a starting point for further improvement work. There exists no clear distinction between doing the job, or reflecting about the job.

Despite the fact that the model is described in terms of being embedded within larger meso- and macro-perspectives, that which influences the system (in this thesis the external and internal conditions) in terms of learning is not problematized in other studies. The present thesis can make a contribution by qualifying the microsystem model with a pedagogical perspective which critically interrogates the learning processes that take place in an improvement practice. In the first study, the conceptual framework that is associated with the microsystem is investigated so as to clarify these pedagogical aspects and use them as basis for the empirical studies that followed Study I.

4.2 A pedagogical practice

So as to broaden the microsystem model's *learning perspective* so that it includes a *pedagogical perspective*, we turn to a pedagogical theory which is grounded on critical theory as formulated, primarily, by Fritzell (1996). Fritzell states that a practice cannot be studied independent from the conditions that govern the practice. A 'split vision' is needed to take note of the external and the internal conditions with respect to the processes that take place within the practice. A practice's pedagogical processes do not just consist of learning, but also a simultaneous social integration and a cultural reconstruction of the practice:

> [I]t seems fruitful to apprehend pedagogical practice as three interrelated processes or action frameworks. First, there is learning as activity and individual function, taken in its broadest meaning, including personality and identity formation. Second, there is social integration as the coordination of persons and their activities in society; learning and social integration are thus to be seen as inherently related in pedagogical practice, structurally constituting and conditioning each other. Third, there is cultural reconstruction manifested in the contents pursued by the participants in their work with particular cognitive-instrumental, moral-practical, and aesthetic-expressive standpoints and perspectives. (Fritzell, 1996: 216).

The *pedagogical* practice, however, focuses our attention toward the idea that the practice is a social context within which participants develop understanding about themselves and the context that they are part of (Fritzén, 1998). In a pedagogical practice (for example, an improvement practice in the healthcare organization), the participants develop socially, as well as in terms of their knowledge; via communication, reflection, and action (Johannessen, 1994). Pedagogical processes are intentional in nature. Improvement practices in a healthcare organization display a marked intentionality to create better provision of care at a lower cost so as to improve the general health of the population. When an improvement practice is placed within a pedagogical practice, then it is possible to analyze this practice by using pedagogical theory.

Similar to Fritzell (1996), Kemmis (2011) states that change within a professional practice does not only include the individual and the individual's interaction with others, but it also includes the cultures and discourses (see Chapter 5) that the individual is part of:

> *In short, changing practice requires changing more than people – it requires changing (at least) the cultural and discursive fields in which practices are understood locally and more generally, the social fields in which practices connect people with one another locally and more generally, and the material-economic fields in which they act in and on the material world – in particular in relation to the acts of production and consumption that locate them in local and wider economies (Kemmis, 2011: 26-27).*

Kemmis (2011) claims that a practice is particularly dependent on its financial management. In light of the closing down of the One-Stop Breast Clinic, one cannot ignore how financial management principles influence improvement practice priorities in practice. The concept of a 'practice' thus allows one to focus on the external and internal conditions which regulate the pedagogical processes within an improvement practice. The pedagogic perspective also highlights the fact that learning and social integration are naturally linked together, which entails that language has a central function. An additional pedagogical point of departure in this thesis is that learning and social integration are based on communication (Dewey, 1916/1997). This is discussed further in the following section.

4.3 Learning and communication

4.3.1 Learning and social integration via language

Language and communication are conditional to the existence of social organisms (Dewey, 1916/1997). The newly-born infant is integrated within

human society via language and is raised into a social life via language (Dewey, 1929). Using language, we live in a community by formulating a common understanding of our environment, our common frames of reference, our norms, and by using language to share individual reflections and experiences:

> *Not only is social life identical with communication, but all communication (and hence all genuine social life) is educative. To be a recipient of a communication is to have an enlarged and changed experience. (Dewey, 1916/1997: 5).*

By using language, we can express and transfer meaning between individuals and thereby test, criticize, and develop these meanings in a continual process of development (Dewey, 1929). The ability to communicate with others also entails that we learn to communicate with ourselves and become self-reflective (ibid.).

In the early 20th century, Dewey (1916/1997) claimed that free communication and education for everyone, irrespective of their social class, was a precondition for a healthy, democratic society. However, since the time of the ancient Greeks, a dualism between theory and practice has reinforced the social divide, where those who control theories (the thinkers) have power, whilst those who merely avail themselves of practice merely execute that which the thinkers have decided on. Theoretical knowledge is reserved for the higher capitalist social classes who benefited from preserving this dualism so that they could profit from and dominate the practical work performed by the lower social classes. Industrial workers did not control the goals of their actions, which was reserved for the owners of industry. Dewey claims that potential remains unexploited when only a part of a citizenship is provided with education on equal terms. Society has greater potential for renewal when *everyone* can engage in intelligent communicative judgment of their circumstances, and not only those who control industrial capital (ibid.).

A practical knowledge interest of this thesis is to increase the reader's knowledge of how improvement work in the future can be supported, so as to achieve sustainable improvement within the healthcare system. The microsystem model enhances the importance that improvement work needs to be performed by individuals who have professional knowledge and experience of healthcare practice, and not by individuals who have knowledge of the management and control of the healthcare system (Batalden et al., 2005). A negotiation about change needs to balance the traditional medical perspective against a service-directed and cost-effective perspective, which challenges the power structure of theoretical knowledge within the healthcare system. It is not the profession which has the most status which owns the voice of change. Instead, it is the mutual dependencies between all of the individuals involved

in the improvement practice which are emphasized to achieve a balanced perspective of that which creates added value for the patient (Nelson et al., 2007). The intention behind quality improvement, according to the microsystem model, is thus similar to Dewey's intention (1916/1997) when he proposed that *everyone* can engage in intelligent communicative judgment of their own circumstances.

4.3.2 A process oriented and interactive view of development and knowledge

An interactive view of development entails that people interact with the demands placed upon them by their environment in a continuum of events which cannot be isolated from each other (Dewey, 1922/2002). This stands in contrast with a behaviourist view, which divides stimuli and actions into isolated events which are disconnected from their context (ibid.). Dewey (1916/1997) claims that knowledge can never be determined:

> *To fill our heads, like a scrapbook, with this and that item as a finished and done-for-thing, is not to think. It is to turn ourselves into a piece of registering apparatus. To consider the 'bearing' of the occurrence upon what may be, but is not yet, is to think. (Dewey, 1916/1997: 147).*

The processes involved in thinking and experiencing entails formulating a problem that has been experienced and then taking note of its conditions, so that the person can form and rationally process a possible conclusion which, finally, can be empirically tested. Knowledge is a point of departure and not a goal, because knowledge can help people predict consequences of future actions (Dewey, 1916/1997). This entails that the previously mentioned dualism between theory and practice is challenged since science is supposed to benefit mankind in practice, and not the other way round:

> *While all thinking results in knowledge, ultimately the value of knowledge is subordinate to its use in thinking. For we live not in a settled and finished world, but in one which is going on, and where our main task is prospective, and where retrospect – and all knowledge as distinct from thought is retrospect – is of value in the solidity, security, and fertility it affords our dealings with the future. (Dewey, 1916/1997: 151).*

Because a final goal cannot be reached with a single direct action, one has to test the situation and observe and reflect over what has taken place:

> *We must change what is to be done into a how, the means whereby. The end thus re-appears as a series of "what nexts", and the what next of chief*

importance is the one nearest the present state of the one acting (Dewey, 1922/2002: 86).

The testing and reflective dimension of learning which Dewey emphasizes can be recognized in Deming's (1994) PDSA-cycles and the emphasis made in improvement work on taking small incremental steps forward towards improved results.

The theoretical pedagogical point of departure taken in this thesis is that learning is a long-term process where communication is central to creating responsible citizens who possess the necessary knowledge to live in, and develop, a democratic society (Dewey, 1916/1997). In this thesis, improvement work is considered to be constituted of pedagogical processes which aim to develop an improvement practice in relation with its external and internal conditions. The participants in an improvement practice need to be held responsible for the development of their own practices using the knowledge and experience that they possess, whilst, at the same time, they develop as individuals and their relationships with others. The benefit provided by this thesis (according to Dewey's view on knowledge) is that by analyzing and explaining the pedagogical conditions that govern improvement practices, these conditions can be modified and tested so as to give support for the development of better improvement practices. In this thesis, the communication that takes place in an improvement practice is considered to be a negotiation about change. By emphasizing the fact that negotiation is the basis for the learning that takes place, we need to take into consideration the internal conditions for such negotiation, which is done in the following section.

4.3.3   Learning as negotiation

Wenger (1998) has described how professionals who are part of a practice enter into negotiations about that which creates value with the concept of 'practice as negotiated meaning' (1998: 52). The concept is based on Lave & Wenger's (1991) empirical studies which form the basis of their book *Situated learning: Legitimate peripheral participation*. These authors describe how the creation of identity takes place when a newly-appointed employee becomes part of a professional practice. The book was widely referred to thanks to its description of learning, which was different from the then current behaviourist and cognitive traditions. Learning was described as a social activity, and not as the individual's construction of new patterns of behaviour or cognitive structure. Brown & Duguid (1991) describe it succinctly as: "*The central issue in learning is becoming a practitioner not learning about practice.*" (1991: 48).

Wenger (1998) later developed the concept of 'communities of practice' (CoP) by deepening the concept in terms of that which characterizes a community in

relation to a specific practice. Four years later, an additional book on this topic was published, namely *Cultivating communities of practice* (Wenger et al., 2002). As the title suggests, the content of the concept has been slightly changed. From initially being an analytical, academic concept, it became a tool for creating increased profits for companies: "*Wenger, McDermott and Snyder is a popularization and a simplification but also a commodification of the idea of community of practice*." (Cox, 2005: 533). In the present study, the earlier description of the CoP concept is used (Wenger, 1998).

The concept of CoP places focus on the practical cooperation and the development that takes place in a work group who are engaged together in a common assignment (Wenger, 1998). A CoP is regulated explicitly or implicitly by common norms, routines, and tools with respect to how the work assignment is to be completed. Professional practitioners share a common language, gestures, and symbols, and they share stories and knowledge which have developed over time and have become part of the community's culture. To participate in such a community, entails that the participants, in negotiation with each other, are in agreement or in disagreement with each other, to challenge and make compromises over that which constitutes the culture. The criteria by which one can label a work group as a CoP include 'mutual engagement', 'a joint enterprise', and 'a shared repertoire' (1998: 73). This description fits the situation that this thesis studied well. The staff members met together to create an image of how the healthcare system worked for the patient, and they tried to change it for the better. In these meetings, negotiations about whether it was beneficial to change current routines or whether it was better to continue as was done previously.

Practice as negotiated meaning (Wenger, 1998: 52) entails that the negotiation that takes place within a community is formed by that which is characteristic of its practice, whilst the practice changes because of the content of the negotiation. This alternation between negotiation and practice is described in terms of *participation* and *reification*[18] (1998: 52). Participation acknowledges the mutual process and interaction which is needed so that the staff members will come to understand what can be done. In the contexts of this thesis, participation refers to the situation where the different professionals realize that none of them hold the answer to how the healthcare system can be improved. Before the professionals can see what needs be done, their different perspectives need to be brought together, to make improvements for the patient from a global perspective.

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[18] Wenger (1998) uses the term *reification* in its purely etymological sense, i.e. 'making into a thing' (1998: 58), and not in the sense proposed by critical theorists (see section 5.5).

In these negotiations, symbols, tools, stories, and terms are used which represent meaningful content: hence, *reification*. Reification can refer to their fixed routines, for example, how medicine is given to the patients. It could also refer to patient cases which have moved them and are recalled as part of the practice's shared stories. It may also refer to follow-up reports on the running of the ward (see Study II and Study III) which the participants use to base their discussions of change on. Meaning-creating negotiations take place in the tension between *participation* and *reification*.

4.3.4 External and internal conditions for a negotiated practice

Wenger (1998) describes the social power struggles that take place in a work environment in terms of 'economy of meaning' (1998: 198) and 'ownership of meaning' (1998: 200). Wenger's concepts fit in well with the social structures that one finds within healthcare organizations. In the context of a healthcare organization, 'economy of meaning' can represent the asymmetry that exists between different professions, specialists, or different care units, for example, at a hospital. In terms of 'ownership of meaning', the staff may enjoy different degrees of access to knowledge and the ability to master the language and the reified symbols which drive the negotiations forward. For example, a physician has access to a particular language, a scientific background, a knowledge base, and a social habit of taking on leadership roles in relationship to other professions. An instance of negotiation is characterized by the status and legitimacy with which utterances are ascribed, along with the fact that each individual puts their own status at risk when they engage in a *negotiation of meaning*. It is only through employing empirical studies that we are able to investigate whether improvement practices are characterized by (i) mutual relationships (Deming, 1994), or (ii) Dewey's (1916/1997) view of a prevailing duality between theory and practice which is reconstructed in terms of *economy of meaning* or *ownership of meaning*, in the negotiations that take place in practice. Article III presents a study of how the internal conditions are expressed in a CoP in relationship with a network, and analyzes whether the homogenous character of a CoP or the heterogeneous character of a network supports learning and change.

Despite the fact that Wenger (1998) and Lave & Wenger (1991) have emphasized the internal social positioning that takes place in a practice, they have not discussed how external conditions, in terms of controlling political and economic forces, can influence learning and change (Currie & Suhomlinova, 2006; Hughes et al., 2007; Amin & Roberts, 2008; Addicott et al., 2007; 2010). Lave (2008) admits that they should have emphasized the role of political forces more, so as to prevent the construction of interpretations that argue that harmony prevails in such practices, as so many studies have shown since the introduction of the concept in the 1990s. In the

present thesis, this is compensated for by complementing Fritzell's (1996) and Kemmis' (2011) concept of 'practice' which is based on critical theory.

4.4   Summary in relation to the aims of the thesis

In my study of the pedagogical conditions that take place in an improvement practice in a 2010s healthcare system, I avail myself of pedagogical theory which is based on (i) the concept of 'practice' (Fritzell, 1996; Kemmis, 2011), (ii) communication as the basis for learning (Dewey, 1916/1997), and (iii) 'practice as negotiated meaning' (Wenger, 1998). The object of study is the organizationally embedded and practical improvement work which is described by the clinical microsystem model. The concept of 'practice' is invoked so as to reveal individuals' interactions with others, on both a local and more general level, and with respect to the cultures and discourses that the individual is part of (Kemmis, 2011). The *pedagogical* practice also places focus on the external and internal conditions, but are added to with a description of how the pedagogical processes are expressed in terms of (i) learning, (ii) social integration, and (iii) cultural reconstruction (Fritzell, 1996). A negotiation about change was studied, with the point of departure in that idea that communication is foundational to social integration and learning (Dewey, 1916/1997). Finally, Wenger (1998) is used to complement the pedagogical theory by considering social learning as negotiated meaning, that is to say, as a model that can be used to study learning as negotiation in a specific practice. Wenger's model includes the internal controlling conditions with respect to negotiation, but it lacks discussion of the external conditions, which the two other concepts of 'practice' admit via their critical perspective.

Wenger (1998) claims that, in a negotiation, there exists a mutual dependency between the practice (the context) and the negotiation, such that the content of the negotiation is influenced by the practice, and the practice is influenced by the negotiation. This mutual dependency between the object of study (the negotiation) and the practice (and its external and internal conditions) is something that even Dewey (1922/2002) and research on the translation of knowledge (Greenhalgh et al., 2004; Bate. 2014; Dixon-Woods, 2014) have highlighted. Two studies analyze and explain what is expressed in negotiations with respect to the external conditions (Study II) and with respect to the internal conditions (Study III). The mutual dependency which Wenger (1998) describes reappears as a theme within the thesis's discourse analytical methodology, which is described in the following chapter. In the study of how the internal and external pedagogical conditions are verbally expressed, we consider the learning improvement practice as an instance of a *discursive practice*, which is also presented in the following chapter.

5 A discourse analytical framework as a point of departure for an improvement practice in healthcare

This thesis uses a discourse analytical methodology with respect to *what* is studied and *how* it is studied, based on Dewey's theory of learning as communication. The external and internal conditions for learning in an improvement practice can be revealed by using a method of critical discourse analysis, and a social theory that is based on critical theory and a theory of communication. The critical interest that is made in this thesis is aimed at revealing that which is taken-for-granted with respect to what learning is based on. This is done with a practical interest in creating knowledge; with the aim of enabling staff members make more conscious choices about the alternatives that are open to them in future improvement work.

5.1 The linguistic turn

The linguistic turn refers to how, in the late 20th century, a constitutive view of language was widely accepted within research in the social sciences (Benton & Craib, 2011). Previously, language was ascribed a purely descriptive function, that is to say, we use language to describe and comprehend the world around us. The constitutive perspective, on the other hand, argues that language serves a social constructionist[19] function with respect to the world around us. Philosophers of language are not all in agreement, however, regarding the

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[19] In this thesis, I will not enter the debate on distinctions between constructionism, constructivism, or construcionalism. When I use the term *constructionism* (or similar related terms), I do it in terms of what these '-isms' have in common: a project that aims at displaying or analyzing actual, and historically-situated, social interactions that led to, or were involved in, the coming into being or establishing of some present entity or fact (Hacking, 2009). The 'isms' share the belief that reality is not what it seems. Or, as Ian Hacking expresses himself: "*questioning of varnished reality, of what the general run of people take for real*" (Hacking, 2009: 49).

degree to which language has this constitutive function. Idealists claim that there is no objective world out there; truth about the world is only mental (ibid.). Linguistic idealism consequently refers to an idea that only that which is talked about exists (Hacking, 2009). Other philosophers of language (for example, Habermas, Fairclough, and Searle), claim that a natural world exists independent of language and irrespective of how we choose to name it. This thesis adopts the second perspective and thus proposes a realist and social-constructionist ontological perspective.

Searle (1997) admits to a realistic view of the natural world at the same time as he acknowledges how language can be constitutive of the world. He clarifies the relationship between realism and social constructionism by differentiating between *raw* and *institutional* facts. Raw facts are descriptions of natural phenomena, for example, our distance from the sun or that there is snow on Mount Everest. These are things which human beings cannot influence, and they exist independently of how we might go about naming them. Institutional facts are facts that we create via language, for example, money, laws, regulations, marriage, and so forth. These are all things that would disappear and lose their meaning if we all decided to choose a different system by which to live. The constitutive meaning of language entails that language influences human life conditions just as humans can influence and create new forms of language (Searle, 1997). That which is expressed in an improvement practice can regulate the interactions and actions that take place within the practice, just as those participants who express themselves are given the possibility to change such regulation via their rhetoric.

As mentioned previously, Dewey (1916/1997) also considers language as a condition for the existence of a social life-form. Dewey (1938) makes the distinction between every-day language and scientific language. Every-day language creates meaning in the close, immediate situation, which is known by every participant within a particular culture and community. In contrast to this, scientific language contains abstract concepts which are used to explain and generalize about events that take place in our every-day lives. Scientific language is subject to a continual re-evaluation through academic review, which is mediated communicatively (ibid.). Using Dewey's distinction, I describe the object of study in this thesis (in Studies II – IV) as the every-day language of an improvement practice, whilst scientific language has been used to validate and construct the conclusions made in this thesis, via an interactive research approach (see section 6.2) and via reviews in academic contexts.

5.2 The field of discourse analysis

Discourse analysis is a branch of the constitutive philosophy of language program which emphasizes the formative power of language on people's life situation (Winther-Jørgensen & Phillips, 2000). Primarily, it is the structuralist and post-structuralist theories of language on how discourse forms and controls human social life which has led to different discourse perspectives. The current discourse analytical interest in language is based on global post-industrial tendencies in society (Chouliaraki & Fairclough, 1999). Modern capitalism, in terms of NPM and neo-liberal marketization, has led to the emergence of a more technical language via the action of economic, organizational, and political goals towards achieving improved results and increased profits. We now need a critical interest in these issues so as to reveal what language symbolizes and reproduces in everyday language use between people (ibid.). What meaning does the term *improvement* have within the context of quality improvement work in a healthcare system? The One-Stop Breast Clinic example suggests that there existed contrasting interpretations of the term *improvement*; for example, for some, it was interpreted as cheaper running costs for mammography scans, for others, lower levels of anxiety for women.

What the different discourse perspectives have in common is the fact that language is instable; language is never *a* reflection of reality – language appears in different parallel discourse patterns which represent different meanings which are inherent to the same reality (Winther-Jørgensen & Phillips, 2000). The difference between the original post-structuralist perspective and the *critical discourse analysis* (CDA) perspective is the basis on which the discourses are formed (ibid.).[20] Characteristic of the post-structuralist perspective is the *discursive formation*, which refers to how a discourse is changed when each discourse struggles to assert its own dominance over parallel, existing discourses. CDA claims that changes in discourse are more dependent on the possibility of combining elements of different discourse practices. This results in an 'interdiscursivity' where existing discourses synthesize elements between each other, which leads to new discourse orderings and concomitant changes in social life. This does not suggest that CDA denies the existence of the struggle for hegemony between different discourses, but it is of importance to identify the ordering of discourses in a specific situation so as to identify which discourse has interpretative dominance and thereby structures our social life (Fairclough, 1992). The thesis' case studies reveal how external and internal conditions influence the hegemony of discourses in improvement practices.

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[20] Proponents of the post-structural perspective include Foucault and Laclau-Mouffe, whilst CDA is represented by Fairclough, Chouliaraki, Wodak, and others (Wodak & Meyer, 2009; Chouliaraki & Fairclough, 1999).

What different discourse perspectives have in common is the idea that discourses, and their effect on social life, are always expressed in human conversations which are conducted in specific situations and are embedded in specific institutional structures (Winther-Jørgensen & Phillips, 2000), for example, conversations in an improvement practice in a healthcare system. The preservation of a discourse and any changes in a discourse should thus always be studied in the actual contexts where language is used. This is called a *discourse practice* in the CDA framework (Fairclough, 1992). Notwithstanding this, different discourse perspectives ascribe different meaning to the particular function that participants in the discourse practice have (Chouliaraki & Fairclouh, 1999). In the CDA framework, there exists a perspective of the participants where the subject and the inter-subjective dialogue admit to a linguistically-based ability to act and influence discourses:

> *Social systems are both the precondition of social action and the products of social action. Every moment in the structure/action dialectic is a moment in the power struggle over whether the social world is to be maintained as it is or changed. (Chouliaraki & Fairclough, 1999: 32).*

The post-structural perspective, however, claims that participants do not possess this ability to act. The participants are not seen as subjects; instead, the utterances control and structure the participants, in terms of inherent systems of rules that govern that which is acceptable to say in specific situations, at particular points in time, and in a particular institutional context (Fairclough, 1992: 40).

5.3 CDA – the discursive point of departure taken in this thesis

In this thesis, CDA is used, as proposed by the methodology outlined by Chouliaraki & Fairclough (1999), including method-developments made by Fairclough (1992):

> *CDA sees discourse – language use in speech and writing – as a form of 'social practice'. Describing discourse as social practice implies a dialectical relationship between a particular discursive event and the situation(s), institution(s) and social structure(s), which frame it: The discursive event is shaped by them, but it also shapes them. That is, discourse is socially constitutive as well as socially conditioned – it constitutes situations, objects of knowledge, and the social identities of and relationships between people and groups of people. It is constitutive both in the sense that it helps to sustain and reproduce the social status quo, and in the sense that it*

contributes to transforming it. Since discourse is so socially consequential, it gives rise to important issues of power. (Fairclough & Wodak, 1997: 258).

If one were to apply the above definition of CDA to this thesis' object of knowledge, then we can translate the term *social practice* into the *improvement practice* in the healthcare system which negotiates change. The discursive events which are referred to in the above quote consist of the empirical observations which were made of the different improvement practices (work meetings and team meetings), where the practice was embedded within the healthcare system as an institution, and the market forces (NPM and neo-liberal discourse) that controls it. That which was expressed in the situations which were observed in the studies included in this thesis is structured by the healthcare system's discourses and society's discourses, whilst, simultaneously, the conversation possesses the possibility to change the meaning-creating import of these discourses. That which is expressed in the conversations is also dependent on the internal conditions of the improvement practice in terms of the participants' identities and their relationships with each other. What is studied in this thesis, in terms of external and internal conditions, can be explained by using discursive terms. These terms refer to the structural power which the market discourses exert on the conversation, and the internal relationships which exert power over the conversation in terms of social positioning. Improvement practices are discursive practices where the discursive patterns create consequences for learning. By using CDA, this thesis adopts an action-oriented perspective towards language, where the intention associated with an utterance should be interpreted in the context within which it was uttered (Fairclough, 1992; Habermas, 2004).[21] A foundational assumption that is made in this thesis is that the participants in an improvement practice speak with intention.

CDA refers to a scientific school of thought which shares a number of common principles, and not a specific theory or method (Wodak & Meyer, 2009). This has entailed that CDA has developed from different theoretical fields which, in turn, have been adapted for practical application with respect to that which is studied. This thesis analyzes and explains human interactions by interpreting people's meaning-creating actions from a hermeneutic tradition. This stands in contrast to the positivist school of thought which, within the framework set out by the social sciences, searches for generalizations about human actions that are based on causal and statistically

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[21] A different perspective that can be adopted is one where a text is considered to have its own meaning which can be further interpreted from the reader's situation (Gadamer, 1975/2004). This entails that every written text has its own historical process where its original meaning can be continually re-interpreted by new individuals, in new historical contexts.

verified correlations. The difference between these approaches is based on different theories of knowledge. Positivists claim that truth pre-exists even before it is investigated, whilst the hermeneutic approach claims that universal truth does not exist, because knowledge is socially, historically, and culturally situated (Gadamer, 1975/2004). In other words, texts can be interpreted differently, depending on who the interpreter is, the interpreter's historical and cultural affiliation, and the theoretical point of departure which the interpreter uses (Chouliaraki & Fairclough, 1999: 67). This does not entail, however, that texts can be interpreted in any old way. The researcher needs to be transparent about his or her role and previous knowledge, and be clear to the reader about how the process of analysis proceeded. This thesis employs a hermeneutic tradition of knowledge, where its practical use, the role of the researcher, and its validation is presented in Chapter 6.

5.4 CDA – the thesis' critical point of departure

Two common methodological principles in CDA research are discourse analysis and a critical interest with respect to the identification of ideology and claims to power in social life (Wodak & Meyer, 2009). This entails that CDA needs to combine a discourse analytical methodology with a theory which is closely associated with critical theory. In three of the studies included in this thesis (Study I, Study II, and Study IV), the concepts of 'strategic rationality' and 'communicative rationality' are used, which Habermas (1987b) developed in his theory of system and life-world. The theory has a critical foundation and is linked to a constitutive language philosophy, or, as Carleheden (1996) expresses it: "*Habermas has allowed critical theory undergo a 'linguistic turn'*" (1996: 27)[22]. In Study III, which investigated the internal conditions within an improvement practice, Wenger's (1998) concept of 'practice as negotiated meaning' was used. This concept was formulated within the framework of Wenger's (1998) practical theory of social learning. This theory is not based on critical theory, but it does provide a model of explanation with respect to how social power-struggles are expressed in a negotiation that is connected to a specific practice, which is thus applicable to a healthcare improvement practice.

The agenda behind improvement in the healthcare system aims towards achieving cost effectiveness and solutions that create value for the patients. A NPM-discourse and a neo-liberal discourse correlate with each other and reinforce each other in terms of their ideology on how improvements in the healthcare system can be achieved in a free and competitive healthcare 'market'. Both of these discourses cause power to be shifted from the

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[22] Translated by the author.

healthcare professionals to the patient (Nordgren, 2004). By choosing his or her care provider, it is the patient who controls the finances of the care provider. Healthcare management is also endowed with more power because management is responsible for the financial agenda; a point which is highlighted in the empirical material that was examined in Study IV. This improvement agenda also contains a feature of emancipation for the patient by stressing that improvements must create value from the patient's perspective, and not from the medical profession's perspective or the organization's perspective. This contrasts with traditional approaches, (or discourses, if you wish), where the patient is objectified (Nordgren, 2004). The institutionalization of the provision of healthcare in the 1700s and 1800s resulted in patients not needing to pay for their medical care. The patient was expected to offer up his body to 'experts' who possessed the knowledge to cure the patient (ibid.). Quality improvement ideas, however, break away from the objectified, 'expert' discourse. Patients are considered to be subjects who can take responsibility for their health and make their own decisions about medical alternatives which are based on the knowledge of the experts. This new 'customer discourse', which is based on the neo-liberal discourse, can be recognized from other social institutions, including schools and universities, where the customers' interpretations of what they want and need are granted a central position. In a contemporary improvement practice where conversations about change emerge, these discourses proliferate in cooperation with and in contrast with each other. The questions to be asked are *Which discourse gains dominance?* and *Is this discourse obvious to the participants who take part in a discursive improvement practice?*

That which Dewey (1938) calls 'everyday language', and is foundational to the learning that takes place in an improvement practice, is taken for granted by those who speak (Fairclough, 1992: 87). Ideologies are embedded in 'common sense', and are thus a natural part of our everyday life, and consequently, the most powerful of discourses. This results in the existence of long-lived structures that are reproduced and prevent change for as long as ideology and social power relations remain hidden (Fairclough, 1992: 93). CDA reveals, and thereby brings to our consciousness, what a conversation contains, how the conversation behaves as it does, and what the conversation can be developed into, with the point of departure that people have the ability to change their life situation (Chouliaraki & Fairclough, 1999: 4). CDA has, thus, an emancipatory goal and is critical in the sense that it reveals the possibilities that are inherent in a discourse practice, and allows one to re-inforce or change prevailing discourses via particular ways of communicating (Wodak & Meyer, 2009). The critical point of departure taken in this thesis is to clarify the negotiation about change that takes place in improvement practices. This is done with the aim of revealing that which is taken for granted with respect to what learning in such improvement practices is based

on. The social interaction and the communication that takes place within an improvement practice can thus be supported in a more conscious way, compared to the unconscious reproduction of prevailing discourses. It is of importance that the research results are linked back to the practice that was studied, so as to fulfil the emancipatory goal that is inherent in CDA (Chouliaraki & Fairclough, 1999). This is done in this thesis within the framework of an interactive research approach (see section 6.2).

5.5   A dialectic social theory with critical-hermeneutic origins

This thesis is concerned with improvements that give rise to cost-effective solutions for the healthcare organization as well as meaningful solutions for the patients. This is supported by Habermas's (1987b) conceptualization of strategic and communicative rationality in his theory about system and life-world. The theory contains a dialectic relationship between a theory about order that is inspired by critical theory,[23] and a hermeneutic theory about action and communication.[24] In contrast to critical theory, which proposes no other way than revolution to overcome the capitalist society's grip on mankind, Habermas's dialectic theory offers a more constructive belief in people's ability to change via rational argument; a view of *actors* and the notion of *agency* with respect to change which are also present in CDA.[25]

The social theory includes a strategic rationality which is characterized by a demand for effectiveness and control, and a communicative rationality which

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[23] Habermas was mostly inspired by the critical thinkers within the Frankfurt School who emphasized the opposition between the individual and modern society. People tended to be reified, that is to say objectified and de-personified, which results in a threat to personal freedom:

The collaboration of men in society is the mode of existence which reason urges upon them, and so they do apply their powers and thus confirm their own rationality. But at the same time their work and its results are alienated from them, and the whole process with all its waste of work-power and human life, and with its wars and all its senseless wretchedness, seems to be an unchangeable force of nature, a fate beyond man's control (Horkheimer, 1937/1972: 216-217).

[24] Hermeneutic theory claims that people interpret news about the world against the background of their history and culture (Gadamer, 1975/2004). Hermenuetic theory criticizes the positivistic view of *understanding* as first understanding something in 'it-self' and then the application of knowledge to a particular context. A hermeneutic belief is that application is part of the very process of understanding, since the individual tests that which is assumed to be universal in a known situation so that that which is unknown is linked and connected to some meaningful context. Hermeneutic epistemology claims that understanding is inter-subjective by nature, and is mediated by language.

[25] Despite the fact that there exists several similarities between CDA and Habermas's (1987b) theory of system and life-world, a distinction needs to be made with respect to the concept 'discourse'. In this thesis, Chouliaraki & Fairclough's (1999) analytical concept of 'discourse' is used, which refers to a specific way of expressing oneself. Habermas's (1991) normative notion of the concept of 'discourse' refers to a more general human communicative ability to achieve mutual understanding.

refs to an individual's need of a meaningful life-world context (Habermas, 1987b; Fritzell, 1996; Fritzén, 1998). Strategic rationality is associated with questions such as *How are economic and human resources used in the best way so as to achieve cost-effective solutions? Which type of reward system should be used so that co-workers will contribute to making the business operation more effective?* Communicative rationality employs a different type of logic, which is aimed at creating a more profound understanding, in cooperation with others. *How can open communication between the professionals and the patient be created? What is the difference between the physician's perspective and the nurse's perspective, and how can these perspectives complement each other?* Communicative rationality focuses on people who, in their meetings with each other, create common meanings, about their selves and the world in which they live in:

> *In one case, the integration of an action system is established by a normatively secured or communicatively achieved consensus, in the other case, by a nonnormative regulation of individual decisions that extends beyond the actors' consciousnesses. This distinction between a social integration of society, which takes effect in action orientations, and a systematic integration, which reaches through and beyond action orientations, calls for a corresponding differentiation in the concept of society itself. (Habermas, 1987b: 117).*

Strategic logic and communicative logic are, in one sense, incompatible with each other, whilst, taken together, they form an inevitable whole. Strategic rationality is dependent on communicative rationality in terms of loyalty and legitimacy, whilst communicative rationality is dependent on strategic rationality in terms of effectiveness. The way in which an improvement practice is formed, for example, cannot be divorced from the participants' assumptions of what good medical care is. In fact, an improvement practice is legitimized by the participants' assumptions concerning good medical care. Similarly, it would be naïve to ignore the goals that have been set for the business, in a complex healthcare system. Strategic rationality and communicative rationality complement each other, and both forms of logic characterize pedagogical practices (Fritzell, 1996).

5.5.1 The discourse of improvement's complementary perspective in policy

The 'improvement discourse' that exists within healthcare is constructed with a complementary perspective with respect to strategic and communicative arguments. Both the Swedish *God Vård policy* (Socialstyrelsen, 2006) and IHI's

The Triple Aim statement[26] claim that cost-effective solutions should be sought after, but in balance with that which is most meaningful for the patient. Improvement knowledge is characterized by system-thinking and inter-subjective communication (Deming, 1994). The microsystem model contains an in-built dialectic between goal-oriented 'business aims' as well as emphasis on the mutual dependency individuals have with respect to each other (Nelson et al., 2007: 2011). But one may question whether this balance which is sought after is actually realized in practice. According to Habermas (1987b), we run the risk of strategic rationality taking over:

> *Steering media such as money and power attach empirically motivated ties. They encode purposive-rational dealings with calculable amounts of value and make it possible to exert generalized strategic influence on the decisions of other participants while bypassing processes of consensus formation in language. Because they not simplify communication in language but replace it with a symbolic generalization of negative and positive sanctions, the lifeworld context in which processes of reaching understanding always remain embedded gets devalued: the lifeworld is no longer necessary for coordinating actions. (Habermas, 1987b: 280-281).*

In Study II and in Study IV, I investigated how the order of discourse was realized in terms of a balance between strategic rationality and communicative rationality. The question that now arises is whether the economic control system in improvement work (P4P) and its technical control system (in the form of measurements and registers) confirm Habermas's fear that communicative rationality is thereby reduced, and is not needed to add legitimacy to decisions.

5.6   Summary in relation to the aims of the thesis

In this thesis, an improvement practice is considered to be a discursive practice, with the point of departure that the discourse patterns that can be identified in such a practice create conditions for learning (Rogers, 2011; Fairclough, 2011). CDA can reveal how external and internal conditions are expressed in a negotiation about change, since language is used to capture the content that is ascribed to improvements, and with respect to what receives interpretive dominance in the improvement practice. We note that Bate (2014) has called for research which explains the interaction between outer- and inner conditions for organizations. CDA is a method which can be used

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[26] The Institute for Healthcare Improvement's statement, *The Triple Aim*, aims to (i) improve the patient experience of care (including quality and satisfaction), (ii) improve the health of populations, and (iii) reduce the per capita cost of healthcare (www.ihi.org/Topics/TripleAim).

to study just these conditions. The discourse analytical methodology employed in this thesis has a critical point of departure and is used to reveal the discourse patterns which are foundational to the pedagogical processes that take place in an improvement practice, and to introduce this to the practice so that the participants themselves can use this knowledge more consciously to create change in their discourse (Dewey, 1916/1997; Wodak & Meyer, 2009).

The current description of the microsystem model (Nelson et al., 2007; 2011) has illustrated the way it is embedded within an organization, but there is no description of the methodology which can be used to investigate what is over-arching with respect to the different levels in a complex healthcare organization. CDA is such an over-arching methodology which can be used to analyze and explain how external and internal conditions are expressed via the use of language. CDA offers a framework to study the contextual influences on an improvement work, an area of research which is much sought-after in the field of *improvement science* (Greenhalgh et al., 2004; Bate, 2014; Dixon-Woods, 2014). How the CDA analysis was designed and performed is discussed in the next chapter.

6 The design of the studies

In this chapter, I present the general design and execution of each of the studies that are included in this thesis, and on more detailed level, whilst the next chapter presents the results of each study. The thesis has an end-to-end discursive point of departure, from its ontological standpoint to the production of knowledge. As an introduction, I present a number of points of departure in the research project where an interactive approach links the thesis's pragmatic, hermeneutic and critical interests together. Further to this, I present how CDA is used in the area of a healthcare system, and how I applied CDA in each of the studies in practice. The chapter ends with the thesis' claims with respect to validity, and a presentation of ethical issues and my role as a researcher.

6.1 Bridging the gaps

This thesis was written within the framework of an inter-disciplinary research project called *Bridging the Gaps* (BtG). The project addresses the 'gap' between knowledge and action within healthcare practices. Foundational to the project is Socialstyrelsen's regulatory document, *God Vård*, which highlights the healthcare system's need for systematic improvement work. BtG consists of several sub-projects which are linked to different scientific disciplines and educational institutes, but share a common research practice in conjunction with the Jönköping County Council (JCC). The case studies (Studies II-IV) included in this thesis were based on observations that were made at different healthcare units in the JCC. This particular county council is well-known, nationally and internationally, for its successful strategy with working with improvement work (Andersson Gäre & Neuhauser, 2007; Bodenheimer, 2007; Øvretveit & Staines, 2007). Thus the empirical studies were performed in a context where improvement work is a common occurrence and is requested by the management group. In the county council, we find support within organizational structures in terms of certified improvement coaches,

methodological tools, and regular conferences which are used to spread good examples.

The BtG project has formulated three prerequisites that each research project needs to fulfil if it is considered to be practical research. The first prerequisite is that the research project must identify, formulate, test, and re-formulate new knowledge. The second prerequisite is that the research should be based on *the clinical microsystem* (Nelson et al., 2007: 2011). The third prerequisite is that the research must apply an *interactive research approach* (Ellström, 2008), so as to enable more profound knowledge and/or construction of theory, as well as improvements in practice.

6.2 The interactive research approach

Ellström's model, as per Figure 3, illustrates that the research process (the upper loop) and the problem-solving process in practice (the bottom loop) have somewhat different characters. An interactive research approach enables a meeting of practice and the researcher so that a mutual production of knowledge can be created to solve the same fundamental problem. The mutual interpretation of the object of knowledge favours the direct application of knowledge in practice, which is in agreement with the hermeneutic school of thought (Gadamer, 1975/2004), and is sough-after in the ever-increasing research area of *improvement science* (Marshall et al., 2013).

Communicative theories support the claim that the translation of knowledge is constitutive to the production of knowledge if qualified conversations take place between the researcher and practitioners in a 'participatory' research model (Fritzell, 2003). The researcher is distanced from the context, but possesses knowledge of theories and methodologies which can be used to reveal the practice's interpretation of its business operations (Carr & Kemmis, 1986/2006). At the same time, the researcher is obliged to validate his or her results so that the results are in agreement with the practitioners' understanding of their own practice (ibid.). The interactive approach enables one to link the discourse patterns to the practice that is under investigation, which, in turn, fulfils the emancipatory goal inherent to CDA (Chouliaraki & Fairclough, 1999). Thus, such research plays a more supportive role than a prescriptive role in its relationship to practice. The thesis's interactive approach is aimed at fulfilling Dewey's (1916/1997) exhortation that research results should benefit practice so that practitioners can make more insightful judgements in the future.

Figure 3. A model of the thesis's interactive research approach

Theories and
concepts

Problems/
issues

Data collection
and analysis

The Research
System

Conceptualisation
and interpretation of
the research object

The Practice
System

Problems/
issues

Organisation
action

Local
theories
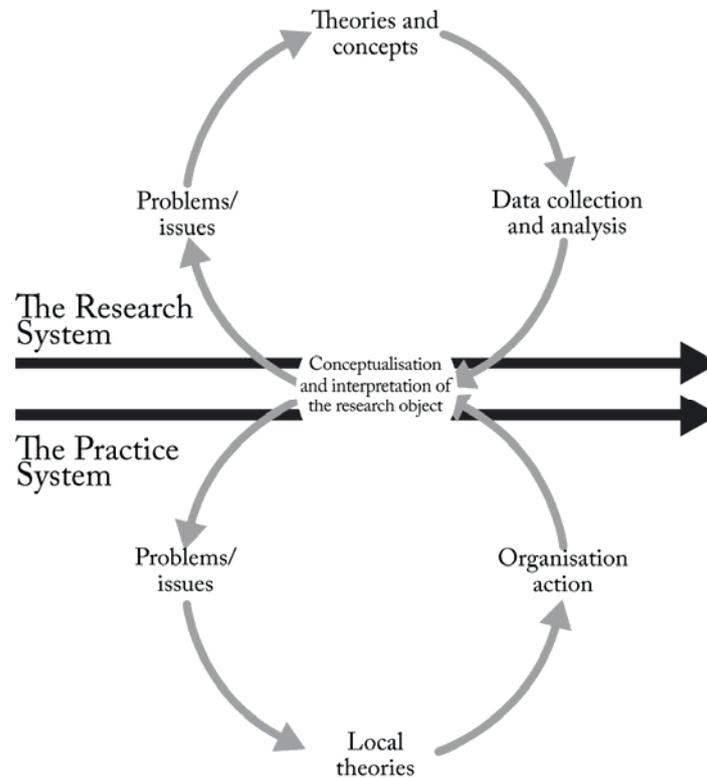
Interactive research as a shared flow of information between research
and practice (Ellström, 2008: 9, Fig. 2)

An interactive research approach reduces 'the knowledge transfer problem' by seeing it as a 'knowledge production problem' which can be solved by the researcher and the practitioner producing the knowledge together (Van de Ven & Johnson, 2006). Nowotny et al. (2001) claim that the production of knowledge becomes more 'robust' in this way, since it is anchored to the practice, which nowadays is characterized by a mass-educated society. This interactive approach enables learning for the researcher as well as the practitioner in a common production of knowledge, which Nowotny et al. (2001) call 'co-evolutionary knowledge development'. The interactive approach employed in this thesis is based on these assumptions which, taken together, argue for a process-oriented and discursive construction of the object of knowledge. This entails that both the method of analysis and the manner in which the knowledge is produced follow a discursive path. Thus, the thesis

is faithful to the 'linguistic turn' in terms of its ontology, epistemology and methodology. How this interactive research approach was conducted can be found in each of the study descriptions.

6.3 CDA toolkit

6.3.1 The use of CDA to investigate quality improvement in healthcare

A literature review was performed[27] so as to investigate how CDA has been previously used within the area of healthcare with connection to improvement work. The literature review revealed the subject areas that CDA has been used in. These areas can be grouped together in terms of (i) treatment of the patient, (ii) healthcare organization, and (iii) validity issues. (See Table 2.)

Table 2. Subject areas in the provision of healthcare that have been previously investigated by using CDA (2005-2014)

Theme	Subject and reference
treatment of the patient	'end-of-life care' (Pattison, 2006)
	'home modification services' (Johansson et al, 2010)
	'participation' (Aasen et al., 2011; 2012)
	'older people with delirium' (Schofield et al., 2012)
	'gender and ethnic discrimination' (Hedegaard, 2014)
healthcare organization	'health policy' (Aldrich et al., 2006; Smith et al., 2009; McIntyre et al., 2012a; 2012b; Malmmose, 2014)
	'sensemaking of change' (Thurlow & Helms Mills, 2009)
	'organizational identity' (Rodriguez & Pozzebon, 2010)
	'change in mental health practices' (Mancini, 2011)
	'patient evaluation websites' (Adams, 2011)
	'interprofessional collaboration' (Haddara & Lingard, 2013)
validity issues	'theoretical overview of the application of CDA' (Traynor, 2005)
	'CDA for nursing research' (Smith, 2007)
	'the usefulness of CDA in healthcare' (Hodges et al., 2008)

CDA: Critical Discourse Analysis

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[27] Because CDA studies can be found in both healthcare and social science databases, an open search (2014/10/07) was made, using the search words 'quality improvement', 'healthcare', and 'critical discourse analysis'. The search resulted in hits for 180 academic texts. The titles and abstracts of these publications were reviewed in terms of their relevance to the present study, leaving 19 articles left for closer study.

CDA has been used to study questions of improvement which touch upon the object of knowledge in this thesis, including, health policy, sense-making of change, and inter-professional collaboration. However, learning and change have not been previously studied by other researchers. How learning is influenced by prevailing contextual conditions has, however, been studied in the area of education (cf. Rogers, 2011; Fairclough, 2011; Lewis & Kotter, 2011; Lund & Sundberg, 2012).

The literature review also revealed a number of validity issues, in response to which, Smith (2007) has noted that the use of CDA increases whilst these studies do not satisfy certain methodological demands. These validity issues are presented in the next section, together with a general critique of CDA. Critique and pitfalls are important to take into account before one designs and practically performs such studies.

6.3.2   A critique and discussion of the pitfalls with CDA

A basic criticism that is directed at CDA is that researchers who use CDA often become too enamoured of their own methods (Breeze, 2011; Billig, 2013; Sayer, 2013). Taking the wide-ranging interest in CDA and its increased use within several different research areas into account, Billig (2013) claims that researchers run the risk of becoming 'corrupted' by their own methodologies. This becomes particularly clear in cases where CDA does not fullfil its emancipatory ambition, despite claims of its use in critical approaches. When a scientific field expands, a scientific ideology becomes institutionalized, which causes researchers to lose their sense of self-reflexivity with respect to what they take for granted. Proponents of CDA regard this as important criticism, because CDA can never be a free-standing activity (Sayer, 2013; Wodak 2013). The methodology must always be applied within the framework of an existing area of research and its specific research questions. It is important that CDA researchers present the content of their critical interest and, simultaneously, maintain a self-reflexive approach towards the theories and methods that they have selected (Wodak, 2013).

Another general criticism that is directed towards CDA is that it is not always rigorously applied (Breeze, 2011), which is something that is confirmed in studies within the context of healthcare provision (Traynor, 2005; Smith, 2007). This is based on the fact that there is no one given concrete method that one can use because CDA is a program which can include diverse social theories and research areas (ibid.). The practical use of a CDA analysis needs to be adapted and constructed in the light of each research question and research area. One methodological pitfall that may emerge is the problem of establishing the basis on which the researcher presents their interpretations and conclusions (Antaki et al., 2003; Breeze, 2011; Baker et al., 2013). On the one hand, the researcher needs a broad perspective over the data that is

collected so as to be able to draw credible conclusions. For example, triangulation is a suggested method where the interpretations are based on different types of data sources, including documents, conversations, or media releases; or the data can be collected over a longer time period (Breeze, 2011). On the other hand, some researchers claim that an analysis cannot be based on a collective summation of data (Antaki et al., 2003; Breeze, 2011). Such researchers argue that the analysis must be made on authentic text excerpts in conjunction with motivation as to why these excerpts are representative for the whole text material (Breeze, 2011). A trustworthy CDA analysis must always be able to present excerpts of the data material as evidence to support the interpretation(s) that is being made (Traynor, 2005; Breeze, 2011), clearly stating in which language the analysis was conducted (Nikander, 2008).

Another methodological pitfall that may face the researcher is that the process of analysis is not always made transparent to the reader (Traynor, 2005; Smith, 2007; Breeze, 2011). The researcher needs to be very clear about how a particular case was chosen and its immediate and socio-cultural context. Furthermore, the data collection method, theoretical assumptions, and how the CDA analysis was practically and methodologically conducted also need to be made clear to the reader. The following section presents how the above-mentioned criticisms and methodological pitfalls were dealt with in the practical execution of the case studies that are reported on in this thesis.

6.4   The research method and the data analysis process

Before I describe how each study was conducted in detail, I will present an overview of how the studies were continuously planned and conducted.

6.4.1   The step-by-step construction of the case studies

There is a succession in how the case studies in this thesis were constructed. The result of the literature overview (Study I) laid the foundation for the design of the case studies (Study II and Study III). In turn, the results of these studies inspired me to perform Study IV. (See Figure 4.)

Figure 4. The step-by-step construction of the studies
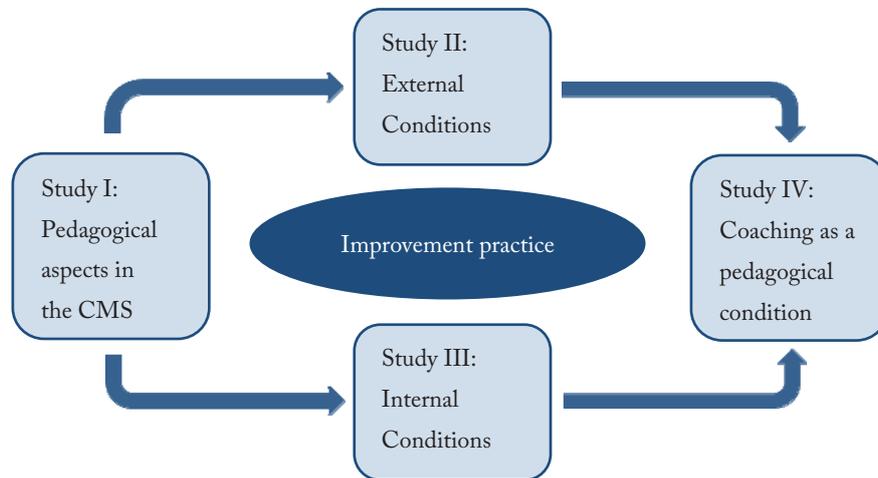
A schematic representation of how successive studies build on the previous studies' results (CMS: Clinical Micro System)

The first study investigated the pedagogical aspects that are included in the clinical microsystem. The results of this study gave rise to a critical interest in the pedagogical conditions which influence improvement practices. One question that was raised concerned what is actually contained in *conversations about improvement*. This was investigated against the background that communication is the basis for learning in an improvement practice (Dewey, 1916/1997). Conversations about improvements were thus recorded at different work-place meetings at an orthopaedic and rheumatology clinic which is run by the JCC. The aim of Study II was to identify the external conditions and their consequences for learning. The aim of Study III was to identify the internal conditions in two different improvement practices (a microsystem and a mesosystem) and compare the consequences for learning in the two different contexts. The results of Study II and Study III both implied that coaching could be a good support for an improvement practice. In the light of this observation, Study IV was deigned to study the coaches' pedagogical approach(es) under the prevailing external and internal conditions.

BtG demanded that the research project identify, formulate, test, and re-formulate new knowledge which was linked to the microsystem model. Study I, Study II, and Study III identify and formulate the pedagogical aspects and conditions for a healthcare system improvement practice in the 2010s. Study

IV 're-formulates and tests' the coaching support in relation to its prevailing external and internal conditions, based on the coaches' own reflections and experiences. For the methodological details, see Table 3.

Table 3. The methodologies that were used in each of the studies

	Study I	Study II	Study III	Study IV
Object of knowledge	Pedagogical aspects in the CMS framework	External conditions for learning	Internal conditions for learning	Coaches' pedagogical approaches, and the influences exerted by external and internal conditions
Object of study	The conceptual framework of the CMS	Negotiation about change in an improvement practice	Negotiation about change in an improvement practice	The coaches' reflections over their pedagogical roles and strategies
Theory or concepts	Eclectic; including theories of learning, communication, and society	Strategic rationality and communicative rationality (Habermas, 1987b)	Community of Practice (Wenger, 1998)	Strategic rationality and communicative rationality (Habermas, 1987b)
Method	Investigation of the relevant literature	CDA: What are they discussing?	CDA: How do they negotiate the meaning?	CDA: Which pedagogical approaches are expressed?
Data source	Literature on CMS which describes its conceptual framework	Observations of work place meetings and team meetings	Observations of work place meetings and team meetings	Reflections over pedagogical roles and strategies by a group of experienced coaches

CMS – Clinical Microsystem; CDA – Critical Discourse Analysis

6.4.2 Performing Study I

Study I was designed to answer the thesis's first research question: How are pedagogical aspects in the clinical microsystem framework presented?

6.4.2.1 Literature review and literature selection

The study was designed as an investigation of the relevant literature. In March, 2010, the PUBMED, JSTOR, and MEDLINE databases were queried with the search word 'clinical microsystem'. Complementary searches were made on the websites www.clinicalmicrosystems.org and www.qultrum.se. In total, 26 articles, one thesis, a book, and two reports were found to address the framework of the microsystem. A selection was made of the literature which was to form the foundation for the subsequent analysis. Articles which dealt with learning aspects, and the conceptual framework and its development were chosen over articles which merely described an intervention where the microsystem was used. The analytical foundation thus consisted of 11 articles and a book, all of which were published between 2002 and 2008.

6.4.2.2 Analytical framework and the analytic process

An analytic 'lens' was constructed with theories of learning, communicative theory, and social theory which was used as a filter to make the literature's pedagogical aspects visible. This eclectic approach was used to capture a broad pedagogical perspective which included aspects of learning as well as those social aspects which the microsystem is part of. So as to facilitate the interpretation and explain these pedagogical aspects, the theories were dismantled into complementary pairs of concepts which represented a strategic rationality and a communicative rationality (Habermas, 1987b; Fritzén, 1998). The process of analysis can thus be said to have taken place via a hermeneutic discursive tradition (Gadamer, 1975/2004; Kögler, 1996; Chouliaraki & Fairclough, 1999). I performed the data collection and analysis, and the co-authors participated by deepening the theoretical aspects of the study and by contributing to the discussion of the results.

6.4.3 Performing Study II and Study III

Study II and Study III were designed to answer the thesis's second research question: How do pedagogical conditions (external and internal) reveal themselves in the negotiation about change that takes place in an improvement practice?

6.4.3.1 Data collection and participants

An orthopaedic and rheumatology clinic in the JCC was chosen to be a participatory clinic, because the clinic has organized its improvement work in the form of a regularly re-occurring point of discussion in the clinic's different

staff meetings. The studies that are presented in this thesis are limited to an investigation of the on-going improvement work that took place at the clinic and does not include improvement work which is part of any time-limited improvement project. The principle that was used to make this choice entailed that I consciously searched for cases based on their specificity (Geertz, 1973), and not in terms of how representative they might be.

The interactive approach was adopted in cooperation with a parallel project within BtG which also collected data at the clinic. Initially, the interactive approach consisted of planned meetings with the clinic's management group and development manager. A collective follow-up was made where the studies' tentative results were presented to and discussed with the management group and development manager, and with the participants of the meetings which were originally observed. A detailed description of the interactive research process and the data collection process can be found in Appendix 1.

The clinic has established a particular manner of working to improve the patient's care process as the patient proceeds through the healthcare system. This entails that different process teams have been formed to review patient safety and the lead times for different patient groups. There are thus a 'wound team', a 'knee team', a 'hand team', and so forth, who regularly meet, to follow-up on their performance within the framework of each respective process. I decided to observe a process team because it represented a mesosystem in the healthcare organization. It consisted of a network of representatives from different microsystems, where the participants did not work with each other on a daily basis, but shared a common assignment to improve the patient's process through the healthcare system. The team that was observed met two times per term and was led by a development manager. During the observations, the number of participants in each meeting varied between 6-8 people. The participants of these meetings came from primary care and from specialist care units. The specialist care participants included physicians, a nurse, a care administrator, an occupational therapist, and a physiotherapist who worked at different units that were attached to the clinic or to the hospital as a whole. The primary care participants included a physiotherapist and an occupational therapist from two different primary care centres. The team was observed on two occasions; on 20-01-2010 and 01-06-2010.

I decided to observe a work place meeting on one of the wards, where the participants knew each other well via their daily work. This represented an example of a microsystem in the healthcare organization.[28] The ward unit is a

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[28] The patients are not part of the dialogues that took place during the work place meetings, despite the fact that the patients are natural members of the microsystem. The patients' voices are heard, to some

cohesive organizational unit which is led by a ward manager, who is also the ward staffs' immediate supervisor. The staff consists of the unit's nurses, assistant nurses, and secretaries. The number of staff varied between 15-19 people during the period when the observations were made. The work place meetings are led by the manager, and the development manager sometimes participates in these meetings. This regular meeting is held every fortnight. Observations of three work place meetings were made on 03-06-2009, 09-09-2009, and 04-11-2009.

From a social learning perspective, the ward unit can be described as a Community of Practice (CoP) (Wenger, 1998). The staff share responsibility for their patients, they work in the same organizational unit, and they share a common 'repertoire' in terms of professional language, routines, and work assignments. The process team, however, is a network of several CoPs, where they share a common responsibility in improving the patient's care process. However, they do not belong to the same organizational unit, nor do they share a common repertoire, and thus cannot be considered to be a CoP.

During their meetings, the process team and the ward staff discuss their performance results which include patient waiting times for operations, estimated patient satisfaction, adherence to hygiene routines, and so forth. The conversations address how the staff members interpret and negotiate improvements in the results of their performance reports. The conversations were audio taped and I took notes to facilitate the transcription of these conversations. A total of 180 minutes of conversation were recorded, equally divided across the ward meetings and the process team meetings. The data collection consisted of a participatory observation. Following Gold's classification scheme (Bryman, 2002: 286), my role as a researcher held a high degree of distance, hence I never participated in any of the discussions. I used the interactive approach to all of my contacts with the practice. I performed the data collection and analysis, and the co-authors participated by deepening the theoretical aspects of the studies and by contributing to the discussion of the results.

For Study II, all of the data from the ward meetings and the team meetings was collated together. The transcriptions were divided into themes in terms of what the primary topic of conversation was so that a CDA analysis could be then performed. In Study III the transcriptions from the two types of meeting were analyzed separately because I wanted to compare the negotiation within the microsystem with the negotiation within the mesosystem. I also wished to

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degree, in the follow-up reports that are presented to the staff members in cases where the patients have evaluated their satisfaction with the way they were initially treated at the clinic and with respect to the result of their medical operations.

study how the internal pedagogical conditions were expressed in the ward meetings in relation to how they were expressed in the team meetings. This was done to investigate the discursive differences between an improvement practice which shared a common work place and an improvement practice that did not share a common workplace. A number of reoccurring themes which represent central issues in the work on change in the healthcare system were chosen which were then used to make a more detailed transcription and CDA analysis which focused on participants' interaction. The theme *hygiene routines* was identified in the ward meetings, and the theme *patient satisfaction* was identified in the team meetings. The decision to make a more thorough interactive CDA on a selection of representative sequences of texts was based on the discussion of the risk of 'under analysis' if one summarizes texts before they are discursively analyzed (Antaki et al, 2002; Breeze, 2011; Baker et al, 2013).

6.4.3.2   The process of CDA analysis

The study of discourse and its attendant social change, demands that language be analyzed in three dimensions. These three dimensions are (i) text, (ii) discursive practice, and (iii) social practice (Fairclough, 1992). (See Figure 5.)

Figure 5. The three-dimensional conception of discourse

TEXT

DISCURSIVE PRACTICE

(production, distribution, consumption)

SOCIAL PRACTICE
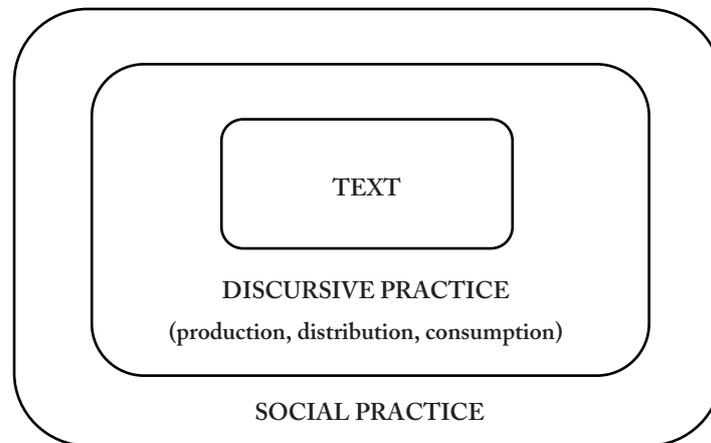
The three dimensions of a discursive event, for instance a conversation about quality improvement (Fairclough, 1992: 73, Fig. 3.1)

The conversational situations that were observed for this study can be considered to be different *discursive events*. During the conversation, a *text* was

produced which was transcribed for further analysis. The text that is produced is influenced by the interaction that takes place during the negotiation. Fairclough (1992) calls this the production, distribution, and consumption of the *discursive practice*. In Study II and in Study III, the discursive practice consisted of the interaction, positioning, and argumentation that took place in the ward meetings and team meetings respectively. Finally, a discursive practice is influenced, and consequently the text that is produced, by what happens and is uttered in the surrounding *social practice*. This is made manifest in the thesis by taking the organization of the healthcare system into account, with particular focus on the financial conditions which characterize the healthcare system of the 2010s. No discursive practice is isolated in a vacuum. That which was said in the meetings that were observed, also needs to be viewed as being representative of what is said in the discursive practice's surroundings.

A CDA analysis consists of three phases which correspond to a (i) descriptive, (ii) interpretative, and (iii) explanatory analysis of the same discourse event. So as to clarify the analytical process, I developed an analytical framework which contained specific empirical questions for each of the analytical phases in the studies that I conducted. This is accounted for in each article included in this thesis. This approach was inspired by Heck (2003), and the earlier mentioned critique and pitfalls of the CDA methodology (Breeze, 2011), which enabled a more distanced analysis of the conversations whilst keeping the research questions in focus.

The *descriptive text analysis* consists of a linguistic analysis which identifies intertextuality and meaning formation in the text. This was done on different levels of detail, depending on the research question that was posed. Study II attempted to capture *what* the participants were talking about and what meaning they placed on what was said. Study III included a more detailed linguistic analysis which contained components of a conversational analysis (Norrby, 2004) since the main research question was to identify *how* the participants conversed with each other.

The *interpretative discourse analysis* is based on what was identified during the descriptive phase of the analysis, and includes the study of the negotiation that took place in the discourse practice. Study II included the discourse practice of the team meeting and the ward meeting together. In Study III, the team meeting and the ward meeting's discourse practices were analyzed separately and then compared with each other. The negotiation in a discourse practice is dependent on the participant's ways of being (their identity), the way that they interact with each other, and the way in which they represent that which is said in the surrounding social practice (Fairclough, 2011). Despite the fact that these processes take place simultaneously, I chose to focus on the aspect

of representation in Study II, and the aspect of interaction in Study III. This was done because the aspect of interaction needs to be related to every specific context where the conversation takes place, and it was of interest to compare the contexts with each other in the light of previous debates in the literature about homogenous and heterogeneous improvement practices.

The interpretative step entailed developing an understanding of the discourses which regulate the text. This included identifying the discourses which place conditions on what can be said or not said in the conversation. The interpretation is based on an articulated theoretical point of departure which was used as a filter in the identification of the discourses that were present and their meaning. In Study II, where the external conditions were studied, the concepts of 'strategic rationality' and 'communicative rationality' (Habermas, 1987b) were used as a theoretical filter. In Study III, where the internal conditions were studied, the notion of a Community of Practice (Wenger, 1998) and, primarily, the concept of 'practice as negotiation of meaning' were used as theoretical filters.

The final, *explanatory phase*, is used to make the discourses that were identified (and their ordering) understood to the reader in relation to the prevailing conditions of the social practice. In Study II, the discourses were explained in relationship to the governance principles of the healthcare system. In Study III, the team and ward staff's meeting were described in relation to Community of Practice theory and to previous research on this area. The explanatory analytical phase allows the researcher to go beyond the text-interpretative level. The description and the interpretation are linked into a wider social context which, together with a social theory, explains why the discourses that were identified are considered to be reasonable and legitimate in the particular situations in which we find them (Lund & Sundberg, 2012).

6.4.4   Performing Study IV

Study IV was designed to answer this thesis's third research question: What identifies coaching as a pedagogical support for learning processes in improvement practices?

6.4.4.1   Data collection and participants

A group of coaches from a development unit in JCC willingly participated in the data collection for Study IV. Since there existed no meeting place where these individuals would normally get together and exchange their experience of pedagogical issues at work, the coaches were invited to form a group specifically for the purpose of this study. The coaches should be considered to be experienced coaches (with an average of 12 years' experience, varying between 3-18 years) who perform improvement work within a number of different healthcare settings and improvement areas. The participating coaches

were also employed as coach trainers for other county councils, as well as in other countries, due to JCC's well-known use of quality improvement as a strategy to improve the provision of care. The choice of coaches thus follows the same principle with respect to my search for specificity in Study II and Study III, such that improvement coaches who had long experience in leading improvement work were chosen.

The study's hypothesis was that such experienced coaches possess tacit knowledge about their approach to learning and the prevailing conditions of an improvement practice. The aim of the study was to create a forum where the coaches could articulate their experience which could also be filmed as empirical material for the study. My role as a researcher was more participatory than compared to my role in Study II and Study III since I led the conversations and the group's reflections. *Dialogue seminars* (Göranzon, 2001) were thus used as a pedagogical method to allow the coaches to articulate their experiences. The coaches prepared themselves before the meetings and talked about some specific events which dealt with learning, which they had reflected over and then discussed with the group. I was present on two occasions with a coach and filmed this person's practical work. I selected clips from this film and showed them to the group so as to facilitate a more profound reflection over their approach to different situations. Despite the fact that I had a more participatory role in these meetings, the coaches' reflections were the object of analysis. The interactive research approach was performed together with the group of coaches. We met twice to plan the study, and then another two times to follow up on the study's results. Data collection took place on four occasions between 06-09-2013 and 12-12-2013. Appendix 2 describes the arrangement in detail as well as how the data collection and the planning were conducted. I made all of the contacts with the practice myself, via the interactive approach. My co-authors on this article participated by discussing the results of the study together.

6.4.4.2 The process of CDA analysis

Similar to the other case studies, I employed an analytical framework on empirical questions so as to increase the transparency of the analysis. The descriptive text analysis focused on *what* the coaches reflected over with respect to their strategies to support learning within an improvement practice. This also included the role that they adopted with their interaction with the practice. The coaches' reflections were classified into three different themes according to the metaphors that they invoked to describe the strategies that they used to facilitate learning in practice. The decision to use the coaches' metaphors was based on the practical knowledge interest of this thesis. Cognitive orientated theories about metaphor and discourse claim that metaphors mediate understanding of the world around us (Lakoff & Johnson, 1980; Musolff, 2012). Metaphors can also support learning processes in

organizations (Fritzén, 2007). The classification of metaphors can thus support future reflections on how improvement coaches can make their support for learning more professional.

In Study IV, the discourse practice is instantiated by the group of coaches. The analysis focused on the interaction between the coaches and the staff in an improvement practice as it was re-told and discussed by the coaches in their discourse practice. To limit the scope of the study, I did not analyze the interaction within the group of coaches. During the interpretative phase of the analysis, the concepts of 'strategic rationality' and 'communicative rationality' (Habermas, 1987b) were used as a theoretical filter in search for the external and internal conditions which influenced the coaches' pedagogical approaches. In a manner similar to Study I, the concepts were deconstructed into complementary pairs which characterized the different rationalities (Fritzén, 1998). In the interpretative phase, the complementary pairs were used as a filter to interpret and locate the different pedagogical approaches within a field between strategic rationality and communicative rationality. During the analysis, a number of discourses were identified and later explained in terms of their relationship with each other. The discourses were also explained with respect to the *God Vård* policy (Socialstyrelsen, 2006), and with respect to the prevailing conditions associated with improvement practices.

6.5 Validity issues

For a long period of time now, the social sciences have been criticized for not having the capacity to generalize conclusions to other contexts (Ercikan & Roth, 2009). In the 1980s, Lincoln & Guba (1985) introduced the notion that qualitative studies should not be evaluated by the same criteria as quantitative studies. They suggested that qualitative studies be assessed by their *trustworthiness* and *authenticity*. Since then, the gap between quantitative and qualitative studies has been questioned, and social scientists claim that generalization from qualitative studies is something that is both feasible and wished for (Ercikan & Roth, 2009; Eisenhart, 2009). The selection of the particular cases that are studied and how the studies are conducted are, however, important prerequisites to fulfil by the researcher, if the researcher wishes to claim results from which generalizations can be made.

This thesis claims *theoretical generalization*[29], in the sense that the conclusions are generalizable in the context of a theoretical debate (Eisenhart, 2009). The conclusions are not primarily concerned with their extension over a larger population. In striving for theoretical generalization, the selection of a site to

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[29] This approach is also referred to as "analytic generalization" (Eisenhart, 2009).

study is based on the likelihood that the case will reveal something new and different. The criterion for selecting cases from which one will generalize is neither random nor representative sampling, but does include the extent to which the selected case is likely to establish, refine, or refute a theory (ibid.). The case selection in this thesis follows this principle, because each case was sampled in terms of its specificity (Geertz, 1973). Theoretical generalization provides a cumulative method of theory elaboration that progressively enhances a refined understanding of a specific phenomenon, which goes beyond the studied context (Eisenhart, 2009). Consequently, within this approach, there is no ambition to generate a new theory via an inductive method, according to Glaser and Strauss (1967). Theoretical generalization corresponds more to a pragmatic view of knowledge considered as an on-going and self-modifying process (Dewey 1916/1997; 1922/2002). This thesis develops the conceptual framework of the clinical microsystem, and contributes to the social constructionist field of improvement science with pedagogical and discursive views on improvement and change. Consequently, previous research on learning and change, as well as previous use of CDA methodology in healthcare research, takes a prominent position in this thesis.

This thesis claims theoretical generalization, but this claim does not disregard the significance of trustworthiness and authenticity as outlined by Lincoln & Guba (1985). On the contrary, this thesis has emphasized how previous critiques of CDA and several pitfalls associated with this methodology have informed the design and performance of the studies. This was done so as to ensure transparency and trustworthiness. For example, the CDA-studies in this thesis were designed to reveal dominant power structures in practice. However, two of the studies did not reveal any such dominant structures. Study III did not show any power conflicts in the network, even though previous research's emphasis on power conflicts in networks was taken into account. Neither did Study IV show any persistent dominant discourse, although the presence of such a discourse may have reasonably been expected. Instead, the order of discourse took on a variable nature, depending on how the contextual conditions correlated with the legitimate ideas that were found in each discourse.

Based on a critical and interpretive social sciences research tradition, this thesis uses language to reveal the mechanisms which regulate the social events that take place within an improvement practice. This was done with the ambition in mind to make participants in an improvement practice more conscious of what takes place in such a practice. With increased understanding of their practices, practitioners can act more rationally and more self-reflectively: "*Practices are changed by changing the ways in which they are understood*." (Carr & Kemmis, 1986/2006:91). One fundamental demand with respect to the credibility of the claims made in this thesis is that its results can be fed back

into these practices, so as to increase the practitioner's levels of knowledge, consciousness, and understanding of their practices and that which governs them. The results of the study also need to be able to be fed back into the practice so that the participating informants can validate the credibility of the claims made in the study. A theoretical interpretation of a participant's actions is only valid if the participant deems the interpretation to be correct with respect to how they themselves ascribe meaning to their actions (ibid: 92). These feedback actions have taken place with respect to the participating informants within the interactive approach that was adopted by the researcher. In Study I, I employed an ecologically inspired validity check (Bryman, 2002: 46) by sending a draft copy of the article to the authors of the microsystem. These authors checked that I had not misinterpreted any of the fundamental points of their framework. The actions that were undertaken to validate and to feed the results back to the site under investigation thereby supports the validity claim of authenticity, as mandated by Lincoln & Guba (1985).

CDA is a three-phase analysis which demands consistency between the different analytical steps. Validity claims are dependent on the inferential links that are made during the analysis to create useful knowledge (Bachman, 2009). In this thesis, I have ensured the analytical trustworthiness by constructing transparent analytical frameworks for each study in which empirical questions guided the analysis forward. The constant use of CDA in this thesis stems from a knowledge interest in the investigation of how the context influences improvement work, and especially, how pedagogical conditions are made manifest in improvement practices. CDA provides a way to 'capture' context in the negotiations about change that take place in improvement practices. This entails that the thesis, in line with a theoretical generalization perspective, elaborates on previous research that proposes that local negotiation about change is a prerequisite for knowledge translation (Greenhalgh et al., 2004; Dixon-Woods et al., 2011). The conclusions of this thesis should thus be regarded as contributions to earlier theories and concepts, and should not be regarded as conclusions that can be automatically realized in new contexts. The CDA program includes the view that discourses cannot travel from one context to another without a new re-contextualization (Fairclough, 2013; Chilton et al., 2013). Every transfer of an argument entails a new interpretation where interdiscursivity and dominance is conformed to the new situation. This implies that a re-contextualization can be considered as an appropriation of an argument (context dominates the argument), or as a colonialization of a new context (the argument dominates the context) (Chilton et al., 2013). CDA proponents (Fairclough, 2013; Chilton et al., 2013), claim that a generalization of a discourse always entails a new discursive process, which is the reason why CDA researchers need to be careful about statements of discourse consequences in other (not investigated) contexts. CDA provides an in-depth analysis of learning and change in specific

improvement practices, where social theory can explain why the identified discourses are reasonable and legitimate at a particular time and situation from a socio-cultural macro perspective. The conclusions drawn in each of the case studies point to a phenomenon of social actions and how it corresponds to previous research and theory elaboration, and thereby transcend contexts.

6.6 Ethical considerations and my role as a researcher

Two ethical consent applications were approved by the Ethics Committee in Linköping.[30] The individuals who were part of this research and from whom data was collected all signed informed consent forms. With respect to the data collection that took place for Study II and Study III, the director of the clinic permitted that the name of the clinic be used in the study, but the participants in the team meetings and staff meeting be kept anonymous. With respect to the data collection for Study IV, the director requested that both the unit and the participants remain anonymous.

My role as a researcher can be described as both (i) distanced but also (ii) well-acquainted with the situations that were observed for the present studies. My professional experiences are based on my primary career as a physiotherapist. I have worked as a development manager and a manager for many years in primary healthcare and rehabilitation. I have also worked as an investigator for healthcare management at a governing office in a county council. I thus have wide-ranging professional experience of the healthcare system's micro-, meso-, and macro-levels, although I have never worked for Jönköping County Council where the studies were conducted. This enabled me to maintain a distance between myself and the informants of the studies. I have also tried to continuously maintain a self-reflexive approach, outlined by the interactive research design, when I have moved back and forth between the empirical contexts and academic contexts that have been part of this thesis project.

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[30] The first ethical consent application covered the data collection for Study II and Study III, Dnr 2009/137-07. The second ethical consent application covered the data collection for Study IV, Dnr 2013/334-31.

7　Results

In this chapter I present a summative result of each study which, taken together, correspond to the overall aim to analyze and explain the pedagogical conditions that take place in improvement practices in a 2010s healthcare system.

7.1　Pedagogical aspects in the clinical microsystem framework (Study I)

The aim of Study I was to (i) scrutinize, and by using pedagogical theory (ii) clarify, aspects of learning that the clinical microsystem framework contained, and thereby support the clinical microsystem model with the pedagogical perspective that was revealed.

The result clarified three pedagogical aspects which concern (i) *governance and ethos*, (ii) *particular and holistic metaphors*, and (iii) *power and equality* within a microsystem. *Governance and ethos* are expressed via the meaning of individual and relational learning. In the framework, there exists a desire to use a relational approach towards learning, but in the description of the practical improvement work we note that individual learning processes are in the foreground. The social interaction is well-documented and is explained in terms of necessary inter-professional cooperation, but not as a condition for learning. The individual learning processes are described in terms of increased production of care and results. The relational learning processes are described in terms of inter-professional trust and respect, along with a joyous and meaningful exchange of experiences. The theoretical framework lacks awareness of the different rational foundations for learning, which could be better used in a more conscious approach to use different learning strategies for different purposes. For example, the individual point of departure might fit when stability and standardization is sought after because this supports a linear way of thinking. However, when the goal is unpredictable and innovative

solutions are sought after, a relational way towards finding better solutions might be a more successful approach.

The literature overview revealed how metaphors that are used to describe the microsystem have changed over time. In the beginning, particulate metaphorical descriptions were used, as seen in the following remark: "*the essential building block of the health-care system*" (Nelson et al., 2002: 474). This was later developed into a more process-oriented view of the microsystem's place in a care chain. This can be explained by the authors' desire to emphasize the importance of practical development work. In their report, *From Front Office to Front Line – Essential Issues for Health Care Leaders* (Batalden et al., 2005), the authors turned the traditional organizational pyramid upside down so that the base of the pyramid was at the top. The inverted pyramid's top was made up of the different microsystems and their interaction in the process of care delivery. In later publications, we find more holistic descriptions, in terms of a hologram (Nelson et al., 2007) or as a model of an atom (McKinley et al., 2008), which are used to capture the complexity of the patient's system of care. The hologram is symbolic of how every small microsystem also represents the mesosystem and the macrosystem's control. The model of the atom symbolizes how the microsystem can be seen as electrons that oscillate around a nucleus which consists of the patient and the patient's family. In this illustration, the microsystem is seen to engage with and support the patient at precisely the right time and with the precision with which the patient needs it. From a pedagogical perspective, the use of metaphors that give rise to a particular way of thinking can be problematic when one wishes to convey a holistic view of a situation. A pedagogical potential is thus to develop a use of language which supports an image of the healthcare system as a complex social system, instead of the use of mechanical language which reduces it to a linear system. This is also supported by research into complex adaptive systems (Begun et al., 2003; Glouberman & Zimmerman, 2004).

The following excerpt suggests that a change in the use of language is needed:

> *Clinical leaders can find new energies for common efforts to study and improve their work for patients as they gather around the focus of the actual unit of daily practice—crossing disciplinary and specialty boundaries—using the language of processes and systems, rather than the more conventional role or discipline-bound conversations that often seem to limit change and improvement. (Mohr & Batalden, 2002: 49).*

The authors argue for a use of language that moves away from certain professional and specialist patterns of speech, but they ignore the fact that change is difficult to achieve in multi-professional and interdisciplinary groups (Skjorshammer, 2001; Pethybridge, 2004; Reeves et al., 2009; Nugus et al.,

2010). It may be the case that the framework highlights the fact that *power structures* can be found in a microsystem, but it does not include the importance that asymmetrical dialogue has for learning, or how communication that is based on equality can be supported so as to avoid hierarchical structures.

In summary, a particular and individual perspective on learning and change emerges, despite the aim to capture a complete image of the complexity in the healthcare system's interactive links. Social processes and unequal conditions are note-worthy, but not in terms of learning. The pedagogical processes are mostly described in terms of how one can learn *about* the microsystem model, via action, experiments, and reflection, with reference to Deming's (1994) PDSA-cycles. The authors have presented a practical model which one can work towards, but the model contains no conceptualization of learning on a more abstract level so that the rational foundations of learning can be understood.

7.2 External conditions as pedagogical prerequisites in an improvement practice (Study II)

The starting point of Study II is how the Swedish healthcare system, during the early 21st century, has become characterized by becoming more service-orientated and more susceptible to market forces (Hasselbladh et al., 2008). Using a critical research interest, I problematize that which is taken for granted in learning by investigating the prevailing external conditions for an improvement practice. The aim of the study was to identify the discursive patterns that were found in conversations about quality improvement in an improvement practice in healthcare, so that, in the next stage of the research, I could discuss how these patterns created conditions for learning.

The study revealed four discourse patterns in the staff members' negotiation about change: (i) a 'market' pattern, (ii) a 'healthcare-for-everyone' pattern, (iii) a 'medical' pattern, and (iv) a 'value' pattern. Conversations that followed the *market pattern* dealt with how a higher rate of production was sought-after so that budgetary constraints could be adhered to and how risk assessments for elderly patients should be prioritized since such assessments attracted additional funding for the clinic. The county council uses a P4P model to motivate the staff to increase the number of risk assessments that they conduct for elderly patients. Conversations in the *healthcare-for-everyone pattern* addressed the issue of using available resources to their maximum effect so that the clinic could provide healthcare for as many patients as possible. Conversations in the *medical pattern* dealt with the professionals' knowledge of what the patients' needs are, and were based on evidence, operation

techniques, and patient safety. The professionals are experts who objectified the patient in conversations about what is best for the patient. The *value discourse pattern* is characterized by a subjective view of the patient. In these cases, none of the participants had solutions to the problem in advance, which is why they all engaged in a process-oriented search for better ways to create value from the patient's perspective.

System logic is most apparent in the market pattern, where money directs and motivates the staff's actions. System logic can also be found in the medical pattern in terms of how the experts objectivise the patient. Communicative logic is most apparent in the value pattern, where solutions are not obvious, but, instead, need to be negotiated so as to deepen the mutual understanding of what needs to be improved. The most atypical pattern is the healthcare-for-everyone pattern, where the staff members discuss different ways to increase their productivity (indicative of system rationality) in their attempt to provide equitable healthcare for everyone who needs it (indicative of communicative rationality). The healthcare-for-everyone pattern tends to integrate both rationalities, which suggests a discursive change with respect to the reproduction of these rationalities.

My analysis revealed that the market pattern becomes dominant when money is linked to quality goals. When there was money to be gained, the negotiations were aimed at how one could attract more money to the clinic, instead of creating equal healthcare for everyone, satisfying the patient's medical needs, or providing that which is most meaningful for the patient. The result of the study also showed a balance between the discourse patterns when financial incentives were not present in the conversation. In other words, the professionals could deal with complex and sometimes contradictory quality aspects when they did not compete for money. The discourse patterns demonstrate that market logic is placed in the foreground when performance-based compensation is linked to a particular quality goal. The inter-professional depth in the discussion about that which creates added value for the patient is suppressed in these circumstances. The study shows that when financial incitements do not influence the improvement practice, then a balance between system rationality and communicative rationality in the professionals' conversations about change obtains, just as is mandated by the *God Vård* policy (Socialstyrelsen, 2006).

Study II shows that market logic can implement short-term control of an improvement practice. However, in the long-term perspective, we should take into account the quality aspects that are left behind, because of displacement effects. The pedagogical conditions, that is to say what the staff members learn when the market pattern is dominant, is that the patient represents an economic value, where short-term profits which improve the budget supersede

questions about long-term, profound development of knowledge (in this case, how orthopaedic care processes can be improved). Because the study shows how the market pattern instantiates a pedagogical condition for the improvement practice, the external conditions were also taken into consideration in Study IV, the analysis of coaching practices.

7.3 Internal conditions as pedagogical prerequisites in an improvement practice (Study III)

Study III investigated the internal conditions for learning and change in two different improvement practices. These two improvement practices represent a microsystem and a mesosystem in the healthcare system, respectively. The microsystem is instantiated by how the ward staff members discuss improvements at a regular ward meeting, and the mesosystem is instantiated by a process team which discuss improvements at a team meeting. The aim of Study III was to analyze and explain how, in their interaction with each other, the staff members negotiate change in the ward meeting compared to the process team meeting.

The results of the study showed that explicit negotiation is key to change. At the interface between adaptation and change, we find that norms are at stake. Explicit arguments open up a space where old habits and innovative initiatives can be evaluated. My analysis showed that the process team found it easier to engage in explicit negotiation when compared to the ward meeting. Because the participants of the team meetings came from different microsystems, and did not know each other very well, they had to explain their work routines more clearly to the others. The negotiations that took place in the process team meetings featured a pronounced interactivity and openness, where stories about patients played a large role in the meaningful content of their conversations. During the ward meetings, negotiation was more implicit in nature. The routines and the hierarchies on the ward were taken for granted, and were thus deemed unnecessary to talk about. This entailed that initiatives for change were not communicatively valued in the same way that such initiatives were valued in the process team meetings. How these explicit and implicit ways of negotiation were instantiated at the meetings can also be explained in terms of the groups' size and the hierarchal structures in the groups. The process team consisted of six people, which gave people more space for interaction, compared to the ward meetings which consisted of about 15 people. The hierarchal order at the ward meetings were more structured when we consider the fact that the ward manger led the meetings and there existed a ranking between the other participants of the meetings. The process team, however, was led by a development manager who was not anyone's boss,

and there existed no ranking between the other participants in terms of delegating work to each other.

Previous research has shown that conflict often hinders the progress work that is done within a network of people (Bate, 2000; Ferlie et al., 2005; Nicolini et al., 2008). But the results of my study reveal no such conflict, and, instead, support other research which has shown that work that is done by a network of people promotes learning and change (Brown & Duguid, 1991; 2001; Health Foundation, 2014). This study contributes to this area of research by providing a discursive explanation of why change is easier to implement in heterogeneous groups. One explanation as to the lack of conflict and social battles within the team can be attributed to the fact that they had worked together for a number of years previously and had established routines for cooperating with each other, which previous research has shown favours work that is done by a network of people (Oborn & Dawson, 2010). Note too, that the team shared a common assignment in improving the patients' care process, which also supports network collaboration (Tagliaventi & Mattarelli, 2006).

By analyzing the interactive process of negotiation in a microsystem *and* a mesosystem, I revealed a number of internal conditions for different organizational improvement practices. The results show that the social positioning within the team was negotiable when patient cases were discussed, which confirms previous research which claimed that stories about previous patients can be used to reduce social asymmetries in negotiations about change (Gabbay et al., 2003). The results imply that improvement practices that feature homogeneous internal conditions need pedagogical support so that the practice can obtain a perspective of what is taken for granted. This is done so that explicit negotiation about change can be created. An external coach, who is not part of the daily work of the improvement practice, would constitute such a pedagogical support. This observation prompted me to study the improvement coaches' pedagogical approaches with respect to improvement practices in Study IV, as examples of further pedagogical conditions in a healthcare system improvement practice.

7.4 Coaching as a pedagogical prerequisite in an improvement practice (Study IV)

In the light of the results obtained in Study II and in Study III, Study IV investigated the pedagogical approaches that improvement coaches use when they consider the prevailing external and internal conditions for an improvement practice. The study notes that there exists a contradiction in the individualization with respect to knowledge of improvement work in specific coaches, whilst success is realized by creating a learning organization that

relies on the improvement practice's own motivation and knowledge. The aim of the study was to identify discourse patterns in how the coaches explain how they support learning in their improvement practices, as well as to explain the discursive patterns in relation to fundamental ideas about improvement and the prevailing conditions in the healthcare system.

Three discourse patterns were identified: (i) a 'management' discourse, (ii) a 'professional' discourse, and (iii) a 'disguised' discourse. The management discourse is aimed towards obtaining results. The pedagogy that appears in this discourse can be described as governing and aims at providing the patient with better solutions. The professional discourse is more process-orientated so that long-term and sustainable results are achieved. The pedagogical approach here features the energy and the needs of the improvement practice. Participants are authorized to engage in the improvement work together with the patient who is also seen as a member of the improvement practice. The disguised discourse includes the same pedagogy as the professional discourse, but also includes a number of manipulative strategies which avoid accepted hierarchies and other obstacles which prevent the emergence of better solutions for the patient.

These discourse patterns represent different claims with respect to quality as documented in the *God Vård* policy (Socialstyrelsen, 2006). The management discourse focuses on the healthcare system's need for effective solutions, and the professional discourse represents patient-centred values and long-term values in terms of establishing a self-supportive learning organization. The disguised discourse, however, cannot be related to a particular quality aspect. Instead, it can be seen as a consequence of how improvement ideas challenge traditional structures in the healthcare system. Effectiveness and patient-centeredness challenges the legitimacy of the professionals 'as experts'. Consequently, the coaches need to 'disguise' their assignment, so that they will be accepted by the improvement practice. The coaches adapt their case examples and their use of language so as not to threaten the existing structures in the improvement practices that they work with. The disguised feature of the discourse entails that the coaches adapt to the practice's social expectations, whilst they remain faithful to their assignment of implementing change. The coaches thus 'infiltrate' the improvement practice by working 'undercover', so that they can get to dysfunctional structures.

None of the discourses which were identified in Study IV were granted an overarching dominance. Instead, I observed an adaptation to the external and internal conditions, which, in turn, determined which discourse gained interpretative dominance. For example, when money and the P4P model emerge as controlling external conditions, then the professional discourse became dominant. Financial incitements were not seen as a support for

achieving quicker results as featured in the management discourse; instead, they were seen as a threat to that which creates value for the patient. The professional discourse became dominant so as to protect the patient against the attraction money may otherwise have for the improvement practice. The dominance of a particular discourse tended to vary, depending on how the prevailing circumstances correlated with the quality claims associated with each of the discourses.

The results indicate that three prevailing perspectives (discourse patterns) regulate the coaches' pedagogical approach towards the practice. This entailed that the way that they supported the group's learning (by driving it forward, guiding the participants, or empowering the participants) was dependant on the conditions. The learning organization which is thereby created is given different content and meaning, depending on which quality claim is being prioritized, taking the prevailing conditions into account. A dominant management discourse leads to an organization which is aimed at action and behaviour which prioritizes quick results where the staff's contributions are evaluated to see whether this has led to better solutions for the patient. A dominant professional discourse, however, leads to an organization which aims to achieve sustainable results. This is done by supporting an approach which is based on understanding, where the practice itself, together with the patient, is engaged in improvement work. A dominant disguised discourse leads to the same type of learning organization as the professional discourse, despite the fact that it may have been done through the use of manipulative strategies.

The results of the study show how an improvement practice can be supported pedagogically so as to promote learning in a healthcare organization. One avenue of approach is to support improvement practices with external coaches (who do not take part in any financial bonuses that the unit might be awarded) in an effort to balance the different values which are of importance for the patient. There does exist a danger that improvement knowledge and the motivation for change becomes individualized and located with individual coaches. The management discourse in the study notes how the coaches take on a great deal of responsibility so that the improvement practice will attain pre-established goals. This entails that the healthcare organizations may become dependent on coaches to conduct improvement work. The pedagogical approach that is instantiated by the professional discourse and the disguised discourse are more long-term and structured ways to establish a learning organization in the healthcare system, since they also include the patient's perspective. However, this demands that improvement coaches do not take learning for granted. They should engage in a professional and critical discussion about how one goes about establishing a learning organization under the prevailing conditions.

8 Discussion

In the following chapter, I discuss the collective results of the four studies and relate them to the overarching aim of this thesis, which was to analyze and explain the pedagogical conditions that take place in improvement practices in a 2010s healthcare system.

The discussion touches on the pedagogical conditions that are expressed in improvement practices and the conclusions that we can draw in terms of theoretical and practical implications further to this. I discuss several methodological issues that relate to what a discursive framework can contribute to our understanding of improvement practices in the healthcare system. The discussion ends with some observations concerning methodological limitations, suggestions for further research, and some summary conclusions and reflections.

8.1 Pedagogical conditions in today's healthcare improvement practices

8.1.1 The mechanism of market logic

When money is used to motivate change, money also creates meaning in negotiations about change (Study II). This is expressed, for example, by the staff members' decision to expend energy and time on risk assessment for patients over the age of 65 because this would bring in extra funding to the clinic. Despite the fact that the staff think that every patient needs to be risk assessed and that taking action to prevent the risk is more important than assessing the risk, they prioritize action that brings in more money to the clinic. Research into the coordination of cancer care in England has come to a similar conclusion, where it was observed that conversations in the cancer network meetings dealt with the division of funding and did not deal with questions of what created added value for the patient (Addicott et al., 2010).

This market logic also makes itself felt in the staff members' approach and assumption of responsibility so that every patient should get the care that they need (Study II). Market logic encourages care providers to reinforce their financial position by attracting as many patients as possible. This was expressed in the empirical material used in this study with reference to a care provider which had a healthy financial status and so could afford to provide an overly polite initial contact with each patient. If the healthcare system's resources are going to be enough for everyone, the care providers also need to take responsibility for the whole system by putting demands on the patients, for example patient self-care or training. This was expressed in the data as: 'There are many doctors who satisfy their patients!' It is easier to be friendly and satisfy individual patients, than to take responsibility and put demands of the patients so that the finite resources that are in the healthcare system are enough for everyone. The market logic impinges on the professionals' responsibility towards the whole system (since it distracts them to focus on small, local issues). This has been noted in previous research too (Reinders, 2008; Solbrekke & Englund, 2011; Malmmose, 2014).

The market logic also gives rise to the formation of professional counter-discourses which are intended to protect that which creates value for the patient. Study II shows that care programs were established to standardize the provision of care for patients, and to prevent *cream-skimming*. Patients are to be provided the care they need irrespective of their cost to the care provider. Similarly, another professional counter-discourse in Study IV shows that coaches defend patient values against the attraction that an improvement practice may have towards money. The coaches, for example, highlighted the need of return visits for cancer patients, because the improvement practice was focused on getting new patients (which gave additional funding).

Despite the fact that ideas about improvement work are sometimes expressed in a contrasting fashion, focusing of effectiveness and on meaningful solutions for the patient, today's improvement work is conducted at a time when competition and financial rewards are frequently used. When money becomes the dominant meaningful content of a conversation, then the staff learns that the patient represents an economic value and short-term profits supersede questions of profound knowledge development. This is not to suggest that knowledge of economic issues is 'boring' compared to the 'exciting' learning discourse. The point being that learning has taken on a direction that was not intended or expected. The market logic obscures the view for the communicative and intersubjective learning processes that are sought-after within the framework of *Improvement Knowledge*. This entails that the microsystem model's simplified image of learning as 'joyous' needs to be qualified somewhat. *Conversations about improvements*, and the learning that is based on the content of such conversations, are governed by a market logic

which needs to be made conscious in the participants' minds so that future improvement work which creates added value for patients in the healthcare system can be supported. One way of doing this is to create understanding by conceptualizing the learning that takes place and conceptualizing that which governs this learning on a more abstract level than what the microsystem model can currently offer.

8.1.2   Interpretive dominance in improvement practices

The composition of an improvement practice is of importance to the character of the negotiation that takes place (Study III). A network, where the participants bring with themselves their different routines, norms, and traditions, favours explicit negotiations about change. Because the participants have to explain their differences to each other, the negotiations become explicit. Simultaneously, the participants' tacit knowledge is revealed and thereby challenges what is taken for granted, the existing way of working, and the *status quo*. In an improvement practice where the participants know each other well and where there is a pronounced hierarchy of delegation, the participants do not get to view what is taken for granted in the same way. The negotiation about change becomes implicit, and the participants merely reproduce the internal power structure and their previous ways of working. The higher a participant is in the professional order of things, then the more power that person has over what creates meaning in the negotiation. A clear example of this was when an assistant nurse suggested an initiative for improved hygiene routines, but her voice was drowned out by a nurse and the rest of the group's support for the prevailing power structure, which was based on the professional ranking of the participants. The *spoken silence* that was observed in the ward meetings in Study III reinforced the hierarchy and prevented initiatives for change from being submitted that would benefit the patient. Admittedly, the delegation of responsibility is important in maintaining patient safety, but it performs no real function in negotiations about change when the *status quo* needs to be challenged by using contributions from *everyone* in the group. This is the case even when there is no obvious answer to the problem that is to be solved. A homogeneous improvement practice which contains a pronounced hierarchy needs pedagogical support so that it can learn to see what it takes for granted, and create an explicit dialogue about improvement, and ease up on the hierarchically structured relationships within the practice.

Who then possesses interpretive preference in a practice which is characterized by differences? Study III shows that the hierarchical social positioning within the group can be suspended when patient cases are discussed. This has also been shown to be the case in previous research (Gabbay et al., 2003). In the conversation, the specialist physician initially claimed interpretative dominance via his expertise, but in the light of the development manager and

physiotherapist's stories about their patients, he admitted that he did not have an answer to what was best for the patient. We thus observe that the interpretative prominence of what creates meaning in this context is negotiable as long as a climate of cooperation exists within the improvement practice. Improvement practices which include a number of participants who come from different clinical backgrounds or different locations may initially need support as they establish rules and norms for their cooperation. It takes time to establish cooperation across a network and this can be supported by common artefacts, including IT-systems, protocols, and check-lists (Oborn & Dawson, 2010). If time is provided to re-formulate social norms so that a better way of working can be established, then this will lead to a better improvement practice (Dixon Woods et al., 2011). This thesis can thus contribute to the research debate on how 'differences' or 'similarities' promote learning and change, by presenting a discursive conclusion that an explicit dialogue is needed to challenge the *status quo*. This is supported by an improvement practice where the participants are based in different geographical locations.

This thesis reveals a social perspective on learning where the hierarchies, norms, and social relationships within an improvement practice instantiated the pedagogical conditions for negotiation. The microsystem's emphasis on a linear, individual perspective on learning is thus not sufficient for a description of the pedagogical processes that take place in an improvement practice. A shift from the individual perspective to a social perspective on learning does not ignore individual development, but, instead, it reinforces and provides new perspectives with respect to the creation of identity by revealing that which is 'individual' in relation to 'others' in an intersubjective process of negotiation. When one possesses knowledge of the significance of an explicit dialogue, stories about patients, and norms for cooperation as conditions for mutual, critical evaluations, then it is possible to construct pedagogical support for a future *learning* improvement practice.

8.1.2.1   The coaches' interpretive dominance in improvement practices

There exist three prevailing perspectives (discourse patterns) which govern the coaches' choice of pedagogical approach towards their practice. The three perspectives are characterized by different quality claims and the prevailing contextual conditions. Within the framework composed by these different perspectives, the coaches make different claims with respect to interpretive dominance in the central negotiation about change in the improvement practice.

In the management discourse, the coaches assume interpretive dominance with respect to the goals and purpose of the improvement practice. This thus places a large responsibility on the shoulders of the coach to actually produce

improvements and achieve results. Results would include better solutions for the patient, but the patient is given no voice to articulate his experiences in this context. Improvement practices are directed towards improvements via the evaluation of behaviour. Within the professional discourse, the improvement practice itself is in possession of interpretive dominance with respect to that which creates meaning in the negotiation. However, there is an exception to this. When market logic makes itself felt within the discussion, in terms of money as an external motivating factor, then the coach takes over the interpretive dominance and reminds the improvement practice of more balanced values. The professional discourse also allows trust in integrating the patient with the improvement practice so as to develop understanding of what brings about meaningful and sustainable improvements. Within the disguised discourse, the coach does not provide the goals and the direction which the improvement practice must take; this is left for the improvement practice. However, the coach reserves the right to judge whether the improvement practice has understood correctly, or is moving in the right direction in its improvement work.

These different discourses create different pedagogical conditions for the improvement practice. The learning organization that is established either employs a change of behaviour to achieve measurable results (in the management discourse), or employs understanding to achieve sustainable results. In the later case, it is the improvement practice (with the professional discourse) or the coach (the disguised discourse) who take on interpretive dominance with respect to that which creates meaning in the negotiation about change. The pedagogical support for an improvement practice demands an experienced and knowledgeable coach who does not take learning for granted. Such coaches should critically evaluate the type of pedagogical support that is needed to promote the development of the healthcare system. Coaches need to encourage a professional awareness of how the different discourses, and the attendant contextual conditions, influence their approach. One way to create an awareness and an increased understanding in the coaches, including others who are responsible for or are engaged in improvement work in a healthcare system, is to conceptualize what are the characteristics of the pedagogical conditions of a *learning improvement practice* in a healthcare system. By abstracting the meaning of the pedagogical conditions, we can qualify the current description of the learning processes in a microsystem.

8.2 Towards a learning improvement practice; theoretical implications

The authors of the microsystem model suggest that the model be modified with the use of different scientific lenses (Nelson et al., 2007). This thesis contributes to this program with a 'pedagogical lens' in the light of the empirical studies and pedagogical theory that are included in this thesis. Consequently, a learning improvement practice can be considered as a pedagogical reconstruction of the microsystem model. With respect to the microsystem model, this thesis adds to our knowledge with the claims that (i) improvement practices are socially constructed via the use of language, (ii) an improvement practice is a discursive practice which is governed by orders of discourse, and (iii) the context is an integrated part of the intervention.

This thesis uses a social constructionist view of knowledge to highlight the fact that improvement work is socially constructed via the use of language, such that the local negotiation is crucial to whether change and learning takes place. Social learning emphasizes the fact that the internal conditions for negotiation need to be taken into account. These conditions include the construction of the said improvement practice (whether it is an individual unit or part of a network), the social relationships, hierarchies, claims to power, interpretive dominance, and dialogues. An improvement practice is thus a discursive practice where orders of discourse govern that which is considered to be legitimate to say in the context where improvements are being discussed. If the order of discourse is made conscious in the minds of the participants, then there exists the potential to intentionally, discursively modify the negotiation about change and that which regulates such negotiation. A social and discourse perspective does not exclude the fact that a technical intervention needs to be translated into practice if the practice is to be actually improved. Notwithstanding this, these perspectives create understanding of what is needed if people are to change their habits. Other researchers have highlighted the importance of social intervention (Dixon-Woods et al., 2011). This thesis contributes to this discussion with a pedagogical and discursive perspective on the social changes that take place within improvement work.

The results of this thesis clarify an inclusive perspective with respect to the contextual conditions. The external and internal conditions are part of the actual improvement work and thus influence the learning that takes place. The context should therefore be considered as part of the intervention, and not something which an intervention should be adapted to. This goes against current approaches which exclude the context: "*Context is everything that is not a quality improvement (QI) – it is the 'environment' within which a quality improvement is carried out.*" (Øvretveit, 2014: 61). This type of description reduces improvement work to a mere technical intervention which is to be

implemented within a context. This perspective fails to take into consideration how orders of discourse can regulate a practice, nor does it take into consideration the importance social change has for the intervention. It is also obvious that large programs of change find it difficult to implement change from a merely technical perspective (Dixon-Woods, 2014). An example of this is 'Quality collaboratives' projects, where approximately 30% of participating organizations achieve 'significant improvements', whilst another 30% exit from the project before its completion (Øvretveit et al., 2002). This thesis claims that improvement work is socially constructed via the use of language and that the context should be considered as part of the intervention, can contribute to changing the perspective of what change actually is, and thereby also reveal how improvement work should be supported with respect to its external and internal conditions.

8.3 Towards a learning improvement practice; practical implications

Knowing that large-scale, planned improvement projects find it difficult to create change in practice, I have focused on the continual improvement work that takes place in a local organization. If knowledge of what characterizes a learning improvement practice can be adopted by a healthcare organization, then a basis for change can be built. This would be a basis that increased one's readiness for planned change, but also allowed practitioners to remain critical of new trends and models of efficiency which are brought to the fore with their own discursive persuasion:

> *When consulting gurus sweep in with their promises of magical transformation through programs invented elsewhere, the wise manager thinks twice before allowing that show to unfold. The informed hesitancy springs from a deeper appreciation that mundane transformation may already be under way in the guise of unnoticed emergent change. Those emergent changes need to be noticed, labeled, and legitimized rather than displaced by the vendor-driven flavor of the month (Weick, 2009: 239).*

The One-Stop Breast Clinic initiative, which clearly led to achieving cost-efficiencies and added value for the patient, would have had a better chance of surviving with a critical approach towards sustainable and long-term improvements. This thesis shows that the market logic runs the risk of undermining a balanced perspective on improvements and removing the professionals' sense of responsibility. The intention behind financial incitements is to create encouragement and support for change, and not the opposite. Thus, organizers of improvement work projects need to acquire knowledge about the unintended consequences that such financial incitements

can lead to. The staff at the observed clinic suggested that financial incitements should be discussed with the profession so as to avoid displacement effects. At a follow-up meeting with the staff members, as part of the interactive research approach adopted in this thesis, one of the participants expressed the following:

> *One must be aware of how controlling money is. The dialogue between the staff and management, when they put money on goals, is really important, so that there is money available for things that must be done anyway. So that it's done for the patients, and not just for the goal.*

This thesis has shown that learning in an improvement practice, in the sense that it is long-term and democratic, cannot be taken for granted; it needs to be consciously supported and equipped as long as sustainability is the goal.

The studies included in this thesis also show that improvement practitioners whose everyday work has become 'common sense' and is not automatically put into question might need support so that they can become aware of what they have taken for granted. The county council that was studied has a development unit with access to coaches who can support their improvement work. Other county councils can have improvement coaches or improvement managers who are part of a clinic, but who can be used by other clinics which exchange services which each other. The clinics can use each other's coaches so as to acquire the external feature of support that reveals and deconstructs old approaches. For example, a coach at a medical clinic can be used to support improvements at a surgery, and vice versa. Another way of using such coaches is to dismantle hierarchies which remain attached to what they have taken for granted. When the ward staff at the observed clinic realized how they hid behind an 'us v. them' type of thinking, they then invited the physicians to their meetings to discuss hygiene routines during the ward rounds. This is an example of how simple steps can be taken to break down discourse patterns which reinforce structures. This demands however that the pattern be made visible and revealed to the practice.

This thesis has also shown that the external character of coaching is of importance to balancing different quality demands against each other. If financial incitements direct an improvement practice towards a specific quality goal, then an external coach (who does not take part of the financial benefit) can support the practice to balance and integrate several contrasting quality goals in the long-term. The external feature, that is to say, that which exists outside my own context and practice that I take part of everyday, generally is of assistance in dismantling the *status quo*. If the improvement work is not aimed at standardizing everyday work practices, where local, practical knowledge is of importance, then one can look outside of one's practice and

examine other people's solutions and ways of working. One's own system is revealed when one looks at other people's systems. Knowing what an inter-subjective perspective on learning and change can add to one's practice, it is worthwhile to engage in a change of perspective so that, using communication, one can navigate towards solutions that are not previously known.

Despite the fact that the focus of this thesis has not been on the management's conditions with respect to improvement practices, the results of this study can be of value to those who organize and manage improvement work in a healthcare system; for example, improvement coaches, healthcare managers, and improvement work managers. This thesis contributes with a number of practical suggestions about how the development of knowledge about a learning improvement practice can be realized. These suggestions can form part of the healthcare system's existing management training, training for improvement coaches, or as material for a short course in improvement work. For example, the discourses that were identified in Study IV can be used as material to reflect upon in a training discussion by different types of improvement managers. By clarifying the importance of an explicit dialogue and then reflecting upon how an explicit dialogue can be achieved can also be a point of departure in a professional discussion or seminar. Knowledge of symmetrical communication can be of particular use if patients are to be involved in improvement work. Sharing how one gets participants to relate patient stories to others in an improvement practice is also a potential point of departure in training conversations. In Study IV it was clear that the coaches prepare patient cases based on their own experiences, and not from the improvement practice's own stories. We now know that the staffs' own stories are important if we are to be freed from predetermined hierarchical claims to knowledge (see Study III).

8.4   Towards a learning improvement practice; methodological implications

In the following section, I present some of my experiences in using CDA. This led to the formulation of a number of statements concerning how CDA can be of assistance in increasing understanding of a learning improvement practice in a healthcare system.

I have adhered to a critique of CDA by constructing an analytical framework for each study included in this thesis. It is my experience that these frameworks increase the transparency of the analysis process, thereby facilitating the evaluation of the validity of the CDA that were performed. In particular, I posed a number of empirical questions when working with the

text. This method has also been used by other CDA researchers in the healthcare context (Aldrich et al., 2006; Smith et al., 2009; Aasen et al., 2011; McIntyre, 2012b). If one follows the quality demands closely, then research articles that employ a CDA method become quite lengthy, to the extent that it is difficult to have them published in improvement science journals which have strict word-limitation requirements. This entails that it is somewhat difficult to present CDA studies of high quality to an audience which is interested in healthcare improvement work. This may seem paradoxical when one thinks of what CDA can offer to the currently expanding research area of improvement science.

My experience is that a CDA-analysis is both extensive and multi-dimensional, but its reliability is negatively impacted upon if it is combined with other methods. It is difficult to employ a reliable and transparent process of analysis when it is not obvious which method has informed the different steps one has taken in the process of analysis. My own experience, and that of other CDA researchers (for example; Mancini, 2011), however, is that an interactive research design is compatible with the CDA methodology. CDA contains an ambition to promote change as it reveals how discursive orderings govern social interaction in a practice. The interactive design creates an area for a two-way dialogue between the researcher and the practitioners, which is something that is called for by proponents of improvement science (Marshall et al., 2013).

The importance of context in the area of *improvement science* is receiving more and more attention. In this field, the context has been characterized as 'everything' (Bate, 2014), 'problematic' (Dixon-Woods, 2014), and even 'mysterious' (Batalden et al., 2011). However, the more one uses descriptions like 'mysterious', the stronger becomes the idea that the context is a phenomenon that cannot be investigated. CDA provides a way to clarify such mysterious descriptions and to investigate methodically how the context influences improvement work. This thesis has shown how different external and internal contextual conditions have created interpretive dominance in improvement practices. By using CDA to "capture" the context it is possible to make its influence more visible. The microsystem model offers an example of how a microsystem is embedded within a wider healthcare system. CDA can deepen our understanding of how the microsystem is embedded within a wider system by allowing us to study the interactivity between different levels within the organization, i.e. how the fact that it is embedded in the way that it is influences the improvement work that is being conducted.

A CDA analysis allows us to show how parallel interpretations exist (the discourse patterns) with respect to how an improvement practice should be changed. These different interpretations are not always obvious. Neither is it

obvious which interpretation is most dominant at any one time, i.e. it dominates the other interpretations and makes claims to be the prevailing approach to improvement. This thesis has provided examples of how discourse orderings have given interpretive dominance for a particular way of thinking or acting. CDA can explain the presence and the tension between different discourses. This is particularly the case with respect to officially accepted truths which have become 'common sense' in a practice (Chouliaraki & Fairclough, 1999; Traynor, 2005; Malmmose, 2014). By revealing the prevailing discourses and which ones are dominant, it is possible to consciously take the initiative with respect to change and the direction in which such change is heading. This is clearly shown in Study III where it was argued that things that were taken for granted became obstacles for change. Because that which obtains interpretive dominance becomes foundational to what we learn, CDA can contribute to our understanding of how learning is made manifest in an improvement practice. This thesis has shown that what we refer to as a 'learning organization' can be one of several different things, depending of the pedagogical discourse that is most dominant. With a more insightful understanding and awareness of what creates a learning organization, we are then able to aim for the improvements that a healthcare organization wishes to achieve.

8.5 Limitations and further research

The case studies reported on in this thesis were performed in a county council in Sweden which has made great progress in its improvement work. Notwithstanding this, this thesis can contribute to our understanding of how external and internal conditions are expressed in a long-standing improvement practice with a tradition of cooperative negotiation and, since long time, developed performance evaluations. This thesis, however, cannot comment on what importance this credible basis of performance measurements have had for negotiation. A future research area might include the study of how access to credible performance evaluations is of importance to the character of such negotiation.

This thesis has been limited to the study of the external conditions in terms of the financial governance of the healthcare system. There are, of course, other external conditions which also create conditions for learning in an improvement practice. The same holds for the internal conditions that were studied in this thesis, where the focus was on investigating individual units in relationship with a network. Other internal conditions in terms of leadership, gender, or patient involvement have not been studied, but may well be in future research.

The results of the thesis imply that *external* coaches can be a support for learning and change. The difference between what an external or an internal coach might contribute to a practice has not been studied within the area of improvement work in healthcare. This may be a topic of future research so that we may increase our knowledge of how improvement work might be organized.

A danger that is associated with the use of the concepts 'strategic rationality' and 'communicative rationality' (Habermas, 1987b) is that it reinforces a dualistic 'either-or' way of thinking. I chose to use these concepts so as to reveal the presence of both forms of rationality within the improvement work which needs to be conducted in the healthcare system. By making these rationalities visible, we are able to create a conscious change which integrates these rationalities, instead of polarizing them. For example, by being reflective, an improvement coach can relate to both a management discourse and a professional discourse, in a consciously pedagogical approach in an improvement practice. The results of the studies also revealed two discourses that integrate system rationality and communicative rationality, namely the healthcare-for-everyone discourse (Study II) and the disguised discourse (Study IV). These integrated discourses indicate that the negotiation has given rise to inter-discursivity, that is a change in and not merely a reproduction of the practice. Longitudinal studies at schools have shown how inter-discursivity takes shape in the staff members' arguments as time passes (Lewis & Ketter, 2011). Longitudinal studies in the healthcare system have also shown that the dominance of market logic can be displaced via understanding that is communicatively based (Booth, 2013). How such displacement is expressed in terms of discourse is a topic of interest in future research.

8.6 Summary conclusions and some remarks concerning future developments in healthcare organizations

Using a pedagogical perspective, this thesis has highlighted the tension between system rational improvements and communicative rational improvements in a healthcare system. This thesis provides knowledge about how learning is influenced by a combination of contextual conditions whilst improvement work is conducted. This fulfils a previously identified gap in our knowledge concerning how outer and inner organizational conditions influence practical improvement work. In terms of theory, this thesis adds to our knowledge about how improvement work is socially construed via the use of language, and the fact that the context should be considered to be an integrated part of a change. The thesis also contributes to the development of a social-constructionist perspective on improvement work, and how changes

are governed discursively, which stands in contrast to the generally accepted positivist viewpoint that improvements entail the existence of a ready-made solution which merely needs to be implemented in a given context. The thesis's pedagogically-informed approach complements current research into the theoretical underpinnings of the microsystem model, which, in turn, is a contribution to the area of research called *improvement science*. With respect to the area of pedagogy and pedagogical science, this thesis contributes with a more profound understanding of '*the human knowledge building and its contextual conditions*' (Ellström et al., 2005: 174) in the area of the healthcare system. This thesis fills a gap in our knowledge about how social learning is realized in continuous improvement work. Current research emphasizes, more and more, the importance of the social processes that take place during improvement work, but not in terms of learning. The same is true for the increased focus of current research on the unintended consequences that market logic give rise to, but not in terms of learning. This thesis adds to this area by discussing how learning is influenced by the current focus on accountability, marketization, and pay-for-performance.

The following conclusions summarize the contribution made by this thesis in our understanding of improvement work in a healthcare system:

- Market logic mechanisms give rise to displacement effects with respect to the communicative and inter-subjective learning processes which are sought-after in the field of *Improvement Knowledge*. When money is the dominant meaningful content during improvement work, the staff members learn that the patient represents an economic value. Consequently, short-term profits supersede questions of a more profound development of knowledge.
- Market logic mechanisms give rise to a professional 'defence movement' in the practice which aims to preserve balanced, holistic solutions, for both the patient and the healthcare system, in opposition to more profitable quality goals.
- The composition of an improvement practice is of importance to the nature of the negotiation that takes place, and thus how the practice is to successfully challenge things that are taken for granted and the power structures that exist within the practice. An explicit dialogue favours change and is naturally produced in networks where the participants have different experiences, norms, and routines. In improvement practices where the participants know each other well, the dialogue becomes implicit and can consequently not be used to challenge old ways of working or the hierarchical structures in the same way.
- The interpretive dominance of that which creates meaning in an improvement practice is negotiable and does not necessarily need to

give rise to a conflict as long as an explicit and open dialogue can be established.

- Improvement coaches adopt different pedagogical approaches towards the practice depending on the prevailing conditions, and how these conditions correlate to different quality goals. The learning organizations that coaches contribute to differ from each other in terms of their content depending of the approach which is most dominant. Unconsciously, either an action-directed organization which wants to achieve quick results where the coach possesses knowledge about what creates value for the patient is favoured, or an organization which is directed towards understanding which pursues sustainable solutions where the staff members and patients are authorized to establish what is meaningful to change is favoured. Improvement coaches cannot take learning for granted. A professional and critical discussion needs to be conducted about how a learning organization can be created under prevailing conditions.

Whilst this thesis makes no contribution to our knowledge of what people learn during improvement work, it does reveal what characterizes and governs learning improvement work. A pedagogical potential is to be found in the possibility that those who are responsible for organizing and running improvement work in a healthcare system can share this thesis's theoretical and practical contributions to our knowledge, and translate this knowledge to his or her local circumstances via reflection and action. A healthcare organization which incorporates features of a learning improvement practice enables (i) an integrated readiness for planned change, (ii) a critical approach towards that which governs change and learning, (iii) enactment of professional ethics and responsibility, and (iv) an in-built ability to ensure readiness to new circumstances.

This thesis also adds to our knowledge of a suitable methodology in the area of improvement science. The overview of CDA studies in the area of healthcare showed that CDA has not been previously used to study improvement work in a healthcare practice. The CDA analysis included in this thesis shows how this methodology *can* provide a qualified understanding of the microsystem that is embedded within a wider healthcare system. To date, the microsystem has merely been *illustrated* in the sense of how it is embedded in the wider healthcare system. Using CDA, this basic 'illustration' can be greatly enhanced by studying the interactivity between different organizational levels via language, which complements, in terms of theory, the current conceptualization of *how the microsystem is embedded within wider organizational- and social structures*.

Summary in Swedish

Mot lärande förbättringspraktiker:
Studier av pedagogiska villkor då förändringar förhandlas i samtida hälso- och sjukvårdspraktiker

Avhandlingen behandlar hur förbättringsarbete bedrivs i hälso- och sjukvård med forskningsintresset riktat mot vilka villkor som styr det lärande som samtidigt sker.

De problem hälso- och sjukvårdens förbättringsarbete har att hantera är mångfacetterade och komplexa. Förbättringsarbetet ska hantera minskade ekonomiska resurser, ökande och allt sjukare patientunderlag, en föränderlig kunskapsbas, tillgång till (men inte alltid resurser för) dyr teknologi och medicin, de enskilda patienternas förväntningar på bot och lindring samt högt ställda servicekrav. Inom ramen för avhandlingen ska *förbättringar* inte tolkas i termer av förbättrad diagnostik och behandling, utan snarare i dess vidaste bemärkelse hur vi kan skapa en evidensbaserad, säker, patientcentrerad, effektiv, tillgänglig och jämlik vård för alla som behöver den (cf. God vård Socialstyrelsen, 2006). I avhandlingen används begreppet *förbättringspraktik* för att tydliggöra att det är det lokala och vardagsnära förbättringsarbetet som studeras. Avhandlingens studier berör alltså det ständigt pågående och kontinuerliga förbättringsarbetet som bedrivs i befintlig vårdverksamhet och inte det arbete som bedrivs i tidsavgränsade förbättringsprojekt.

Eftersom kvalitetskraven spänner över ett brett område av resurseffektivitet, service och evidens behöver olika yrkesperspektiv mötas för att diskutera vad som skapar mervärde för patienten i ett helhetsperspektiv. Det innebär att deltagarna utvecklar förståelse om varandras arbete, förståelse om den gemensamma praktiken samt förståelse om det egna individuella bidraget. Förbättringsarbetet kan därmed förstås som en *pedagogisk* praktik där deltagarna utvecklas socialt såväl som kunskapsmässigt via kommunikation, reflektion och handling (Johannessen, 1994). Avhandlingen utgår från tidigare forskning som tydliggör att en lokal förhandling är en förutsättning för att ny kunskap ska komma till användning i praktiken (Greenhalgh et al., 2004). Denna lokala förhandling är därför också en kärna i allt förbättringsarbete. Det är en förhandling om att bryta invanda rutiner till förmån för något nytt vilket samtidigt utmanar befintliga strukturer och normer i praktiken. Under förhandlingen försvarar respektive utmanar deltagarna det invanda sättet att arbeta samtidigt som styrande ekonomiska villkor gör sig gällande. I avhandlingen benämns dessa pedagogiska villkor som externa och interna

villkor. De externa villkoren står inom avhandlingens ram för politiska och ekonomiska styrprinciper medan de interna villkoren är mer sociala till sin karaktär och handlar om personalens inbördes interaktion, positionering och maktanspråk. En diskussion om förändring på en arbetsplatsträff kan därför ses som en förhandling av olika intressen där både systemmässiga och relationella villkor gör sig gällande. Den övergripande forskningsfrågan för avhandlingen är vilka pedagogiska förutsättningar som kommer till uttryck om man tar hänsyn till förbättringspraktikens externa och interna villkor.

Övergripande syfte och kontextualisering

Avhandlingens övergripande syfte är att genom ett språkanalytiskt perspektiv analysera och förklara pedagogiska villkor i hälso- och sjukvårdens förbättringspraktik.

För att uppnå syftet har fyra studier designats utifrån följande frågeställningar:

- Hur framställs pedagogiska aspekter i det kliniska mikrosystemets ramverk?
- Hur yttrar sig externa och interna villkor såsom pedagogiska förutsättningar i förbättringspraktikens förhandling om förändring?
- Vad kännetecknar coaching som pedagogiskt stöd för lärandeprocesser i förbättringspraktiker?

Den första studien är en litteraturgranskning som fungerar som en bas för de forskningsfrågor som formuleras för de följande fallstudierna. I litteraturgranskningen är det en modell för ett praktiknära förbättringsarbete, det kliniska mikrosystemet (Nelson et al., 2007; 2011), som granskas utifrån dess pedagogiska aspekter. Empirin bestod således av akademisk litteratur som beskriver mikrosystemets konceptuella ramverk. Fallstudiernas empiriinsamling baseras på observationer från olika hälso- och sjukvårdsenheter i Landstinget i Jönköpings län eftersom avhandlingen bedrivs inom ramen för ett tvärvetenskapligt forskningsprojekt kallat *Bridging the Gaps* där Landstinget i Jönköpings län är en samverkanspart. I studie II och III observerades möten där förbättringar diskuteras på en ortoped- och reumatologiklinik. Observationer utfördes på en arbetsplatsträff på en vårdavdelning där främst sjuksköterskor och undersköterskor deltog, samt på ett processteamsmöte där representanter från olika hälso- och sjukvårdsenheter möttes för att diskutera förbättringar av patientens vårdprocess. På processteamsmötet deltog specialistläkare, sjuksköterska, sjukgymnaster, arbetsterapeuter, vårdkoordinator och en utvecklingsledare. I studie IV utgår empirin från en grupp förbättringscoacher som arbetar på en utvecklingsenhet i landstinget i Jönköpings län. Det är coachernas reflektioner över sitt

pedagogiska förhållningssätt till förbättringspraktiken som utgör empiri för studie IV.

Teoretiska och metodologiska utgångspunkter

För att kunna studera pedagogiska villkor för en förbättringspraktik i 2010-talets hälso- och sjukvård tar avhandlingen utgångspunkt i pedagogisk teoribildning som beskriver vad som karaktäriserar (i) lärande i en praktik (Fritzell, 1996; Kemmis, 2011), (ii) kommunikation som grund för lärande (Dewey, 1916/1997), samt (iii) lärande som förhandling i en praktik (Wenger, 1998). Avhandlingen tar sin utgångspunkt i det organisatoriskt inbäddade och praktiknära förbättringsarbetet vilket beskrivs av den kliniska mikrosystemmodellen (Nelson et al., 2007; 2011). Modellen sätter fokus på dess inbäddning i ett större hälso- och sjukvårdssystem (externa villkor) samt de interaktioner som sker internt i mikrosystemet (interna villkor). Modellförfattarna menar att nyckeln till hälso- och sjukvårdens utveckling ligger i mikrosystemens förmåga att bedriva ett systematiskt förbättringsarbete. Den pedagogiska teoribildningen synliggör att mikrosystemet är en praktik som är influerad av dess individer, deras interaktion samt de kulturer praktiken är en del av på både ett lokalt och ett mer generellt styrande plan. I praktiken förhandlas det om det är meningsfullt att förändra gängse rutiner eller om det är bättre att fortsätta som tidigare. Förhandlingen är därmed en kommunikativ grund för det lärande och den sociala integration som samtidigt sker i praktiken.

För att kunna studera det som kommer till uttryck i en förhandling om förändring använder avhandlingen kritisk diskursanalys (Chouliaraki & Fairclough, 1999). Kritisk diskursanalys erbjuder ett sätt att analysera och förklara hur pedagogiska villkor kommer till uttryck och manifesteras i praktiken under rådande organisatoriska förhållanden. I förhandlingen görs olika anspråk och tolkningar på vad som behöver förbättras. Med stöd av kritisk diskursanalys går det att identifiera vilka tolkningar som kommer till uttryck. Det som är intressant att studera och förklara ur ett kritiskt perspektiv är vilken tolkning av förbättringar som får företräde när de externa och interna villkoren gör sig gällande i en förbättringspraktik. Med utgångspunkten att lärande baseras på kommunikation (Dewey, 1916/1997), innebär det att det som får företräde i en förhandling om förändring blir även basen för det lärande som sker. Med andra ord betraktas förbättringspraktiken som en diskursiv praktik där de diskursiva mönstren skapar villkor för lärande (Rogers, 2011; Fairclough, 2011).

Syfte och resultat för respektive studie

Syftet med studie I var att (i) granska, och med stöd av pedagogisk teori, (ii) klargöra vilka lärandeaspekter den kliniska mikrosystemmodellen omfattar och därigenom stödja dess konceptuella ramverk med det pedagogiska perspektiv som blev synligt. Resultatet visar ett partikulärt och individ-inriktat synsätt på lärande och förändring även fast strävan är att fånga helhetsbilden och komplexiteten i vårdsystemets interaktiva kopplingar. Sociala processer och ojämlika förutsättningar är uppmärksammade, men inte i termer av lärande. De pedagogiska processerna beskrivs mest i termer av hur man kan lära sig *om* mikrosystemmodellen via handling, experiment och reflektion med referens till Deming's (1994) PDSA-cykler. Författarna har tagit fram en praktisk modell att arbeta efter, men modellen har inte konceptualiserat lärande på en mer abstrakt nivå så att den rationella grunden för lärande kan förstås.

Resultatet från första studien resulterade i ett kritiskt intresse att studera hur pedagogiska villkor yttrar sig i en förbättringspraktik. *Den andra studien* belyser därför de externa villkoren där syftet med studien var att analysera och förklara diskursiva mönster om kvalitetsförbättringar i hälso- och sjukvård, samt att diskutera hur de identifierade mönstren skapar villkor för lärande. Resultatet synliggjorde fyra diskursiva mönster i personalens förhandling om förändring: (i) ett marknadsmönster, (ii) ett "vård-för-alla"-mönster, (iii) ett medicinskt mönster, samt (iv) ett värdemönster. Talet i marknadsmönstret handlar om hur högre produktionstakt eftersträvas för att budgeten ska hålla och hur personalen prioriterar handlingar som bidrar till ökad lönsamhet för kliniken. Talet i "vård-för-alla"-mönstret handlar om att resurserna ska utnyttjas på ett maximalt sätt så att kliniken kan bereda plats och vård för så många som möjligt. Talet i det medicinska mönstret handlar om professionens kunnande om patientens behov där evidens, operationstekniker och patientsäkerhet är bärande element i talet. Talet i värdemönstret kännetecknas av ett processinriktat sökande efter värdeskapande lösningar ur patientens perspektiv, där ingen av deltagarna har ett på förhand givet svar. Analysen visar att marknadsmönstret får dominans då prestationsbaserade ersättningar kopplas till givna kvalitetsmål. Samtalets interprofessionella fördjupning om vad som skapar högre värde för patienten hamnar därmed i bakgrunden. Studien visar samtidigt att då ekonomiska incitament *inte* influerar förbättringspraktiken råder det balans mellan olika kvalitetsanspråk precis som policyn *God vård* (Socialstyrelsen, 2006) eftersträvar. Studien visade att marknadslogik kan skapa en kortsiktig styrbarhet av förbättringspraktiken. I ett långsiktigt perspektiv däremot måste man beakta de kvalitetsaspekter som hamnar i skymundan i termer av undanträngningseffekter. De pedagogiska villkoren, det vill säga vad personalen lär sig då marknadsmönstret dominerar, är att patienten representerar ett ekonomiskt värde där kortsiktiga vinster som budgetförstärkning överordnas frågor om långsiktigt fördjupad kunskapsutveckling, i det här fallet hur de ortopediska vårdprocesserna kan förbättras för allas bästa.

Den tredje studien undersöker de interna villkoren för lärande och förändring i två olika förbättringspraktiker som representerar ett mikrosystem respektive ett mesosystem (ett nätverk av olika mikrosystem) i vården. Mikrosystemet utgörs av hur vårdavdelningspersonal diskuterar förbättringar på en arbetsplatsträff, och mesosystemet utgörs av ett processteam som diskuterar förbättringar på ett teammöte. Syftet med den tredje studien var därmed att analysera och förklara hur personal i sin interaktion förhandlar förändringar på en arbetsplatsträff i relation till ett processteamsmöte. Resultatet visade att en explicit förhandling är en nyckel till förändring. I gränssnittet mellan anpassning och förändring står normer på spel och den explicita argumentationen öppnar för en värdering mellan gamla vanor och nya initiativ. Analysen visade att processteamet hade lättare att skapa en explicit förhandling. Tack vare att teamdeltagarna kom från olika mikrosystem och inte kände varandra så väl behövde de förklara och göra sina rutiner tydliga för varandra. Teamförhandlingen karaktäriserades av en tydlig interaktivitet och öppenhet där patientberättelser spelade en stor roll för det meningsbärande innehållet. På vårdavdelningen var förhandlingen mer implicit till sin karaktär. Vårdavdelningens rutiner och hierarkier var tagna för givet och kändes därmed inte nödvändiga att diskutera. Det innebar att förändringsinitiativ inte blev kommunikativt värderade på samma sätt som i teamet. Hur den explicita respektive implicita förhandlingen kom till uttryck kan också förklaras av de observerade gruppernas storlek och dess linjära hierarkiska ordning.

Resultatet från både andra och tredje studien implicerade att coaching är ett sätt att stödja hälso- och sjukvårdens förbättringsarbete. *Syftet med Studie IV* var därför att identifiera diskursiva mönster utifrån hur coacher beskriver sina pedagogiska förhållningssätt till förbättringspraktiken, samt att förklara de diskursiva mönstren i relation till basala förbättringsidéer och rådande villkor i hälso-och sjukvårdssystemet. Resultatet identifierade tre diskursiva mönster: (i) en ledningsdiskurs, (ii) en professionell diskurs och en (iii) maskerad diskurs. Ledningsdiskursen kännetecknas av en resultatinriktning där det pedagogiska förhållningssättet är styrande och metodtroget för att så snabbt som möjligt kunna erbjuda patienter bättre vårdlösningar. Den professionella diskursen är mer processorienterad för att kunna nå långsiktiga och hållbara resultat. Pedagogiken präglas därför mer av förbättringspraktikens energi och behov där personal bemyndigas att själva driva sitt förbättringsarbete tillsammans med patienten som en medlem av förbättringspraktiken. Den maskerade diskursen kännetecknas av samma pedagogik som den professionella diskursen men med vissa manipulativa strategier för att överbrygga förbättringspraktikens vedertagna hierarkier och normer som hindrar bättre lösningar för patienten. Coacherna infiltrerar därmed förbättringspraktiken genom att arbeta *undercover* för att inte hota befintliga strukturer med sitt förbättringsuppdrag. Ingen av diskurserna framträder med

någon övergripande dominans, utan det är snarare anpassningen till de externa och interna villkoren som avgör vilken diskurs som får tolkningsföreträde.

Resultatet tydliggör att det råder tre förhärskande synsätt (diskursiva mönster) som reglerar coachernas pedagogiska förhållningssätt till praktiken. Det innebär att på vilket sätt de stödjer gruppens lärande (drivande, guidande eller bemyndigande) är beroende av rådande externa och interna villkor för förbättringspraktiken. Den lärande organisation som skapas ges därmed olika innehåll och betydelse beroende av vilket kvalitetsanspråk som är prioriterat i kombination med rådande villkor. En förhärskande ledningsdiskurs leder till en handlings- och beteendeinriktad organisation som premierar snabba resultat medan en dominant professionell diskurs leder till en organisation som strävar efter hållbara resultat genom att stödja ett förståelsebaserat angreppssätt där praktiken själva, tillsammans med patienten, bedriver sitt förbättringsarbete.

Slutsatser

Studiernas resultat och efterföljande diskussion i avhandlingen sammanfattas enligt följande:

- Marknadslogikens mekanismer leder till undanträngningseffekter av de kommunikativa och intersubjektiva lärprocesser som eftersträvas inom ramen för förbättringskunskap. När pengar är det dominerande meningsbärande innehållet under förbättringsarbete, lär sig personalen att patienten representerar ett ekonomiskt värde där kortsiktiga vinster överordnas frågor om fördjupad kunskapsutveckling.

- Marknadslogikens mekanismer leder även till att en professionell 'försvarsrörelse' bildas i praktiken som värnar balanserande helhetslösningar, för patienten såväl som hälso- och sjukvårdsorganisationen, i förhållande till kvalitetsmål som ger ökad lönsamhet.

- Sammansättningen av en förbättringspraktik har betydelse för förhandlingens karaktär och därmed också hur praktiken lyckas utmana förgivettaganden och maktordningar i praktiken. En explicit dialog gynnar förändring och utförs naturligt i nätverk där deltagarna bär med sig olika erfarenheter, normer och rutiner. I en förbättringspraktik där deltagarna känner varandra väl blir dialogen

implicit och kan därmed inte utmana gamla arbetssätt och hierarkiska strukturer på samma sätt.

- Tolkningsföreträde för vad som skapar mening i en förbättringspraktik är förhandlingsbart och behöver inte vara konfliktfyllt såvida en explicit och öppen dialog går att etablera.

- Förbättringscoacher antar skilda pedagogiska förhållningssätt till praktiken beroende av vilka förutsättningar som råder, samt hur förutsättningarna korrelerar med olika kvalitetsanspråk. Den lärande organisation som coacherna bidrar till skiljer sig innehållsmässigt beroende av vilket förhållningssätt som är det mest dominanta. På ett omedvetet sätt premieras antingen en handlingsinriktad organisation som vill uppnå snabba resultat där coachen har kunskap om vad som skapar värde för patienten, eller, så premieras en förståelseinriktad organisation som strävar efter hållbara lösningar där personal och patient bemyndigas att säkerställa vad som är meningsfullt att förändra. Förbättringscoacher kan inte ta lärande för givet, utan det behöver föras en professionell och kritisk diskussion om hur en lärande organisation kan skapas utifrån rådande förutsättningar.

Avslutningsvis kan konstateras att den här avhandlingen har bidragit med kunskap om hur lärande under förbättringsarbete influeras av samtida kontextuella villkor. Det fyller en beskriven kunskapslucka om hur yttre och inre organisationsvillkor influerar på det praktiska förbättringsarbetet. På ett teoretiskt plan tillför det kunskap om hur förbättringsarbete är socialt konstruerat via språket, samt att kontext bör betraktas som en integrerad del av en förändring. Avhandlingen bidrar därmed med ett socialkonstruktionistiskt perspektiv på vad förbättringsarbete är, och hur förändringar regleras diskursivt, i förhållande till ett vedertaget positivistiskt synsätt att förbättringar innebär en färdig lösning som ska implementeras i en kontext. Avhandlingens pedagogiskt informerade kunskapsbidrag kompletterar därmed den pågående forskningen om det kliniska mikrosystemets teoretiska underbyggnad, vilket samtidigt är ett bidrag till forskningsfältet 'improvement science'. Till det pedagogiska vetenskapsfältet bidrar avhandlingen således med en fördjupad förståelse för "*mänsklig kunskapsbildning och dess kontextuella villkor*" (Ellström et al., 2005: 174) inom hälso- och sjukvårdens område. Avhandlingen fyller ytterligare en metodologisk kunskapslucka inom forskningsfältet 'improvement science'. Kunskapsöversikten visade att kritisk diskursanalys inte är använt för att studera förbättringsarbete i hälso- och sjukvårdens praktik. Avhandlingens analyser visar hur kritisk diskursanalys stödjer en kvalificerad förståelse av mikrosystemets inbäddning i ett vidare hälso- och sjukvårdssystem. Med stöd av kritisk diskursanalys kan interaktivitet mellan organisationsnivåer studeras

via språket, vilket teoretiskt kompletterar nuvarande illustrering av hur mikrosystemet är inbäddat i vidare organisations- och samhällsstrukturer.

Avhandlingen fyller även en kunskapslucka om hur socialt lärande yttrar sig i det vardagsnära förbättringsarbetet. Forskning har alltmer poängterat vikten av de sociala processerna under förbättringsarbete, men inte i termer av lärande. Inte heller har lärande uppmärksammats i forskning om oönskade konsekvenser av marknadslogik. Avhandlingen kompletterar kunskapsbilden med hur lärande influeras av samtidens fokus på en friare hälso-och sjukvårdsmarknad som styrs via prestationsbaserade ersättningar. En framtida pedagogisk potential är att de som organiserar och bedriver vårdens förbättringsarbete tar del av avhandlingens teoretiska och praktiska kunskapsbidrag samt översätter kunskapen till sina lokala förutsättningar via reflektion och förhandling. En hälso- och sjukvårdsorganisation som inkorporerar vad som kännetecknar en lärande förbättringspraktik möjliggör (i) en integrerad beredskap för planerad förändring, (ii) ett kritiskt förhållningssätt till vad som reglerar förändring och lärande, (iii) ett tillvaratagande av ett professionellt etiskt ansvarstagande, samt (iv) en inbyggd återhämtning för nya omständigheter.

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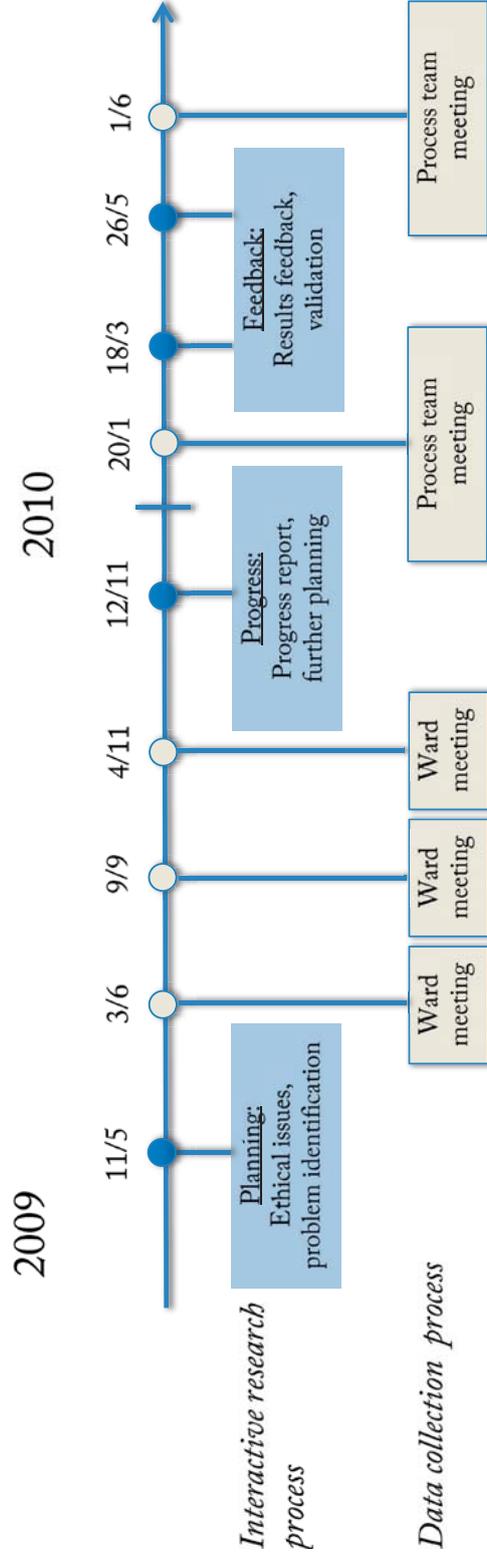
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Appendix 1

Interactive research process Study II and Study III

Timeline figure showing the interactive research process. Years 2009 and 2010 mark the timeline.

Dates along the timeline: 11/5, 3/6, 9/9, 4/11, 12/11, 20/1, 18/3, 26/5, 1/6

Interactive research process boxes:
- Planning: Ethical issues, problem identification
- Progress: Progress report, further planning
- Feedback: Results feedback, validation

Data collection process boxes:
- Ward meeting (3/6)
- Ward meeting (9/9)
- Ward meeting (4/11)
- Process team meeting (20/1)
- Process team meeting (1/6)

Appendix 2

Interactive research process Study IV

2013

| 30/4 | 10/6 | 6/9 | 17/9 | 8/10 | 29/10 | 22/11 | 18/12 | 3/3 | 22/9 |

2014

Planning:
Ethical issues, problem identification

Data collection:
Reflections roles and strategies

Video observations in practice

Data collection:
Video feedback, reflections

Feedback:
Results feedback, validation