

Dealing with the Primacy of Knowledge in an In-Patient Mental Health Setting

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INTRODUCTION

This article brings together three strands of interest to IS researchers: the problem of managing knowledge, particularly deep experiential knowledge; the opportunities and limitations of process and process-based systems (PBS); and the interplay of organizational culture across both. Similar work has been done in medically oriented departments, such as pediatrics and admissions, where a link between PBS and changes in organizational culture has been observed (Perry, 2003) and where an argument has been developed that PBS actively contribute to the creation of organizational knowledge (Perry, 2004).

Healthcare processes can be complex, and often appear to be unique to the patient (Smith, 2000). Although case mix systems and, in the last few years, electronic patient record (EPR) systems, have become common (Smith, 2000), the problem of handling highly iterative, possibly idiosyncratic processes remains. Although “care pathways” can be defined and often executed with little change, many treatments nevertheless are composed largely of ad hoc patient-carer interactions where the carer may be using a large amount of experience and expertise, overlaying their training (Ward, 1992).

A mental health unit was selected as the setting for this particular piece of research because it displays characteristics that are qualitatively different from those other areas of health care (Altschul, 1997). Mental health units, due to the nature of their work, deal with a myriad of variables in terms of physical, behavioral, and cognitive disorders, and staff appear at least to use a high degree of tacit knowledge (Clarke, 1999).

The results, it will be argued, point toward the value of PBS rather than the more static use of databases. On the other hand, the problem of interpreting system-generated data, unaccompanied by interpretive clues from other members of the community of practice, still remains.

Kakabadse, Kakabadse, and Kouzmin (2003) discuss a continuum of types of knowledge that runs through data-information-realization-action-wisdom. Substantially, they identify a deepening complexity and usefulness of knowledge as more and more cognitive and interpretive processes are deployed. At the far end of the continuum, wisdom therefore becomes a mode of symbolic processing by a highly developed will (Kakabadse et al., 2003). Importantly, intention and personality, including life experience, are essential to make the most use of knowledge. It is this aspect of knowledge management that forms a key issue to be dealt with in this article.

PROCESS-BASED SYSTEMS

PBS can be defined broadly as systems that enact business processes. They may be highly prescriptive, like some of the insurance claims applications in large financial institutions, where agents have little choice in the order and number of steps they must follow. They may be ad hoc systems, like some groupware applications. They may be what has been described as proto-PBS (Perry, 2004), systems such as electronic patient records that do not automatically move from one stage to another but indicate when a new stage may be necessary (e.g., viewing the results of a hematology report).

Additionally, the EPR records themselves constitute the content of a number of organizational processes, particularly in the area of patient care. Systems that *address processes rather than transactions* have been an area of research focus for some time (Doherty & Perry, 1999). The argument has been that these systems accrete organizational knowledge as they move through their process; in this way, they help to create and expand organizational knowledge by bringing existing and new data together and prompting staff to look afresh at the available information (Perry, 2004).

An example of a proto-PBS in a mental health setting is discussed by Bloomfield (2005), who describes the electronic whiteboard used by a number of District Health Boards (DHBs) in New Zealand. This system—officially termed the Current Customer View (CCV)—acts as a metalayer for existing mental health systems. It permits staff at a DHB to view important patient data that may be held on the systems of other DHBs. This is significant, as mental health patients may well move abruptly and without informing their doctor; in such situations, clinicians in a new area need current information about the patient's history, recent problems, behavior, and medication (Bloomfield, 2005).

Managing knowledge in health care

A general problem in the discussion of knowledge management in any complex social setting is to understand the nature of the knowledge being created, manipulated, or communicated. Polanyi (1958) was among the first to identify the significance of tacit knowledge, while Nonaka (1990) reinterpreted the concept, asserting that tacit knowledge could be made explicit. Hitt and Tyler (1991), studying the behavior of business executives, concluded that they use automatic and nonconscious processes. Further, they believed that these processes drew upon experientially established cognitive structures (Hitt & Tyler, 1991). We can see how significant tacit knowledge can be; these processes and structures were being used in making *strategic business decisions*. Later, Nonaka (1994) noted how people used stories, metaphors, and analogies in order to share and communicate tacit knowledge. This sharing of oblique or interpreted knowledge is central to the problem of complex knowledge management, since health care includes not only medical evidence but also opinion and experience, particularly in relation to patient care (Priebe & Slade, 2002).

CULTURE AND CLIMATE

Organizational culture is most often revealed in how it and the organization are perceived by organization members (Schein, 1999). In large health care organizations and even within hospitals, it is to be expected that a variety of cultures will exist (Helms & Stren, 2001; Hofstede, Neuijen, Ohayv & Sanders, 1990). Additionally, research seems to show that whatever the type of culture, it will affect the perceptions of the staff. Similarly, major organizational changes

will affect staff attitudes and practices, and this will affect culture (Schein, 1999). In the NHS (the United Kingdom's National Health Service), a study during intense change was carried out by Litwinenko and Cooper (1994). They found not only that the proposed changes cut across traditional beliefs and expectations held by the health care worker, but also that all types of culture present in the organization were changing (Litwinenko & Cooper, 1994).

A critical element of nursing practice and knowledge transfer is 'organizational climate'. (R. B. Brown & Brooks, 2002) This is associated with but different from organizational culture, which is the broad set of commonly held attitudes, beliefs, and assumptions that characterize an organization (Brown, 1998; Sathe, 1985; Schein, 1999; Smircich, 1983). Organizational climate refers to the atmosphere that employees perceive in their organizations. It is created by practices, procedures, and rewards, and may differ markedly from one hospital department to another. Organizational climate is also associated with shared emotion or feelings. This emotional dimension has been shown to be both a social influence on the behavior of individual staff members and on their collective actions (Brown & Brooks, 2002). As a result, Brooks and Brown identify emotional climate as an important social construct in the interaction among staff. While their study does not specifically address knowledge management or creation, it does make it very clear that individual and group self-identification both stem largely from stories and from shared experience. For students of knowledge transfer, this observation is highly significant. In a nursing environment, we have to consider not just the transfer of explicit knowledge or the passing on of know-how, as defined by Nonaka (1991). We are also dealing with feelings and emotions, which are sometimes very deep-seated and contribute to the identity of the unit.

MANAGING KNOWLEDGE IN MENTAL HEALTH

Scott (2005), in an informative paper on knowledge workers as part of a social network, makes some initial points: "Their daily work may be unpredictable, multidisciplinary, and nonrepetitive. The jobs assigned to them have long term goals and, due to the relatively standard ambiguity and complexity of the task, require knowledge workers to routinely collaborate with co-

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