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Dialogues and dialetics: Limits to clinician–manager interaction in healthcare organizations

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ABSTRACT

This paper examines clinician–manager interactions within healthcare organizations in the UK and contrasts the notions of dialetics and dialogues within such interactions. We draw particularly on Bakhtin's work on dialogue to frame our focal research question, which considers the extent to which clinician–manager interactions are dialogic. Using data drawn from a thirty-two month study of five UK healthcare organizations we suggest that clinician-manager interactions are more dialectic than dialogic in their orientation. Further, we suggest that, despite the appearance of dialogical possibility between clinicians and non-clinicians, the tendency to dialectic positioning reinforces opposition between these groups and we conclude that local, rather than system-wide interventions, offer the best means of disrupting these dialectics and fostering productive dialogues.

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Introduction

Modern healthcare organizations are complex social settings where separate managerial and clinical discourses mean that legitimacy in one field may not translate to another (Llewellyn, 2001). Clinician–manager relationships have been examined by a number of scholars (e.g. Armstrong, 2002) and evidence of increasing dissatisfaction among clinicians (Davies & Harrison, 2003) has been attributed to attempts to reduce clinical autonomy and deliver suitable governance arrangements (Edmonstone, 2008; Harrison & McDonald, 2008; Kirkpatrick, Jespersen, Dent, & Neogy, 2009; Learmonth, 2003). This has led to research based on competing logics and 'contested terrains' (Grint, 2008; Learmonth, 2003).

The separation in clinician–manager interactions is often predicated on a lack of common language (Tsoukas, 2009), which is critical in better understanding the relationship between the two groups. Thus, when considering the contribution of organization studies to healthcare, we draw on the distinction between dialetics and dialogue (Bakhtin, 1981) to examine such interactions and in particular to consider whether the application of so-called 'soft power' (Courpasson, 2000) is likely to be problematic in healthcare organizations. Drawing on a longitudinal study, we argue that many interactions between managers and clinicians, whilst appearing to be dialogical, may be better characterized as dialectical (Bakhtin, 1981), producing and reinforcing distance (or separations) between the two groups. Based on our analysis, we argue for a dialogical approach, which we see as being more productive, since dialogue does not seek to dissolve distance but to identify forms of separation that enable rather than disable relationships.

The paper proceeds as follows. First, we consider recent analyses of manager–clinician relations in five UK health organizations in the acute sector to reveal their dialogical assumptions. We then elaborate our understanding of dialogue by drawing on the work of Bakhtin. Following our method statement we analyse data from five healthcare organizations, drawing specific conclusions about the nature of interactions that might appear to be dialogical but, in essence, are dialectical. Finally, we consider the consequences of this finding for interactions more generally.

Analyses of clinician–manger relationships and their dialogic assumptions

Attempts at reforming healthcare vary since medicine has differing structural positions in different countries (Kirkpatrick et al., 2009), yet structural changes may impact both the autonomy of clinicians and the nature of clinician-manager relationships (Degeling et al., 2006). Davies and Harrison (2003), point to the increasing dissatisfaction of doctors internationally because of (a) their diminished autonomy, and (b) the application of a form of systematized medical knowledge that renders clinicians more

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open to measurement for managerial purposes such as financial incentives or state regulation of clinical practice. The dominant mode of medical practice is shifting from being based on tacit knowledge, individual experience and internal motivation to being based on explicit knowledge and evidence-based clinical practice implemented through external, collective procedures (Goldenberg, 2006). Davies and Harrison argue that the application of scientific-bureaucratic models to healthcare is at the root of clinical dissatisfaction.

Other researchers question the extent to which such rationalist reforms have significantly impacted clinical autonomy and traditional manager–clinician relationships. For example, in the UK, Buchanan and Fitzgerald (2011) suggest that powerful clinical groups have retained significant professional autonomy, despite managerial controls. Although reforms have created the appearance of a rationally-based managerial bureaucracy in the NHS, the reality is closer to an 'accessorized' bureaucracy, which provides the 'trappings', in the form of structures, processes and discourses, of managerial control but which still allows for a traditional system of clinical governance by strong professional groups. Courpasson's 'soft bureaucracy' and 'soft power' (2000), have also been used to analyse healthcare systems (Sheaff et al., 2003; Speed, 2011). Soft bureaucracy reflects attempts by professional organizations to provide the appearance of bureaucratic control in line with external stakeholders expectations, especially political stakeholders, but allows loosely coupled controls over powerful professional groups, especially where they have a foothold in governance structures. Courpasson suggests that public sector organizations can then present an image and, indeed, a reality of using hard power to apply to non-professional groups - by using direct supervision and discipline, work allocation and deployment, rewards and performance management, and employment security, while allowing certain powerful professional groups a strong degree of internal self-regulation. Such self-regulation is increasingly tied to attempts to incorporate powerful professional groups such as doctors into clinical leadership structures (Kirkpatrick et al., 2009). For example, Sheaff et. al., examined the strategy of co-opting primary care clinicians into the broader political aims, values and leadership of the English healthcare system, concluding that 'some English GPs now exercise a soft governance over others through a gradual introduction of managerial techniques…' (2003: 425).

The use of soft bureaucracy might be seen as facilitating dialogic interactions between clinicians and managers. However, this may be problematic if the two groups remain relatively insulated from bureaucratic control and attempted incorporation. Clinicians remain embedded in governance structures, perhaps in part because of the esteem in which they are held among the general public (Dickinson & Ham, 2008). Also, Reinertsen, Gosfield, Rupp, and Whittington (2007) discussion of quality management in healthcare highlights differing values, cultures and beliefs between clinicians and managers while Edwards, Kornacki, and Silversin (2002) argue that doctors are trained with an individual orientation which is inconsistent with the demands of healthcare systems, even those built on soft power. Hence, though dialogic interactions between clinicians and managers may be more constructive, there is a need for further empirical investigation and analysis.

A Bakhtinian dialogical approach

Dialogue has long been researched within literary and communication studies, and in these fields Bakhtin is highly influential but recently, his work has been used in organization studies. Shotter (1993) draws on Bakhtin's concept of dialogue in his conceptualization of social construction, which he sees as occurring through interaction and projection of identities. Cunliffe (2004) developed this work, arguing that a dialogic approach is the foundation of critical reflexivity where managers can challenge and change their self-identity and practice. Tsoukas (2009) has also adopted Bakhtin's dialogical concept in his exploration of intersubjective knowledge and enacted reality in organizations, while Boje and colleagues (Boje, 2007; Jabri, Adrian, & Boje, 2008) have shown how people, as participating subjects in organizations, are engaged in constructing a reality that may be contested and differentiating. Bakhtin's dialogue differs from other communication and dialogue studies where the emphasis is on mutual consensus-building (Bohm, 1996) and we have argued that Bakhtin helps conceptualise the ways in which dialogues resonate over time (Beech, MacIntosh, & MacLean, 2010), hence it is pertinent to the empirical situations we explore here.

For Bakhtin and his followers the world is a 'live event' constituted through dialogue (Emerson & Morson, 1990; Pollard, 2008) and hence social and psychological entities are regarded as processual in nature. Bakhtin (1981) distinguishes between dialectics and dialogue in his work, opposing a dialectical perspective in which there is a 'mechanical contact of oppositions'. He saw dialectics as two monologues (thesis and antithesis), which were distinct from genuine dialogue because they are 'finalizing'. That is, each pole in a dialectic entails a completed view and change occurs only when it is supplanted by another completed view. In a monological world a thought is "either affirmed or repudiated" (Bakhtin, 1984: 80) whereas, for Bakhtin, dialogue is always unfinalized, in process and inherently potentially changeful. This is commensurate with his view of the self and the social as taking shape and never finishing taking shape. Thus, dialogue is not merely a form of interaction but is an ontological position (Holquist, 2002).

The dialogical construction of the psychological and social operates at three levels (Bakhtin, 1986). At the broadest level, or what is sometimes referred to as a 'great' dialogue, world-views are expressed through languages. Languages are divided into social dialects that both express and construct world-views as well as characterize group behaviour. Examples of social dialects include the languages of generations/age groups, 'circles', authorities, professions and passing fashions. Membership of the group entails speaking the right language and doing so both reflects and influences thought and behaviour. Languages and social dialects, in Emerson and Morson's (1990: 219) terms, "set the tone for action in a given sphere of life and are assimilated into the psyche to set the tone for a particular sphere of thought". Languages and dialects are dialogical in the way they are formed and practiced. They are also in dialogue with each other, in part through people in different spheres interacting with each other and partially through individuals naturally having a repertoire of different languages. Bakhtin (1981) gives the example of a peasant who lives in several language systems, praying to God in one, singing songs in another, speaking to his family in a third and petitioning the local authority in a fourth. While each language has genre rules for its operation, none is finalized as they are always changing and influencing each other.

The second level is 'internal' dialogue, which occurs as speech acts and utterances relate to each other. Such dialogue between voices can be between people in a specific social context or conducted by an individual between voices that have been internalized through experience. Although this is referred to as internal, it entails intersubjectivity (Holquist, 2002). For Bakhtin (1984) an idea does not reside in one person's head, but only comes alive in a dialogical relationship with other ideas through embodiment in the voice of another. Natural ambiguity allows for ongoing reinterpretation and the generation of new versions of itself and new ideas. This is an internal dialogue since the self is understood as

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