

THE SOFT SIDE OF KNOWLEDGE
MANAGEMENT IN HEALTH
INSTITUTIONS

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THE SOFT SIDE OF KNOWLEDGE MANAGEMENT IN HEALTH INSTITUTIONS

BY

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PREFACE

The aim of this book is to contribute to the understanding and clarification of leadership and organizational problems in hospitals. Economists focus on cost-effectiveness when looking at hospital leadership and organization. Obviously, we agree that cost-effectiveness is important, but knowledge-effectiveness is equally important because knowledge, skills and attitudes are the most important competence factors in hospitals. The innovative contribution of this book lies in how a knowledge perspective and, in particular, knowledge-effectiveness can contribute to hospital leadership and organization from a continuous-change perspective.

The method we employ is conceptual generalization (Adriaenssen & Johannessen, 2015).

Knowledge management in this context is about managing, controlling and communicating knowledge within social systems. Managing knowledge relates to the management perspective. Controlling knowledge relates to information processes, vision, goals, discrepancies and correcting the course along which the system is heading. Communicating knowledge is defined here by the statement: Who talks with whom over which channels and with what effect.

This book follows up on our earlier book *Knowledge Management Philosophy* (Emerald, 2020) and continues our development of a new paradigm for knowledge management. The particularly innovative feature of this book is its focus on knowledge management, information, communication, organizational learning, tacit knowledge and negotiations within hospitals.

Our new paradigm raises knowledge management from an organizational to a social level, while at the same time uncoupling knowledge management from the technical- and solution-oriented models to which it has previously been linked.

We use our new paradigm to focus on knowledge management in relation to epistemology, development, change and innovation in social systems.

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KEY POINTS IN THIS BOOK

The question we are investigating in this book is as follows: Why are hospitals so difficult to manage? We believe that if we can help answer this question, we will be helping to ease the task of hospital management.

The answers we give in this book can be summarized along six axes.

- (1) Management philosophy: There are two contrasting philosophies of hospital management. These are the organizational philosophy and the healthcare-oriented philosophy. In order to establish clarity in the leadership of a hospital, it is essential to ensure the integration or coordination of these two management philosophies.
- (2) Value creation processes: To a large extent, hospital leaders are trained to think about value creation along a value chain. In hospitals, there are five value creation processes, all of which are equally important. These five value creation processes are: the value chain; the value network; value workshop; value community; and the value dialogue. Each of these value creation processes has its own particular emphasis. Management of a hospital will be difficult unless a hospital's leadership attaches importance to all of these processes.
- (3) Knowledge processes: Hospital management and leadership teams do not attach sufficient importance to the strategic significance of tacit knowledge.
- (4) Organizational learning: Organizational learning is insufficiently implemented within hospitals.
- (5) Negotiating processes: Hospitals are institutions where a negotiated reality is part of everyday working life. There is little enthusiasm for training all staff members in negotiating skills, however. Accordingly, knowledge of negotiating skills is not equally distributed in hospitals. This is not in anyone's interests and is not to the benefit of other actors. Until knowledge about negotiating becomes part of the knowledge base of all

employees, everyday life at a hospital will be dominated by other conflict-resolution strategies than negotiation. In our opinion, this does not benefit a hospital's management.

- (6) Performance of health professionals: Improving the performance of health professionals is considered crucial for management competence in hospitals.

METHODOLOGICAL AND THEORETICAL BASIS FOR THIS BOOK

Both theoretical and practical knowledge comprise knowledge that is both explicit and tacit (Jakubowska, 2019). It is a misunderstanding to believe that tacit knowledge belongs to the practical domain, while explicit knowledge belongs to the theoretical domain (Lim, 2016). The necessity of making a connection between tacit and explicit knowledge is clearly expressed by Nonaka (1994, p. 22):

...in order to raise the total quality of an individual's knowledge the enhancement of tacit knowledge has to be subjected to a continuous interplay with the evolution of relevant aspects of explicit knowledge.

Tacit knowledge is understood here on the basis of the tradition that views participation and interaction with other people and with technology as the essential component of knowledge processes, or as Polanyi puts it (1958, p. 189): 'I have said that the premises of science are tacitly observed in the practice of scientific pursuits and in the acceptance of their results as true'. This is practical knowledge or knowledge in action (D'Cruz et al., 2009). Knowledge in action may also give rise to theoretical knowledge, which may not necessarily be directly applicable in practice, i.e. practice is the starting point but not necessarily the end point for the knowledge process (Turner, 2014).

In Western thinking, the tacit dimension has not been given much attention because the emphasis has been on so-called scientific knowledge that can be measured, quantified and tested, i.e. objective knowledge (Zappavigna, 2014).

By 'objective knowledge', we mean the following:

Let p be a piece of explicit knowledge. Then p is objective if and only if (a) p is public (intersubjective) in some society, and (b) p is testable (checkable) either conceptually or empirically.

(Bunge, 1983, p. 80)

Thus, according to this definition, objective knowledge must be intersubjective and verifiable. However, truth is not necessarily an integral part of objectivity; a statement may be objectively correct but false, and non-objective but true. For example, ‘there is a high tide because the dough is swelling’ – this is an objective statement because it is intersubjective and testable, but it is false. The statement ‘my dog is always kind’ is not objective, but it may be true. Tacit knowledge is difficult to codify. It is, therefore, not exact in the sense that it can be quantified, measured or tested. On the other hand, tacit knowledge may be verified in action, e.g. by the physician or nurse’s clinical gaze. In its consequences, tacit knowledge is thus objective, since it can be tested by verifying it in practice (Zembylas & Niederauer, 2020).

Technical rationality, with the natural sciences serving as a theoretical model for knowledge, has been the ideal in Western science. The tacit dimension is opposed to this view of knowledge; in a scientific context, and in practice, it stems from intellectual empathy, emotional commitment and action. Polanyi (1958, p. 134) clearly expresses his view of knowledge in the following statement: ‘Science is regarded as objectively established in spite of its passionate origins: It should be clear by this time that I dissent from that belief’. What then is Polanyi’s contribution to Western philosophy and epistemology? Allen (1990, p. 15) expresses this fittingly: ‘Polanyi’s theory of tacit integration is his distinctive contribution to philosophy’. This may be interpreted as meaning that all our knowledge development, not just tacit knowledge, has as its starting point the details upon which we have a subsidiary focus in relation to the object or phenomenon under investigation. It is this *from-to* structure, from the subsidiary to that which is in focus, which constitutes the structure in the tacit integration. All knowledge, according to Polanyi, has this tacit basis as its foundation.

Schön (1983, 1987) compares tacit knowledge to the artist’s method of working, where knowledge is unique from situation to situation. The tacit dimension belongs to professional practice (Schon, 1983, p. 39) without a theoretical foundation. The problem that arises in practice, no matter how similar it may seem to be to other problems, is unique, and the solution must be found within the specific context. It must, therefore, be defined each time. In such contexts, problem-definition knowledge (e.g. development of concepts) is as important as problem-solving knowledge (e.g. use of tools). In many cases, problems can only be defined in relation to practical situations that often have unclear boundaries, where explicit knowledge is not sufficient to define the problem or solve it. To define a problem in a practical context, a hospital should create a framework around the work situation. This is the strategic, organizational and managerial implication of the focus on tacit knowledge

(Souleiman, 2016). If this framework is not generated, then explicit knowledge and technical rationality will gain acceptance because of their historical importance and position as the dominant logic. When the system does not create structures, relationships and processes that allow the possibility of a tacit dimension, then the explicit dimension will dominate decision-making (Gill, 2016). Our point is that such 'rational' solutions will ultimately lead to less rationality at the system level, and in the worst-case scenario, could damage a system's performance.

An organizational and managerial deficit will occur if tacit knowledge (e.g. the front line in a hospital and in other places in a hospital where tacit knowledge is located) is given less emphasis in favour of explicit and verifiable knowledge (Jaziri-Bouagina & Leal Jamil, 2017).

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ABSTRACT

The aim of this book is to contribute to the understanding and clarification of leadership and organizational problems in hospitals from a knowledge management perspective. We develop the concept of knowledge-effectiveness contrasted to the concept of cost-effectiveness. The innovative contribution of this book lies in how a knowledge perspective and, in particular, knowledge-effectiveness can contribute to hospital leadership and organization. The question we are investigating in this book is as follows: Why are hospitals so difficult to manage? We believe that if we can help answer this question, we will be helping to ease the task of hospital management.

Keywords: Hospitals, leadership, knowledge-effectiveness, knowledge management, innovation, continuous change, conceptual generalization