

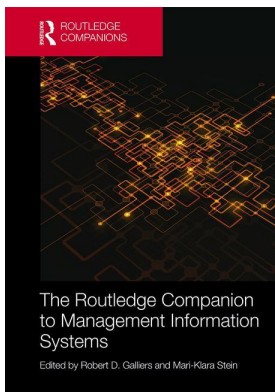
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INNOVATION IN HEALTHCARE SETTINGS

The power of everyday practices

Marco Marabelli and Sue Newell

Introduction

Coordinating the practices of different healthcare professionals is very important, particularly when dealing with life-threatening situations such as in the ER (emergency room), or when healthcare workers deal with severely ill patients who need speedy diagnoses (Kaelber and Bates 2007). This coordination is especially crucial when patients have multiple diseases that require several different interventions (Abraham and Reddy 2008). Doctors and nurses may well be undertaking interdependent activities, which is challenging when health workers have different backgrounds, knowledge and approaches to problem solving and yet are required to coordinate their practices in providing services to patients, families, carers and communities (Gittell et al. 2013; WHO 2010). This issue becomes even more complex when the parties involved do not all sit within the same organization. For example, medical staff in a hospital may need to coordinate not only with other clinicians in the same healthcare facility (or at least the same healthcare organization) but also with professionals in other healthcare-related and social organizations, like social services, independent physicians, psychologists and schools.

It is precisely this type of broader networked coordination that is the focus of many current innovation projects in healthcare settings. For example, the problem of ‘bed-blocking’ is related to the lack of coordination between hospitals and social service agencies, leading to the situation where, for example, an elderly patient has to remain in a (scarce) hospital bed because the preparations for moving her to a residential home have not been completed in a timely fashion. Many innovation initiatives are geared toward facilitating better coordination across a network of organizations and professional groups in order to improve the efficiency and effectiveness of healthcare service delivery. Yet, as we will discuss, in networked settings, improving coordination requires more than a directive to each party to ‘work together’ because there are no hierarchical power relations that can impose direction (Swan and Scarbrough 2005). Moreover, a lack of physical proximity can increase the problems of coordination (Ardichvili et al. 2003; Whittington et al. 2009).

Innovations that improve healthcare coordination require that those involved mobilize knowledge and change practices (Currie and White 2012; Kimble et al. 2010; Scarbrough et al. 2014). Given the challenges that using hierarchical power in network settings poses,

we focus on the power and knowledge of everyday practices because this helps to understand “the political nature of networking and knowledge management practices undertaken by various interest groups” (Hislop et al. 2000, p. 401). Thus, in this chapter we concentrate on the role of knowledge/power in the success of innovation projects focused on changing practices to improve coordination in the networked healthcare setting. Moreover, informed by the strategy-as-practice (SAP) literature, we acknowledge the relevance of human as well as material agencies (thus, people and ‘things,’ such as a medical sheet, a document and a presentation) in practices associated with change. We aim, therefore, to address the following research question: what power do everyday social and material practices have in strategic innovation initiatives in networked healthcare settings?

We address our research question using longitudinal and qualitative data collected in a healthcare network in Canada. We found that everyday practices play a key role in fostering innovation in healthcare contexts. In particular, we identified three distinct practices that emerged from our data analysis: talk, text and things. These practices, albeit analyzed individually, are interlocked with each other and ‘have’ power – they help promoting changes in the healthcare settings that we examined, and ultimately supported changes leading to innovation (here related to improving coordination and communication across carers).

The remainder of this chapter is structured as follows. We begin by providing a theoretical background before outlining our research methods. We go on to present and analyze our findings before discussing them in light of prior literature. We conclude the paper with a consideration of the implications of our study – for theory and practice.

Background literature

The creation of innovative practices (changing how people do things in ways that deviate from their daily tasks/activities) is generally challenging. In healthcare settings, clinicians (i.e., doctors and nurses) are particularly reluctant to change their everyday practices because they typically receive very technical training and ‘learn’ how to do things in ways that they believe are optimal (Hall 2005; Reese and Sontag 2001). Consequently, change agents (generally visionary physicians, researchers or healthcare managers) need to act strategically to convince (other) clinicians that it is even worth trying to adopt a new practice.¹ The challenges (and associated benefits) of these healthcare changes are often considered strategic.

To this end, strategy has often been conceptualized as a grand vision – to do something different – which is formally planned by the top executive team and then executed by others lower in the management hierarchy (e.g., Prahalad and Hamel 1994). While planning by a top executive team may be important to study, the SAP literature suggests that strategy is a much more messy process than this, and indicates that rather than focusing on the planning of the top executive team, we can learn more from looking at the everyday practices of the range of stakeholders (practitioners) involved in the context of interest, here an innovation project around improving coordination through networking. From the SAP perspective, strategy is studied as an emergent process (formation and execution) where strategy is constantly unfolding in the flow of practices as undertaken by practitioners (e.g., Jarzabkowski 2005; Whittington 2006). In this perspective, knowledge is central, but it is more than simply knowledge held by senior managers who use it to direct activities; in the SAP perspective, knowledge is more complex (and fluid) than this.

Given our interest to examine everyday practices, in this chapter we consider healthcare innovation using the SAP view of strategy, and integrate it with power, a construct that is relevant to accomplish changes (Hardy 1996; Hardy and Thomas 2014) and that has often been

studied together with knowledge because, as Foucault (1980) argues, power emerges through social processes underpinning the negotiation of knowledge.

Foucault departs from the (traditional and Weberian) idea that power is owned by individuals or groups who use it as an instrument of coercion and moves toward a view where power is seen as diffused rather than concentrated. Drawing on Foucault, Latour (1986) provides a useful example that contrasts the Weberian view of power (power as a resource) with the perspective we take in this chapter, which implies that power emerges through everyday (social and material) practices. For Latour, an order, a claim or an artifact (described as a token) can be proposed by a powerful individual (or group), and the token, according to the inertia principle, will move in the direction given by the powerful actor (the actor with resource power) as long as there are no obstacles (e.g., frictions or resistances). In this exercise of power (the ‘diffusion’ model according to Latour), the order (or the token) does not need to be explained, and the greater the strength with which the token is delivered, the more the token will travel and overcome resistances. However, ultimately the token will encounter resistance and this will slow down the order’s pace of impact so that the original force (power) is reduced. In contrast, power can be seen as performative, and this relates to the idea that the spread of the token “is in the hands of people” (Latour 1986, p. 267). Its displacement is not caused by the initial impetus (i.e., it is not dependent on the resources of the person attempting to make the change), because the token here has no impetus; instead, it is the energy given to the token by people who keep it going. In this context, the token is not a ‘mandatory’ order, but is something that people reshape, by “modifying it, or deflecting it, or betraying it, or adding to it, or appropriating it” (Latour 1986, p. 267). Latour calls this way to understand power a ‘translation’ model, because power relates to social processes where the order is negotiated rather than ‘executed’ (or spread). Given that mandates are likely to face significant resistance in network settings, because there is not a single authority to ‘push’ the strategy across the network, we need to examine how the strategy to innovate spreads through everyday translation practices in the focal context.

In this chapter we use this idea of *translation* to examine how innovation practices unfold. In doing this we illustrate how power is not a ‘tool’ that is used to accomplish long-term planned innovation projects (Weberian way) but, instead, power is action, therefore practice itself – being embedded in the everyday micro-level actions of practitioners. We next turn to describing our fieldwork.

Context and methods

The case focuses on a pilot innovation project, which was set up to improve coordination of care for children with complex care needs at the Canadian hospital, Dooly, and between Dooly and other (external) healthcare agencies such as social services. While the need to improve healthcare coordination at Dooly emerged in 2008, the project analysis and bidding process (and approval) took two years. On April 1, 2010, the pilot was granted funds and a partnership was established involving the hospital and three agencies. The partnership created with the pilot project implies that all four organizations involved in this healthcare network have the same decision-making ‘rights,’ through representatives of each partner. The funding originated from a surplus of one of the three agencies of the partnership.

Children with complex care needs were defined as children with multiple and life-threatening diseases who need to be seen by several specialists. The necessity to improve healthcare coordination for this group emerged in 2008, when some families of these children pointed out that the different physicians (specialists) who were taking care of their child did not exchange

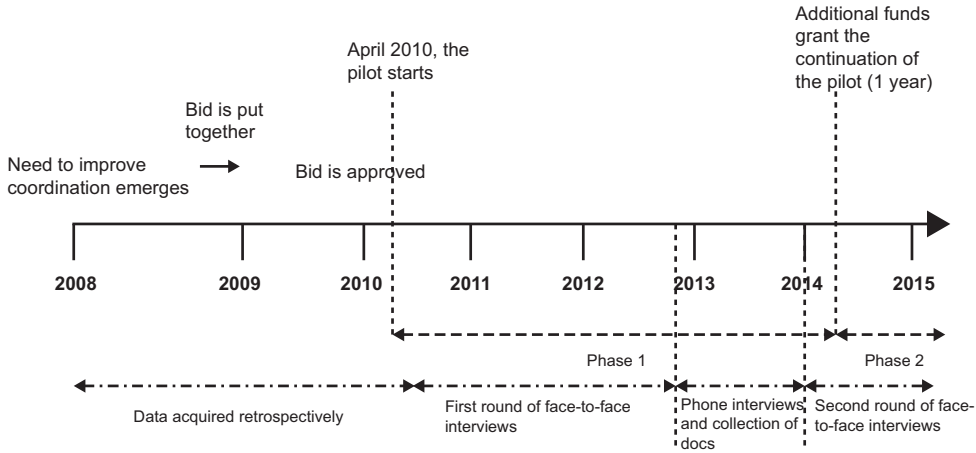


Figure 21.1 Time line of events and data collection at Dooly

crucial medical knowledge with each other. As a result, the families were often overwhelmed and emotionally drained because it fell to them to coordinate the care of their child. Additionally, the external agencies (e.g., social services) were not always aware of each child’s most recent health issues, and this too posed health risks. Further, the hospital did not receive the most recent updates – from school or social service agencies – about the children’s social/psychological conditions. The project started in April 2010, with 20 children being enrolled in the pilot. A nurse dedicated to the project (nurse coordinator) and a project manager were hired, and one of the hospital doctors, who was already taking care of children with complex needs, undertook the role of full-time responsible physician. In spring 2014 (second phase), additional funds made it possible to add resources: an additional nurse (full-time) and three physicians (one full-time and two part-time) were hired. This allowed them to enroll 20 additional children (see Figure 21.1 for time line of key events).

Fieldwork was undertaken longitudinally (September 2010–April 2015) *in situ* and retrospectively (2008–2010, including the review of documents), adopting an interpretive qualitative approach (Walsham 1993; 2006). Figure 21.1 synthesizes the various phases of our fieldwork.

Findings

From conception to the start of the pilot innovation project (2008–2010)

Dooly hosted a family forum that gave parents the opportunity to share their experiences and feelings about their child’s care. Families used the forum to highlight coordination problems they had experienced both within the hospital (specialists not sharing information) and between the hospital and the other agencies. Examples brought up in this forum included a mother recalling that she had to head to the hospital three days in a row, to have her child undertake the same test, but for three different specialists (the physicians were not sharing the information about tests needed); a foster mother pointing to the difficulty she experiences

when she needs to talk to a specialist about what another specialist said, about her child; a mother indicating how she was not listened to when taking her child to the ER because of a medical emergency, with the outcome that there was a delay in deciding about treatment while the doctor looked up the medical record; and a father telling how he had put together a short binder related to his child's health (he calls it a 'cheat sheet') in order to help him remember things about his child's diagnoses and treatments when trying to communicate with different doctors. Some specialists seemed relatively sympathetic to the families' complaints, in particular in relation to sharing information with colleagues, but all prior attempts to 'force' specialists to share clinical information about patients had been unsuccessful. For example, on one occasion a mother had formally complained that she had had to go to the hospital three days in a row for the same test. The chief pediatric consultant had rebuked the specialist who had requested the unnecessary repeat test, and for a short while this specialist (and others who were aware of the incident) had notified other doctors about the tests that they were prescribing in order to avoid another complaint about wasted resources.

While this order to improve coordination did not last, those healthcare professionals involved in the forum were moved by the emotional content of many of the families' stories and decided to try and do something about the poor coordination that they were hearing about. One initial activity that was instigated was to sponsor a master's student to undertake a research project examining how coordination in healthcare had been approached in other contexts and with what effects. Another activity that emerged was that a core 'team' (six in total, three from Dooly and three from three other healthcare agencies) involved in the care of the children began to informally meet (including dinners) to discuss how to help the families. In these discussions of what would help, they identified how they would need additional resources to improve coordination and so they decided to put together a proposal to bid for money. They informally approached the CEO who initially was not supportive of the need for a project, especially because resources were tight at Dooly. The core team then, on the one hand, used the evidence produced from the master's thesis to convince the CEO, and on the other hand, decided that it could be worth seeking external funds. In early 2008 the core team put together an eight-page letter addressed to the CEO where they formally asked him to co-sign a bid for obtaining funds to start a pilot innovation project. This time the CEO agreed to advocate for the creation of a pilot and a year and a half later the bid was accepted (effective April 1, 2010) and steering and advisory committees were created. The steering committee includes Dooly's CEO and the CEOs of the other agencies, plus the responsible physician and a project supervisor (vice president of academic affairs at Dooly). The advisory committee includes the individuals who bid for the project (core team) plus two family members, representative of the 'voice' of the many families in the family forum.

The pilot project (April 1, 2010–April 1, 2015)

The pilot had its official start on April 1, 2010. The families soon perceived the benefits of improved coordination. The responsible physician arranged formal meetings to present to her colleagues why improving coordination was important. This involved a PowerPoint presentation, which included evidence about improved coordination (e.g., taken from the master's dissertation) as well as more personal anecdotes from families. Following these formal meetings, the responsible physician took action to improve communication on a more permanent basis. She did this not by imposing strict, mandatory 'rules' for the specialists (who would probably resist); instead, she was able to persuade the specialists of the relevance of each of them having a holistic view of each case. So, she arranged case meetings for each child, where all the

specialists involved share their expertise, opinions, test results, and the like. While previous attempts to ‘force’ doctors to share information had not lasted, these case meetings quickly became established practice.

Families attended these case meetings. However, for them, what made more of a difference was being able to contact the nurse coordinator, whose main role was to act as the interface between the hospital, the families and external agencies. The nurse coordinator reports directly to the responsible physician, from whom she receives the most recent updates about each of the 20 children enrolled in the pilot. The nurse coordinator calls, on average, each family at least once a week – often just to check to see how the child is doing, sometimes to share a lab result or to ask families to take the child to the hospital. The families contact the nurse coordinator about once a week too. Most often contact is made via email, the main reason being that the families need to a refill a prescription. Other times, phone calls are made because of a ‘quasi-emergency,’ when the child does not feel well and the family struggles with whether or not a visit to ER is required. In these situations, generally, the nurse coordinator immediately contacts the responsible physician, and, if necessary, the responsible physician checks with the specialist(s), and feedback is provided to the family within minutes, avoiding needless trips to Dooly. The project manager supervises these processes, coordinates the advisory committee meetings, and is in constant contact with the families to gather feedback that is then shared with the nurse and the responsible physician.

Aside from these new staff roles and processes, the main ambition of the pilot innovation project had been to create an ad-hoc electronic medical record (EMR) to allow the sharing of the children’s medical records across the network of organizations involved. This is because the evidence (e.g., produced by the dissertation) had suggested that such systems were vital components of improved coordination. In fact, in 2010 the hospital already had electronic records where most clinical information about patients was stored. However, different units had their own systems, and this represented a barrier to coordination even within the hospital. The external agencies did not have any type of EMR. Once the pilot project team started to look at implementing something to allow electronic sharing of medical records across the network, they soon realized that it was not feasible:

So originally I think the goal for our project was to have an electronic record but because of funding we couldn’t develop that, it was too expensive and too time-consuming.

(Project Manager)

After some deliberation, the advisory board came up with the idea of developing a single point of care (SPOC). The SPOC was based on the one father’s practice of using a ‘cheat sheet.’ The SPOC is a short (two-page) medical sheet that synthesizes the most relevant information about each child in the pilot. As the nurse coordinator explains, the SPOC works as follows:

Every family after they had their first intake visit would come back to what we call the family focused team meeting. So at that meeting we would say this is who your family coordinator is, we would present them with that [cheat sheet] document, that summary of their child. And we developed a medical roadmap that looked over their child’s care over a year and said okay, every three months this needs to happen, every six months this needs to happen, every year . . . So they had something visually they

could follow and make sure that nothing got missed. Because we didn't want to just take away all of their empowerment, we wanted to be able to give them documents that facilitated making things easier for them, not necessarily do everything for them. So they could look and say oh yeah, he's due for blood work in the next month, let me remember that. . . . The binder was supposed to also help communication between specialists and between the community and [Dooly]. So dieticians could write notes in that and then they could bring it to the GI and say the dietician wrote this.

The nurse coordinator updates the SPOC when a change in a child's condition occurs. The SPOC is then handed to the families, so they can bring it to different specialists, and if needed, to ER – even in other hospitals. The SPOC is also sent via fax or email to the external agencies (providing coordination across the network). The SPOC is designed to include only relevant (e.g., life-threatening) information about the child, and in a way that is specific enough to be meaningful for doctors, but easily understandable by non-clinicians (the families and other non-medical agencies like schools). The families quickly started to use the SPOC and found it very helpful, giving them legitimacy when they were discussing their child's illness with a professional, because “it was signed by a doctor, not by a mum” (mother of a child involved in the pilot).

The SPOC was also well received by the external agencies involved. Prior to the start of the pilot there had been attempts to promote communication between Dooly and the external agencies, but these attempts were unsuccessful because they were very poorly organized. However, now, with additional resources (in particular the nurse coordinator) and a joint plan created at the advisory committee level and constantly revised to overcome challenges and ‘make things happen’ (e.g., the creation of the SPOC in place of a ‘real’ EMR), they were able to dramatically improve communication and coordination at Dooly between specialists as well as across the partnership (Dooly and the agencies) and with the families.

A second phase of the innovation pilot was granted in 2014. This was based on surplus funds from the agencies involved. This second phase allowed the enrollment of 20 more children and the associated new doctors and nurses to support the project. The families continued to use the family forum to advocate for turning the pilot into a program, providing evidence of how the project has helped them. For instance, we interviewed a mother of a child involved in the pilot, who highlights the difference that it made for her and her son:

Before the [Pilot Project] it was like if I was in a business, you know, I wouldn't be the only person having to do all that work. You would have a manager, and you would have secretaries, you would have clerks, you would have a whole system of people and I before the project didn't have that, you know, so what would happen before the project would only be related to how much energy I had or what his health is, and so that I could only advocate so far to make things happen, you know. But now all doctors work together to talk about how it's going to work and who's going to take responsibility for pieces of making it work. It's not just a nice touchy-feely, this is a good idea, see you all later, but it's more okay, who's going to be responsible for which pieces and for somebody took notes about it, you know, so each doctor has access to those notes and is accountable, and again it's not left to me to run to a doctor and say well, you did do that part, you didn't do that part.

At the end of 2014, the new Dooly CEO was actively trying to convince the provincial government that the innovation at Dooly should become a permanent program with

provincial-level funding. There are several pilot projects in Canada that are good candidates to become programs, but funds are limited, and being able to influence relevant decision makers in government can make the difference. Given this, the CEO was actively involved in trying to convince the province of the merits of this program. He was doing this by sending to the province ‘official’ documents that reflect the success of the pilot and by giving presentations about the innovation. The CEO has drawn on an independent study conducted by an external university that shows that the pilot has substantially improved service delivery. This university study concluded that most families indicate that their workload in managing their child’s health is dramatically reduced, while their child receives better support. Interestingly, an internal evaluation study conducted by the research center at Dooly was less conclusive, because using a quantitative approach it had been unable to identify any measurable improvements for the children’s health or the hospital efficiency. This evaluation study is not part of the case that the CEO is using to get funding for a program. The outcome of this CEO work is not known at the time of writing, but as one interviewee mentioned – “he (the CEO) knows people, a lot of people [and] this will hopefully help us, otherwise the families will feel that we’ve abandoned them.”

Analysis and discussion

The Dooly case illustrates the myriad everyday practices that both create a strategic innovation initiative and sustain its momentum over time. It shows that senior management were not the instigators of the innovation in this case; rather it was the families – those one might assume would be ‘bottom of the pile’ in terms of the power they could wield across a complex healthcare network. Moreover, the case highlights practices involving talk, text and things, and their power to mobilize knowledge that supports innovations in practices (see Table 21.1). Of course, many practices contain talk, text and things, so this distinction is for analytical purposes only.

The table illustrates how everyday practices involving talk, text and things have power to mobilize knowledge in a strategic innovation initiative. This resonates with the SAP view of how strategy happens, but there are several points in our analysis that require additional consideration.

The power of talk

First, the role of emotions in practices involving talk that has power to influence future action is highlighted in our analysis. The stories of the families (both before – horror – and after – relief) are passionate, and it is their emotional intensity that helps to feed the existing narrative that improving knowledge sharing among healthcare professionals in the network can positively affect coordination to benefit sick children. These emotional narratives were repeated in a variety of settings to build and sustain momentum for the innovation. For example, the CEO saw the power of these narratives, incorporating family stories in his negotiations with the province (in presentations and speeches). Thus, our case clearly illustrates that the ‘pathos’ that accompanied the families’ stories strongly affected those who were initially skeptical about supporting the pilot innovation project or later engaging with the province to turn the pilot into a long-term program.

Second, we observe the power of talk in informal face-to-face meetings (Balogun and Johnson 2005). For instance, informal meetings (including dinners) among those from the different organizations who were all supportive of the proposed innovation strategy were important

Table 21.1 The power of ongoing practices

<i>Practice</i>	<i>Power of Practice</i>
<p>Talk</p> <p>Stories, anecdotes and narratives told by the families at the family forum illustrate the problems with the existing situation. These stories have significant emotional content: the parent losing a job; the parent trying desperately to get an ER doctor to listen to what they know about their child's problems but being ignored.</p> <p>Holding informal face-to-face meetings among those supportive of the initiative (e.g., dinners between the 'core team,' prior to 2010). The advocates discuss why the innovation would be helpful and develop short-term tactics for supporting the innovation – e.g., the SPOC, as a 'patch' because they were not able to create an EMR.</p> <p>Informal meetings are held between the responsible physician and the specialists. The aim of these meetings is to have the specialists understand the relevance of sharing patients' information.</p>	<p>Emotional content of the stories leads those who listen to empathize with the plight of the families and want to do something to help them. Such emotional content is a well-known tactic, used for example in campaigns to get the public to donate to worthy causes.</p> <p>Talking with others supportive of the initiative helps to reinforce the 'rightness' of the innovation being promoted without opposition. This helps to keep the momentum of the initiative going and builds consensus among the core team members.</p> <p>The responsible physician's reputation plays a key role in having the specialists take her seriously. This is also reinforced by the fact that she provides support to her claims using evidence from the literature.</p>
<p>Text</p> <p>Writing a dissertation on the basis of literature showing how coordination improvements can produce benefits for both patients/families and the hospital.</p> <p>PowerPoint presentations delivered during formal meetings, which use evidence from the literature and the family stories (e.g., meetings in Dooly where the pilot project is presented).</p> <p>Crafting official documents: the core team writes a long letter to ask the commitment of the first CEO; the second CEO writes to the province.</p> <p>Conducting and presenting results of evaluation studies: an evaluation study undertaken by the hospital was not able to prove that the project was successful because of the small number of children involved. A second independent qualitative study, which involved interviews with the families, demonstrated the benefits of the pilot.</p>	<p>In the field of medicine there is a strong tradition of ensuring that diagnostic and treatment protocols comply with existing 'best practice' evidence. This helped legitimate the project, e.g., by convincing the skeptical first CEO to support the project funding bid.</p> <p>PowerPoint slides used during presentations helped to give the message durability, so that the text could continue to influence after the meeting. Moreover, slides generally embed metaphors and figures that create links to concepts, and these have symbolic power.</p> <p>These official documents provide a durable commitment to the project that is difficult to subsequently renounce. Talk can be denied, but it is more difficult to deny what is written down and circulated to many.</p> <p>The CEO decided to use only the study that provided supporting results in the materials he presented to the province. Again, the text is important because it provides the evidence base, not simply for the effectiveness of this sort of initiative but for this specific initiative.</p>

<i>Practice</i>	<i>Power of Practice</i>
<p>Things</p> <p>Initially the core team attempted to create a shared EMR, but this was thwarted by a lack of funds and time. The core team then devised a new, paper-based system that would allow those involved to share information. While this SPOC was circulated to the network of organizations involved, it was the families that were the carriers of the SPOC, having a vested interest in ensuring that the health and social care professionals involved were kept fully informed about their child's problems, diagnoses and treatments.</p>	<p>An EMR is the established way of improving coordination across healthcare professionals – the literature review evidenced its importance. The inability to create a shared EMR could thus have stalled the project. However, those involved found a work-around to the problem by creating the paper-based information system. It is important to note that while the SPOC is also a text and has durability, its importance goes beyond merely reinforcing support for the initiative. Rather, the SPOC itself carries information between specialists involved and is constantly updated and signed-off (by a doctor, not a mum). The SPOC, thus, plays a symbolic role by legitimizing certain practices, e.g., when it is handed to a healthcare professional by a parent.</p>

in keeping the initiative live in the early days, before funding was secured. Clearly mobilizing knowledge to improve coordination involved several changes of current practices across the network. Our case shows that such strategic initiatives require significant work, and that this can be made easier when those involved talk together and reinforce the reasons for their engagement.

Another example of the power of talk was shown in the informal meetings between the responsible physicians and the specialists – these led to huge improvements in terms of knowledge mobilization within Dooly. The responsible physician was able to use evidence to legitimate her assertions about the importance of improved coordination, for example, by highlighting evidence of healthcare improvements because of the willingness of doctors to share patient information. Importantly, however, interviewees indicated that it was not simply what she said that was important, it was also who was saying it. Thus, the responsible physician had been working at Dooly for several years and was well respected – and this helped to legitimate what she said. In conclusion, the power of talk was relevant for initiating the strategic innovation initiative, and more importantly talk continued to be important in sustaining the initiative through knowledge mobilization. However, practices at Dooly did not involve just talk. For instance, text played a key role in legitimizing the pilot project, as we explain next.

The power of text

At Dooly, text was used by those who advocated for the pilot project to legitimize the initiative. Creating formal documents and PowerPoint presentations based on ‘evidence’ highlighted that the initiative could be (master’s student’s dissertation) and was (external university study) successful. It is clear that talk and text are related, because texts are often powerful when they are used in talk (e.g., see later discussion of PowerPoint presentation). However, texts have a durability that talk does not have. Ancient Romans used to say that “*verba volant,*

scripta manent” – by this suggesting that spoken words (*verba*) can easily be forgotten (*volant*), while written documents (*scripta*) can be conclusive in public matters, because of their ‘durable’ nature (*manent*). Legitimizing the initiative with text (something ‘concrete’ that can be reviewed at any time) was used by the advocates of the initiative to embed evidence of the benefits of the pilot project in a written (and durable) format. For example, official documents (e.g., the master’s dissertation) provided evidence from the literature about the relationship between knowledge mobilization, coordination and improvement of healthcare. Given the importance of evidence-based practice in healthcare, it is not surprising that this textual evidence was drawn upon in many different practices to help promote and maintain the pilot project. Thus, the results of the dissertation were included in an official letter addressed to the CEO, by which the core team aimed to gain support for the changes they wanted to introduce, as well as in subsequent PowerPoint presentations at various meetings.

PowerPoints, along with other official documents and emails, were also the means used by the CEO negotiated with the province to grant the pilot long-term funding. He uses ‘all sort of internal data, evidence from the community, families feelings’ in his presentations to feed the narrative that the pilot project leads to improvements on several fronts. In the case of the CEO and the province, the former is trying to convince a higher-level entity (the province) that a change (long-term funds granted to the pilot) be undertaken. The CEO uses PowerPoint presentations, which have a durability that talking alone does not. For instance, presentations can be accessed and reviewed after a presentation (often PowerPoint handouts are distributed to the audience for this very purpose). Interestingly, the CEO’s presentations were not just based on text. Other elements include images (e.g., representing together the logos of the four organizations involved in the partnership) that have symbolic power (in this case providing a sense that the four organizations are working together and have a shared sense of purpose indicating that the network is cohesive). Representing the journey of the pilot with a graphical image to illustrate the timeline is another example that suggests how the pilot has built legitimacy over time. In sum, creating official documents and PowerPoint presentations are illustrative of the power of text that helped to give legitimacy to the innovation project.

The power of things

The SPOC is an object (thing) that is created with input from numerous people and signed off on by a doctor. The SPOC can be described as a material agent because it has agency – has power to affect practice – in its own right when it is used by various individuals at Dooly, by the external agencies and by the families. Moreover, during its use, the SPOC was modified several times – for instance by adding and removing fields that, through practice, were found to be more or less important for sharing information in a professional (for specialists), synthetic (for ER doctors), yet understandable way (by non-clinicians, i.e., families). This clearly illustrates how the SPOC gained power through use and recalls Latour’s translation model. The spread of Latour’s ‘token’ (in this case the SPOC) “is in the hands of people” (Latour 1986, p. 267), and the energy that gives it power (initially, the adoption of the SPOC by the external agencies, for instance) lies in its use and appropriation by different actors, who make changes (reshaping it, when needed), but in so doing they preserve the essence of it (that it is understandable in different ways). Moreover, the SPOC allows for effective communication between Dooly and the agencies, and between the specialists and the families. Namely it maintains its main functionality and this is consistent with Star and Griesemer’s (1989) definition of boundary objects that, albeit ‘plastic,’ are also “robust enough to maintain a common identity across sites” (Star and Griesemer 1989, p. 393). The SPOC, therefore, allows local

understandings to be reframed in different ‘sites’ of practice by different practitioners. Similar to the PowerPoint presentations, the SPOC does not simply play a role in creating common understanding that allows coordinated actions; it also plays a symbolic role, and has power because it legitimizes certain practices for those involved (Swan et al. 2007).

In conclusion, the SPOC’s ability to mobilize knowledge across the network is an example of how boundary objects are ‘things’ with their own agency – they can gain power in their own right. Moreover, it is interesting to note that the SPOC reflects the emergent and unpredictable nature of innovation, as it occurs in practice. The SPOC is nothing but a paper-based way to mobilize knowledge across the Dooly network, and represented a ‘patch,’ or better a work-around to circumvent the (emergent) problems associated with the impossibility of creating an EMR (initial plan). Here we first show that the SPOC enables knowledge mobilization (quite a radical change, as before the SPOC the healthcare network had struggled for years because of the lack of knowledge mobilization). Second, and probably more importantly, we argue that the SPOC was not just a ‘tool’ that empowered individuals (e.g., the families). Instead, the SPOC was a boundary object (Star and Griesemer 1989) with agency that gained increased power over time – namely, it was not used as a tool to support an innovation but instead was an emergent element of innovating itself (as a human practitioner can be).

Conclusions and implications

In this chapter we demonstrated that it takes myriad everyday practices (including talk, text and things) to ‘make things happen’ in network settings. These practices involve a range of practitioners, not just senior executives, as much of the existing strategy literature focuses on. Two examples are (1) the involvement of the ‘end users’ (in our case, the families) that were fully engaged in strategic practices that promoted knowledge mobilization, which eventually occurred not just between healthcare agencies, but also from and to those who were in receipt of the care; and (2) the emergence of the SPOC as a boundary object gaining power on its own right. Therefore, the main contribution of this chapter focuses on the power of everyday practices to promote innovation. In our healthcare context we found that social and material practices *do* embed power, which can promote innovation. The practitioners in our healthcare network were all engaged in making decisions – jointly – with a view to improving the healthcare of the children.

We therefore contribute to the literature by illustrating the relevance of accounting for the power of different types of practice and practitioners (including end users and material objects) in network settings. Moreover, we were able to show how Latour’s translation model of power fits with strategizing in the sense of allowing us to understand how innovation happens in networks settings, with talk, text and things all involved in this translation process.

Finally, we highlighted the power of ‘pathos’ that unfolds through practice. We found that passion and emotion in advocating for some kind of innovation – especially by the parents during the family forum sessions – had a strong influence, for instance with the CEO. In sum, it is important to consider emotional talk as a form of power in its own right. This leaves a question for future research about whether such emotional talk can be ‘made up’ to provide additional power for a narrative.

Note

- 1 To this end, please refer to the several studies illustrative of the difficulties associated with the introduction of EMR systems in hospitals: Cresswell et al. (2014), Middleton et al. (2013) and Miller and Sim (2004).

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