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An exploratory study of knowledge brokering in hospital settings: Facilitating knowledge sharing and learning for patient safety?

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ABSTRACT

This paper reports on an exploratory study of intra-organisational knowledge brokers working within three large acute hospitals in the English National Health Services. Knowledge brokering is promoted as a strategy for supporting knowledge sharing and learning in healthcare, especially in the diffusion of research evidence into practice. Less attention has been given to brokers who support knowledge sharing and learning within healthcare organisations. With specific reference to the need for learning around patient safety, this paper focuses on the structural position and role of four types of intra-organisational brokers. Through ethnographic research it examines how variations in formal role, location and relationships shape how they share and support the use of knowledge across organisational and occupational boundaries. It suggests those occupying hybrid organisational roles, such as clinical-managers, are often best positioned to support knowledge sharing and learning because of their 'ambassadorial' type position and legitimacy to participate in multiple communities through dual-directed relationships.

Introduction

Knowledge brokering has become a prominent strategy for supporting learning, innovation and improvement within healthcare services (Canadian Health Services Research Foundation, 2003; Lomas, 2007; Nutley & Davies, 2001; Oborn, Barrett, & Racko, 2010; Ward, Smith, House, & Hamer, 2011). In broad terms, knowledge brokers build relationships between communities to support the creation, sharing and use of knowledge (Burt, 1992; Hargadon, 2002; Meyer, 2010). The contribution of knowledge brokers to healthcare improvement is commonly related to the diffusion of research evidence into clinical practice (Canadian Health Services Research Foundation, 2003; Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004; Lomas, 2007; Ward et al., 2011). Less attention is given to knowledge brokers at the intra-organisational level (Currie & White, 2010). That is, 'embedded' actors who facilitate the sharing and use of knowledge between organisational departments, clinical teams and healthcare professions to support, for instance, more integrated, collaborative or patient-centred working.

Two contingencies impact intra-organisational knowledge brokers in healthcare organisations. The first relates to the idea that clinical practice is informed, to a great extent, by experiential know-how, which is situated within the routines of clinical communities. Unlike more explicit knowledge, this is difficult to articulate and share with others. Second, and linked to above, the close ties between practice-based knowledge and group membership make it difficult to share knowledge across occupational boundaries; especially where professional jurisdictions are premised on the acquisition and control of knowledge (Abbott, 1988; Waring & Currie, 2009). Research suggests, for example, that attempts to extend management access to clinical knowledge are often stymied by professional boundaries (Currie, Waring, & Finn, 2008; Ferlie, Fitzgerald, Wood, & Hawkins, 2005). Reflecting on these contingencies, further insight is needed about which healthcare actors might support knowledge sharing, focussing on their relationships and roles at the intra-organisational level.

Our paper reports on an exploratory study that aimed to identify and compare 'embedded' knowledge brokers working at the intra-organisational level. It examines how brokers vary according to their structural positions and relationships within and between communities, and how this influences their ability to share and support the use of practice-based knowledge between professional and managerial communities. In particular, it compares the brokering activities of those with formal and less formal roles in regard to organisational learning. The study focuses on the challenge of knowledge sharing in the context of patient safety. Over the last decade patient safety has become a global health policy

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priority with the introduction of various strategies to support organisational learning (Department of Health (DH), 2000; Institute of Medicine, 1999; WHO, 2004). More recently, the Public Inquiry into Mid-Staffordshire NHS Trust (Francis, 2013) further highlighted the systemic failure to learn and respond to unsafe patient care. However, reforms to enhance patient safety have been difficult to implement, exemplifying the broader challenge of knowledge sharing and learning at the intra-organisational level (Rowley & Waring 2011; Waring, 2005). The paper offers an elaboration of the challenges to learning in the context of patient safety and, drawing upon exploratory research with purposively selected groups, develops tentative suggestions for the wider role of knowledge brokers in healthcare.

Knowledge brokering in healthcare organisations

Knowledge brokers are actors, technologies and objects (Oborn et al., 2010), that enable the knowledge of one community to be shared with and used by those in another (Burt, 1992; Hargadon, 2002; Meyer, 2010; Michaels, 2009; Pawlowski & Robey, 2004; Ward et al, 2009a, 2009b). Following Burt (1992), they bridge the 'structural holes' between unconnected actors, and facilitate the "translation, coordination and alignment" of knowledge between communities (Wenger, 1998: 109). Elaborating how knowledge brokers support innovation, Hargadon (2002, 2003) suggests they identify and access knowledge located in different communities; build connections between knowledge pools; support capacity building; and facilitate social engagement and learning. With reference to healthcare innovation, the Canadian Health Services Research Foundation (2003) suggests knowledge brokers gather evidence and appraise knowledge; identify and seize opportunities; and mediate the boundaries between communities.

One prominent way of developing the knowledge broker concept is to elaborate their structural position and relationships within and between communities (Meyer, 2010; Michaels, 2009). Gould and Fernandez's (1989) seminal typology remains a key contribution to the literature and informs the analysis developed in this paper. By comparing knowledge brokers' positions and relationships they differentiate between:

- 'coordinators' who broker between two or more actors from their own community;
- 'itinerant brokers' who mediate contact between actors within a community they themselves do not belong;
- 'gatekeepers' who broker incoming exchanges from outgroups;
- 'representatives' who broker out-going exchanges from their community;
- 'liaisons' who broker exchanges between two or more communities to which they do not belong.

Despite increased interest in knowledge brokers, and their contribution to healthcare improvement (Lomas, 2007; Ward et al., 2011); there is less attention to the position of brokers at the intra-organisational level (Currie & White, 2012), and importantly, the types of knowledge and boundaries these actors broker. Much of the policy literature conceives knowledge as an explicit resource that can be accessed, codified and exchanged for the purpose of learning (e.g. DH, 2000). A contrasting view suggests knowledge is 'situated in practice' and learning occurs through doing (Blackler, 1995). People acquire shared meanings, know-how and their sense of identity through participating and learning *within* a community (Brown & Duguid, 1991; Gherardi, 2006; Lave & Wenger, 1991). From this perspective, knowledge is experiential, tacit and bound by use, rather than evidential, explicit and abstract (Blackler, 1995). In other words, knowledge is not a 'thing' that a community 'has', but rather it is what they 'do' and who they 'are' (Lave & Wenger, 1991). Following Szulanski (1996), this explains why some knowledge is 'sticky', or cannot be easily shared because it is only acquired through participation, used in context and privileged by membership.

This literature highlights how social boundaries frame practice-based knowledge and learning (Lave & Wenger, 1991). Attention to the boundaries that distinguish and separate communities is essential for understanding the work of knowledge brokers (Meyer, 2010; Williams, 2002). Research suggests, for example, 'boundary spanning' involves the mediation of inter-personal, ideological, socio-cultural and hierarchical attributes that define and differentiate social groups (Abbott, 1995; Williams, 2002). With relevance to healthcare, professional boundaries are highlighted as inhibiting knowledge sharing, innovation and learning (Currie et al., 2008; Dopson & Fitzgerald, 2006; Ferlie et al., 2005). These are institutionalised through a variety of socio-cultural and political strategies, which commonly rely upon an occupation's claims to exclusive knowledge (Freidson, 1970). Knowledge is therefore bound up, not only with group membership, but also professional legitimacy and power within the division of labour (Abbott, 1988). As such, professional groups are often reluctant to share knowledge where it might threaten their status or identity (Currie & White, 2012; Waring & Currie, 2009).

The challenge for knowledge brokers is how to access, share and support the use of practice-based or sticky knowledge across these professional boundaries. This knowledge is not readily available for exchange, but needs to be acquired and diffused, in part, through participation and engagement in practice. Knowledge-use and learning is less likely to occur through passive communication, but through helping actors to incorporate knowledge into existing practices and by mediating institutionalised boundaries. Nonaka's (1994) model of organisational innovation describes a similar process where the tacit know-how of one group is made explicit and 'externalised' so that it can be re-combined with and 'internalised' into the practices of others. In this sense, the knowledge broker not only has to build connections between organisational units, but also integrate the know-how of one group with the practices of another (Hargadon, 2003). Knowledge brokers therefore need forms of membership and legitimate participation within multiple communities to gain understanding of practice-based knowledge and to support practice-based change (Lave & Wenger, 1991).

Applying these ideas to the intra-organisational level, the ability of an actor to broker knowledge across professional boundaries is likely to be shaped by their structural position and relationships within and between different communities. It might be tentatively proposed, for instance, that membership of a given community enhances understanding of practice-based knowledge, but might make it difficult to articulate the more taken-for-granted aspects of practice. Equally, those outside a given community might be able to discern innovative practices, but their position might limit their exposure or legitimate access to practice-based knowledge. The aim of this paper is to better understand how a broker's structural position and relationships at the intra-hospital level influences the brokering of knowledge across organisational and occupational boundaries. In particular, it seeks to compare the experiences of those with formal and informal responsibilities for knowledge sharing.

The challenge of brokering patient safety knowledge

Our study focuses on the challenge to knowledge sharing and learning associated with patient safety improvement. It is typically argued that healthcare organisations should 'learn the lessons' of