TENSIONS IN THE FIELD OF HEALTH CARE

KNOWLEDGE NETWORKS AND EVIDENCE-BASED PRACTICE: AN ACTION RESEARCH APPROACH

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A thesis submitted in partial fulfilment of the requirements of Liverpool John Moores University for the degree of Doctor of Philosophy

December 2011

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Abstract

Empirically, this thesis has focused on nine research and development (R&D) networks set up to promote a professional approach to care and strengthen the collaboration between health care sectors in a Swedish health care setting. The research project was embedded in an action research approach intended to encourage network development by means of a dialogical process. The specific research question was: What are the actors' perceptions of knowledge networks and how might we account for the networks' evolution, role and ways of working? Bourdieu's concepts reproduction and symbolic violence were used as analytical tools and were chosen as a way of answering and explaining the empirical story line. Data was collected by use of a multi-method approach consisting of 39 interviews, observations, document review and reflexive notes. The intention was to elicit data that supported both network development and the theoretical explanation to come. It appeared that the networks concerned had several advantages, such as being a forum for internal dialogue and exchange of experiences. In addition, two main patterns emerged: Firstly, most of the participants within the networks were advocates of a linear top-down model of implementation of evidence-based knowledge into practice. Secondly, they experienced inertia in the transfer process. From the collaborative process undertaken it emerged that their linear top-down model of knowledge transfer seemed to be firmly rooted. Theoretically, the thesis contributes to an understanding of why the process of knowledge transfer was considered by the participants within the networks to be a sluggish process. The thesis also contributes to an explanation of why they adhered to the macro-discourse of evidence-based medicine at the expense of involving practitioners outside the networks in horizontal patterns of exchange. It is argued that the networks had a symbolic value and were also a product of and reproduced the evidence-based discourse and the prevailing structures within their field. This contrasted with the role of networks as arenas for generation of local knowledge in the network literature. A major challenge facing health care sectors is that of how to support practitioners in the incorporation of new practices resulting in actual changes.

Acknowledgements

Many people have lent me support in various ways during my years as a PhD student. First, I would like to thank my supervisor, who was also my director of studies for the major part of the time, Professor Jane Springett, School of Public Health, University of Alberta, Canada, for guidance and patience throughout the process and for introducing me to the exciting field action research. I would also like to thank my assistant supervisor Associate Professor Tony Huzzard, School of Economics and Management, Lund University, Sweden, for close reading and constructive comments that have strongly contributed to the progress of this thesis. Thanks are also due to my assistant supervisor Professor Karin-Anna Petersen, Institute of Social Medicine, University of Bergen, Norway, for great commitment and valuable contribution, especially to my understanding of Bourdieu's theories.

I have to thank Staf Callewaert, professor emeritus, for fruitful discussions on Bourdieu's theories and action research during seminars, and for valuable viewpoints on some selected chapters. Thanks also to Leif Karlsson, senior lecturer at Kristianstad University, Sweden, who held the role as local advisor for the major part of the research process and provided me with useful advice during the feedback sessions undertaken during the first stage of the collaborative inquiry process, and also contributed with critical feedback on a much of the text. I would also like to acknowledge Daz Greenop who became my director of studies at the end of the process and guided me through the administrative procedures at Liverpool John Moores University, England, where I have been enrolled. Thanks are also due to the professional proof reader Katriona S.W. Hardie-Persson for flexibility and quick work.

Moreover, a large number of PhD students and colleagues at Kristianstad University, both within and outside the research group I was part of, have inspired me and supported me in different ways. You are too many to name, but my sincere thanks to you all! I would also like to acknowledge Region Skåne and Kristianstad University in Sweden for their financial support, and Kristianstad University for the facilities. Naturally, I would like to thank the participants of the study for

collaboration, engagement and contribution to the knowledge production. Last but not least I would like to thank relatives and friends for encouragement and love and for being there for me. I love you all. Special thanks are given to my beloved daughter Sofie since she is the person who has been affected most directly by my thesis writing and this at times winding journey. You are always in my heart.

Yvonne Johansson

Hässleholm, Sweden in October 2011

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1. Setting the Scene

The Focus of the Research

In most health and social care sectors in the Western world during the last few decades there have been increased demands for a more scientifically supported knowledge base in practice (Roberts & Yeager, 2004; Sackett et al., 2000; SOU, 2008). The gap between scientifically generated knowledge and practice is generally considered a dilemma, and to reduce this gap much research suggests models of knowledge transfer and how to make scientifically generated knowledge more available to practitioners (see for example Bahtsevani, 2008; McColl et al., 1998; Roy et al., 2003; Sackett et al., 2000). In the literature, evidence-based practice (EBP) has become the overall term used to describe skills that are required of practitioners in their decision-making in everyday work practices. In theory EBP involves the integration of research and other best evidence with clinical expertise and patient values in health and social care decision- making (Sackett et al., 2000).

EBP ought to be an uncontroversial ideal; however, a critique of EBP is the widely promoted linear top-down models of knowledge implementation that it entails. For example, critics argue that implementation of EBP in reality corresponds to a rational way of thinking, not taking the complex conditions in practice into consideration (Petros, 2003). Moreover, a vast body of research asserts that practitioners do not adopt evidence-based knowledge to a great extent and neither do they find it supportive (Greenhalgh et al., 2005; McCaughan et al., 2002). Whether it is possible or not to develop scientific theories and methods that can guide practice is still a matter of dispute[1].

Advocacy of EBP is emerging at a time when health and social care sectors in most western countries are meeting considerable and similar challenges. In Sweden, for instance, where the current research project was undertaken, there is increasing pressure on these sectors to maintain or improve quality of care in the face of demographic changes, new medical technology and financial constraints, which has resulted in structural transformations and enacting of major health-care reforms

[1] The subject of EBP and whether practice could be theory-driven or not is discussed in chapter three and four.

(Anell, 2005; Hjortsberg & Ghatnekar, 2001; Wendt & Thompson, 2004). Through these reforms, a substantial part of caring has been transferred from hospital care to lower, more cost-effective levels of care (Anell, 2004; The National Board of Health and Welfare, 2007). It is argued that this transformation has been inspired by market thinking with links to an ideology which gained impetus in the 1980s, often referred to as new public management (NPM) (Hasselbladh et al., 2008). The NPM ideology implies increased emphasis on market solutions, cost efficiency and control (Pollitt & Bouckaert, 2004). Moreover, characteristic of Swedish health and social care systems is their relatively vertical structure with strong features of sub-specialisation and fragmentation. These are circumstances that entail difficulties in the coordination of activities for patient treatment and an increased need for collaboration across sectors (Anell, 2004; Åhgren, 2003).

To reduce the gap between scientifically generated knowledge and practice, and to respond to requirements for a more integrated care within health and social care sectors, networks are emerging as a solution (Bate & Robert, 2002; Goodwin et al., 2004). For example, it is argued that networks due to their flat structure and low degree of bureaucracy have the capacity to facilitate the transfer of knowledge into practice (Bate & Robert, 2002). It is also asserted that networks, through their flexible nature, have qualities to cross organisational and professional boundaries (Goodwin et al., 2004; Meijboom et al., 2004). Moreover, research has demonstrated that networks have the potential to encourage dialogue and have possibilities of promoting learning and the sharing of knowledge amongst professionals (van Wijngaarden et al., 2006). The area of networks as a measure for facilitating knowledge transfer and integrated care within health care sectors has links to the particular field of research in the present research project.

The present research project focuses on nine research and development (R&D) networks within the field of health care in the north-east district under the county council *Region Skåne* in Sweden (see Appendix 4 for a geographical map). The subject areas of these networks have been: Palliative Care, Documentation, Drugs & Elderly, Ulcer, Nutrition & Eating, Psychiatric Rehabilitation, Pain, Hygiene and Discharge Planning. In the overall aims of the networks there was an emphasis on collaboration across sectors and the transfer of knowledge to support knowledge

development in practice (unpublished network document, 2002). The networks had ramifications in hospital care, primary care and care provided by municipalities, and created links across professions, workplaces and organisational sectors. The network participants were mainly practitioners, of which the majority were registered nurses. The key participants involved in the research project have been the coordinators of the nine networks and their facilitator, who all have been interconnected in their own meta-network. Other participants involved were the network participants of the networks Pain, Discharge Planning and Psychiatric Rehabilitation.

The idea to create the networks proceeded from the facilitator of the meta-network. The facilitator was a part of the managerial group at the central hospital in the area and had an overall responsibility for the hospital's collaboration with primary care and the six municipalities in the area. From her position, she noticed a need locally for increased collaboration between these care providers, including a need for knowledge development in practice. In 2002 she formed a preliminary steering group and started the process of building up the networks. The networks were later on linked to a local health care restructuring programme called *Integrated Care*[2],[3].

Networks have become an important area of research within different disciplines, such as health policy (cf. Meijboom et al., 2004; van Wijngaarden et al., 2006), medicine (cf. Baker & Lorimer, 2000), organisation studies (cf. Docherty et al., 2003) and public administration (cf. Bate, 2000) to mention a few. Literature usually presents the advantages of networks and discusses, for example, their potential for learning, boundary crossing or successful implementation of knowledge (cf. Bate & Robert, 2002; Lugon, 2003; Meijboom et al., 2004; van Wijngaarden et al., 2006). Critics argue that just because knowledge networks do exist it should not be taken for granted that the desired flow of knowledge actually

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[2] In Swedish, this health care restructuring programme is called *Närsjukvård*. *Närsjukvård* is a generic label for many different practices and applications, which is not directly translatable into English. For example, Edgren et al. (2006) have found close point of similarities to the notions of `extended primary care´ and `local health care´. However, in this thesis, in conformity with Huzzard et al. (2010), I use the term *Integrated Care* as being equivalent.

[3] The networks are presented in more detail in chapter six, and the local health care restructuring programme is described in chapter two.

comes about (Bate & Robert, 2002). Odin (2006) in turn observed overconfidence in networks as being the ultimate solution for change, and poses the risk that individual development takes precedence over organisational development. However, there is not much work which brings health and social care networks under critical scrutiny. This is an area that needs to be further explored, and this thesis contributes to such an exploration. The thesis analyses the network participants' perceptions of knowledge networks and explains how we might account for the networks' evolution, role and ways of working by use of Bourdieu's theory of practice and theory of fields, including the concepts symbolic violence and reproduction functioning as analytical tools[4].

Aims and Objectives

The empirical phase of the research is embedded in an action research approach (AR)[5]. The overall aim of this collaborative process of inquiry was to support network development, which could possibly initiate a process of change. The process intended by means of a dialogical process to encourage the coordinators of the networks in reflection on a subject that emerged from their own interest. The AR approach adopted implied that I did not have fixed research questions or an established study design from the start (Dadds & Hart, 2001). Rather, the establishment of research questions and design was an evolving process that took shape parallel with the collaborative process undertaken. The idea was to be open-minded and adjust to what emerged. Initially, discussions with the coordinators of the networks and their facilitator were undertaken to clarify the focus of their interest, as well as to identify research questions of interest to me. The intent was to combine the interests of the participants with research interests, including requirements for thesis writing, and that the parallel processes would have a cross-fertilising effect upon each other.

The initial interest of the coordinators of the networks and their facilitator was to be engaged in a research project focusing on the development process of the

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[4] The theoretical framework of the research is presented in chapter four and the contribution of the research is further discussed in chapter eleven.

[5] Action research and what it implies in this particular research project will be explained in more detail in chapter five.

networks. The more specific subject that emerged from the introductory phase of the collaborative process, which the coordinators of the networks, their facilitator and I came to explore together, was that of knowledge transfer. The reason why this subject was adopted was that it turned out in fact that the transfer and implementation of knowledge into practice was regarded by them to be an urgent matter for the networks to handle[6].

The overall aim of the thesis is to explore the network coordinators', their facilitator's and the network participants' perspectives on the role of the networks and their ways of working. The thesis also seeks to explain these perspectives in relation to networks as a phenomenon and the context in which they operate, which includes structures, strategies and interactions in play. The specific research question is: What are the actors' perceptions of knowledge networks and how might we account for the networks' evolution, role and ways of working?

The theoretical tools used in this thesis were chosen as a way of answering and explaining the empirical story line. The initial data analysis suggested the explanatory value of Bourdieu's theory of practice and theory of fields (Bourdieu, 1982; Bourdieu, 1988; Bourdieu, 1990a; Bourdieu & Passeron, 1990). Bourdieu's theory of practice is used as a research framework as it allows me to explore the relationship between scientifically generated knowledge and practice, and how practitioners acquire knowledge in their everyday work practices. To further analyse and explain the networks as a phenomenon and the structures, strategies and interactions in play, I draw on Bourdieu's theory of social fields. Through this lens, the networks can be outlined in a field of tensions between two poles: the discourse of evidence-based practice (EBP) versus the logic of actual practice. Making such a theoretical reconstruction provides opportunities to understand the network coordinators' and network participants' perspectives and to discuss the power structures involved. In this respect, the concepts reproduction and symbolic violence are used as analytical tools (Bourdieu & Passeron, 1990).

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[6] The subject of knowledge transfer will be discussed in chapter three.

Outline of the Conditions for the Research and the Researcher's Position

In 2003, a cross-disciplinary research group was set up at *Kristianstad University*, Sweden, based on an agreement between the university and the Regional Government (Forskningsplattformen för utveckling av Närsjukvård, 2005). In this agreement it was stated that research projects should be undertaken that were supportive of the local health care restructuring programme called *Integrated Care*, mentioned above. Moreover, it was decided that action research (AR) should provide a common approach for these projects, as engaging in collaborative processes of inquiry was considered favourable to health and social care service development. Furthermore, research endeavours were expected to emerge from inquiries from practice. A co-ordination group embracing participants from the University, the county council and municipalities involved was established to support the research collaboration.

My own research position derives from social science theory, and more specifically from the field of social work, providing me with a lens through which social structures and phenomena are interpreted (Ginsberg & Miller-Cribbs, 2005). This lens has supplied me with a specific interest in overall structures, power relationships and conflicting interests. Regarding my view of knowledge, I assume that knowledge is constructed and shaped by social, institutional, political, cultural and economic contexts that not only affect what we do, but is also affected by what we do (Guba & Lincoln, 2005; Zeichner & Liston, 1996). I also sympathise with the epistemology that underpins action research, i.e. that knowledge is constructed in interaction with other people through action in horizontal rather than vertical approaches (Reason & Torbert, 2001). In addition, I believe that meaning is attributed to knowledge in context (Cook & Brown, 1999). However, I am not an extreme adherent of constructionism. In conformity with Bourdieu (1988) for example, I also believe that it is possible to establish a core that is true for the present. Such a core, for example, could be well-established structures within a society. My epistemological standpoints will be further described in chapter five.

Furthermore, as this thesis to a great extent focuses on the subject of knowledge transfer, I would like to assert that I find this term a bit problematic. From my point of view, data and facts can easily be transferred, but not knowledge (Ellström,

2005; Parent et al., 2008). Instead, I argue that it is possible to create conditions for learning and knowledge development in practice (ibid.). Nevertheless, since the term knowledge transfer is accepted usage (see for example Argote & Ingram 2000; Parent et al., 2008; Roy et al., 2003) and it is the term that the participants within this research project use, I draw on it myself with this reservation.

My work experiences from the field of health and social care is first as a social care worker within care of the disabled, and later on as a trained line manager within elderly care and as a municipal administrator of means-tested home-help services. These are experiences that have been of advantage during the collaborative part of the present research process in that it helped me to understand better discussions that were related to health and social care organisation. My background also provided me with an understanding of the complexity of practice. For example, I was aware that changes in practice do not usually take place quickly and without resistance, since people from various professions and backgrounds have different experiences and interests. My own experiences of being a line manager that is of relevance to this study is that occasional endeavours such as half-day lectures directed towards practitioners did not automatically have a clear impact in practice. Even if I did not explicitly reflect upon this when it took place, it might have made me a bit hesitant regarding the value of such interventions. However, I believe that these kinds of interventions are generally inspiring and vitalizing for the moment, which of course should not be underestimated.

Outline of Chapters

The structure of the remaining chapters of the thesis is as follows:

Chapter two seeks to place the networks in the focus of this study into a context, with specific focus on health care organisation and structural changes. Firstly, the main features and origins of Swedish health and social care organisation are presented. After that, recent decades' health care restructurings and the relationship to market-orientation is discussed. Finally, a local response to the national structural changes described is presented since this response has links to the networks in question.

In chapter three, the subjects of evidence-based practice and knowledge transfer are discussed as these were important areas of the networks involved in the current research project. First, the concept evidence-based practice is defined and elaborated. The next section discusses the implementation of evidence-based practice and the challenges involved, followed by a section on the views of critics. Furthermore, contemporary requests for a broader understanding of the concept evidence-based practice are also highlighted. The final section in this chapter discusses networks and the growing interest in such as a solution to support collaboration, but also as a measure to close the gap between scientifically generated knowledge and practice.

In chapter four, the theoretical framework of the research is presented. This framework is intended to support an exploration of the network coordinators', their facilitator's and the network participants' perspectives on the role of the networks and their ways of working. The framework is also considered to provide an explanation of the participants' perspectives in relation to the networks as a phenomenon and the context in which they operate, which includes structures, strategies and interactions in play.

Chapter five focuses on the methodological aspects. The chapter contains my research position and approach to knowledge. It also gives an account of the action research approach underpinning the research project and the collaborative inquiry process involved. In addition, the participants in the study are presented, as well as the methods used for data collection and how the analysis was undertaken. Finally, the issue of trustworthiness is discussed.

Chapters six to nine present the results of the empirical phase of the research, following the three stages that came out of the collaborative inquiry process undertaken. Chapter six gives an introductory presentation of the networks in the focus of this study and why they were formed. It also includes the facilitator of the meta-network's perspective of the network formation since she was the initiator of the networks and led the continuing build-up phase.

Chapter seven contains the network coordinators' perspectives on the role of the networks and their ways of working. It also describes the collaborative inquiry process undertaken during this stage of the research (stage one) and what emerged from it.

Chapter eight focuses on the networks Pain, Psychiatric Rehabilitation and Discharge Planning and their network participants' perspectives on the issue of knowledge transfer. It also describes the collaborative processes conducted within each of the networks and the results of these processes (stage two). The chapter concludes with a presentation of the reflexive notes that the coordinators of the network wrote parallel with this stage of the research.

Chapter nine presents the final feedback and dialogue process with the coordinators (stage three). This is followed by the coordinators' final reflexive notes on what they had learnt from the collaborative process as a whole. Finally, the facilitator of the meta-network's concluding views on how the networks worked is presented.

Chapter ten contains a theoretical analysis of the research findings presented in the four previous chapters, and seeks an explanation for the inertia shown to be a feature of the network coordinators' and network participants' experiences of knowledge transfer. It also seeks to outline the networks in a field of relative strengths between two poles: the discourse of evidence-based practice (EBP) versus the logic of actual practice. The intention is to develop an understanding of and an explanation of the networks as a phenomenon and the context in which they operate, including structures, strategies and interactions in play.

Chapter eleven contains the contribution of the current research project. It also embraces critical reflections on the research undertaken, which include reflections on the collaborative inquiry process that was part of the study. The last section in this chapter presents some suggestions for future research.

2. Health Care and Social Welfare Systems in Change

This chapter describes the contextual framework of the networks as focused on in this research project regarding health care organisation and structural changes. The intention is to provide a foundation for further discussions on the context the networks emerged and operated in. The chapter starts out from a brief overview of Swedish health and social care organisation and its origin and continues with a glance at the recent decades' health care restructurings and the links to mercantilism. Finally, the local response to these structural changes is presented since this initiative has links to the actual networks.

The Organisation of Swedish Health Care – Main Features and Origins

In Sweden, health care is regionally-based, predominantly provided as a public service, paid for primarily through national and regional taxes (Hjortsberg & Ghatnekar, 2001). As in the other parts of Scandinavia, Swedish health-care services have a long tradition of strong local autonomy, which provides local authorities with great freedom to determine the extent and quality of services (Trydegård, 2000). Striving for equity is regarded as a cornerstone. This is evident in the legislation, which states that the basic needs of citizens should be met irrespective of gender, age, residence or income (Trydegård & Thorslund, 2001). Furthermore, Swedish health care and social welfare services are typically organised in a vertical structure, characterised by strong departmentalisation of different responsibilities (Anell, 2004; Åhgren, 2003). It has been argued that the health and social care systems do not function in an integrated manner, but rather in a fragmented fashion, which makes it difficult to meet the full needs of the citizens (Swedish Association of Local Authorities and Regions, 2006).

Moreover, the responsibility for health care is divided between three levels of government. Overall responsibility rests at the national level. The Ministry of Health and Social Affairs sets out policy frameworks and directives, formulated through legislation, regulations and economic steering measures (Hasselbladh et al., 2008; Hjortsberg & Ghatnekar, 2001; The National Board of Health and Welfare, 2007). At regional level, county councils are responsible for the provision

of health and medical care (The National Board of Health and Welfare, 2007), and together with the national government they have laid down the basis of the health-care system (Hjortsberg & Ghatnekar, 2001). The county councils have a legal responsibility to plan for all health services (ibid.), however, the distribution of power and responsibility between the two levels of government is not strictly regulated (Region Skåne, 2005). At local level, municipalities are equal partners of the county councils regarding self-government (ibid.).

Both the county councils and the municipalities are autonomous authorities with directly elected assemblies and have full discretion to levy taxes (Hjortsberg & Ghatnekar, 2001; The National Board of Health and Welfare, 2007). The municipalities are legally obliged to take the main responsibility for social welfare provision, including aspects of the health and medical care of the elderly, the disabled and individuals with psychiatric diagnoses (Hjortsberg & Ghatnekar, 2001). Citizens have a statutory right to request services when necessary, but the municipalities have the scope to decide on eligibility criteria, service levels and the range of services provided (The National Board of Health and Welfare, 2007). The vertical structure and the three levels of government in Swedish health and social care organisation indicate the boundaries and power dimensions involved.

Gustafsson's (1987) research on Swedish health care organisation demonstrates that the way health care is organised today derives from organising traditions from the late Middle Ages. During this period, the first delimitations of health care activities into sub-divisions emerged. A distinction between care of the body, mental health care and poor relief could be perceived, intended as a way to keep social problems under control (ibid.). This fragmentation of health care delivery has continued throughout history. During the second part of the 18th century, a number of regulations supported a demarcation of institutional care. At this time a separation of care of the elderly, mentally ill individuals and necessitous children became formalised, a structure that is on the whole still valid (ibid.).

During the 19th century, new medical categories and distinctions grew between what was viewed as normal and abnormal (Johannisson, 1997). Moreover, through the growing significance of hygiene in Europe at the time, it became important to

discover diseases at an earlier stage and to take appropriate action, which resulted in a stronger link between medical and social control (ibid.). However, it was during the second half of the 19th century that an essential change-over took place. From this period medicine obtained a stronger identification with science (ibid.). Medicine turned into a knowledge system based on empiricism, a culture that gave higher priority to biological and scientific interpretations of the body (ibid.).

In the work `The birth of the clinic´, Foucault (1975) calls particular attention to the change-over described above, which was valid for the whole European medical tradition. At the end of the 19th century, a completely new idea and dichotomy of medicine was established: that of traditional and clinical medicine respectively, the latter referring to a scientific rationality. The number of hospitals grew rapidly and from these institutions it became possible for the physicians to diagnose and treat patients in a more rational way, for example by use of newly evolving techniques (ibid.). Foucault has argued that an underlying rationale of this expansion was to serve educational purposes, also implying that physicians were given higher status (ibid.). Hereafter, narratives on symptoms described by patients received diminished value in favour of a view of diseases built on inner causes, an area to which only the physicians had access (Johannisson, 1997). Accordingly, a new discourse emerged involving a focus on diseases instead of on patients. This shift also established the physicians as experts. It has since been in the physicians' interest to encourage specialisation and a demarcated form of health care organisation (Gustafsson, 1987). The reasoning above implies that the position of the physicians has strongly contributed to maintaining contemporary ways of organising.

An important episode for the present structure of the Swedish health care system was the foundation of the county councils in 1862 (Hjortsberg & Ghatnekar, 2001). The institution of county councils involved a mission to direct the hospitals and included both economic and political responsibility (Gustafsson, 1987). These circumstances entailed that two parallel hierarchies emerged; a medical hierarchical structure and an administrative/economical equivalent (ibid.). The development of Swedish health care services has since been characterised by an expansion of this structure, including intentions to supervise the community

(Gustafsson, 1987; Johannisson, 1997). Essentially, structure and the allocation of resources have mainly been directed by the development of the medical profession. For that reason it is argued that the consolidation of Swedish health care organisastion also has roots in mercantilism (Gustafsson, 1987).

The Enacting of Major Structural Health Care Sector Reforms

The Swedish economy and welfare state were developed and expanded in the years that followed World War II, but if we take a look at current conditions, it looks different. During the last few decades, Swedish health care and social services have been subjected to increased pressure. In fact, since the early 1990s these sectors have been subjected to raised demands for cost containment, efficiency and scrutiny of performance (Anell, 2005; Hjortsberg & Ghatnekar, 2001). One reason for this is that the demographic profile is changing towards an increasingly aging population (Anell, 2005; Edgren & Stenberg, 2006; Hjortsberg & Ghatnekar, 2001). Between 2000 and 2005, the population in Sweden in the age group 65 years and older increased by almost 1 percent and the group 80 years and older by more than 5 percent (The National Board of Health and Welfare, 2007). The changing demography is leading to growing numbers of people with complex health problems requiring multiple service responses, which implies that resources do not keep pace with these changes (ibid.).

Moreover, an overall growth of the health care sector along with improved specialist treatment and expansion of new medical technology has led to increased options for medical treatment and to operations that can now be performed for milder forms and earlier stages of diseases. In addition, as society changes towards a service- and information orientated, multi-cultural, better educated population with access to medical information, people's expectations with regard to health service provision have changed as well. Today, people have higher demands for quality and accessibility (The Ministry of Health and Social Affairs, 2000). The various examples mentioned above are circumstances that have naturally changed the nature of health care and affected health care costs (Hjortsberg & Ghatnekar, 2001; The Ministry of Health and Social Affairs, 2001).

Demographic changes, technical and medical developments and financial constraints are not just Swedish phenomena. Governments throughout Europe, including the transition countries, are all searching for ways to improve the equity, efficiency, effectiveness and responsiveness of their health systems for the same reasons. These conditions have contributed to the enacting of major structural health care sector reforms within these countries (Anell, 1996; Dussault & Dubois, 2003; Edgren & Stenberg, 2006). A trend regarding these reforms is a transition of responsibility from expensive to more cost-effective health care alternatives, often referred to as primary health care reforms (Atun, 2004).

The process of successive transfer of health care responsibilities from central to regional governments during the last few decades has also become a core issue in Swedish health care reforms (Hjortsberg & Ghatnekar, 2001; Saltman & Bergman, 2005). A substantial part of caring has been transferred from hospital care to lower, more cost-effective levels of care; in some cases to primary care, in others to care provided by the municipalities (Anell, 2004; The National Board of Health and Welfare, 2007). One of the most central reforms in this respect, as it has influenced further development, is a care manager reform called the *Community Care Reform*[7] established in 1992 (Anell, 2004; Hjortsberg & Ghatnekar, 2001). Through this reform, the responsibility for long-term inpatient, health care and social services regarding the elderly and disabled, including payment of costs, was transferred from the county councils to the municipalities[8] (Edebalk, 2008; Hjortsberg & Ghatnekar, 2001; The National Board of Health and Welfare, 2007). Previously, the county councils had the whole responsibility for the financing and provision of this service (Hjortsberg & Ghatnekar, 2001). From now on, the remaining duty of the county councils was restricted only to medical concerns (Henriksen & Rosenqvist, 2003). This reform entailed that one fifth of the total county council health care expenses was relocated to the municipalities (Hjortsberg & Ghatnekar, 2001).

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[7] In Swedish; *Äldreformen.*

[8] One of the problems before the reform was enacted was the length of stay at hospitals among elderly patients waiting for municipal care, sometimes for months or even years; an international phenomenon called bed-blockers (Styrborn et al., 1993). As a result of this reform, almost half of the numbers of beds at hospitals were reduced in the period from 1992 to 2005 (The National Board of Health and Welfare, 2007).

As indicated above, the *Community Care Reform* is regarded as a starting point for a new direction within Swedish health care, which has since undergone considerable changes (Anell, 2004; Hjortsberg & Ghatnekar, 2001; The National Board of Health and Welfare, 2007). For example, shortly after the enacting of this reform, the municipalities instead of the county councils became responsible for the physically disabled and of those suffering from long-term mental illnesses (Hjortsberg & Ghatnekar, 2001). Later on, transfer of responsibility was accomplished within the municipalities as well. For instance, the numbers of beds at municipal special forms of housing for the elderly have been reduced by 20 % during the 21st century and replaced by means-tested home help services (The National Board of Health and Welfare, 2009). However, a complication following the implementation of the *Community Care Reform* was that patients came to move between the different health care providers more frequently than before, which raised higher demands for collaboration and coordination (Anell, 2004).

Moreover, the enacting of the *Community Care Reform* coincided with the economic recession in the early 1990s, leading to financial cut-backs. Taking municipal elderly care as an example, a previous generous allocation of resources had to give way to more restrictive strategies, a development that still continues (The National Board of Health and Welfare, 2007). Edebalk (2008) amongst others argues that from this time, the ground was prepared for rhetoric inspired by market thinking. By now, the political argumentation was characterized by concepts such as market competition and consumer choice. The latter implies possibilities for recipients of care to choose, for example, private care providers (ibid.). Furthermore, in the 1990s, a purchaser-provider split was implemented within elderly care. This model involved a separation of the responsibility for the assessment of needs of the elderly patients versus provision of care, i.e. a separation of production and financing. Traditionally, both the assessment process and the organisation of service provision had been combined by the same administrator. Now these areas of responsibility became divided up between different agencies within the municipal organisation (The National Board of Health and Welfare, 2007). Blomberg (2004) argues that this purchaser-provider split was the real start of the market-oriented trend within care of the elderly in Sweden.

This market-oriented trend is not just a Swedish phenomenon. From an international perspective, public sectors have gradually created internal markets by introducing a division into purchasing and providing functions within authorities and contracting out of services to the private sector (Trydegård, 2000; Quaye, 2001). In the comparative literature on health care reforms of the late 1980s and early 1990s in the United Kingdom, the Netherlands and Sweden, Jacobs (1998) identified similarities between the market-oriented models applied. The reason for that was argued to be that nations respond in similar ways to demographic, economic, technological and social pressures (ibid.). Moreover, several of the Swedish health care reforms undertaken, such as the introduction of the purchaser-provider split described above, have been heavily influenced by the British NHS (National Health Service) reforms (Hjortsberg & Ghatnekar, 2001; Whitehead et al., 1997). In the UK, restructuring in both private and public sectors was a distinctive feature during the 1980s, and many of the changes undertaken at the time derived from Thatcher's right wing political economy (Pettigrew et al., 1992). In the UK as well, reorganisations and growth of primary care services is a continuing process.

Furthermore, the market orientation that takes place within public administration is also a part of a management philosophy introduced in the 1980s, known as New Public Management (NPM) (Hasselbladh et al., 2008). Characteristics are the influences from the private sector and the focus on modified market solutions, cost efficiency and public choice (Schedler & Proeller, 2002). The NPM philosophy is argued to be a relatively vaguely defined governance model with strong ideological links to the neo-liberal discourse (Peters, 2001; Pierre & Peters, 2000; Osborne & Gaebler, 1992). According to Harvey (2005), neo-liberalism is "a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within a framework characterized by strong private property rights, free markets and free trade..." (p.2). Neo-liberalism occurred on the world stage in the 1970s, offering central guiding principles of political-economic practice in general (Harvey, 2005). The turning point occurred in Chile under Pinochet's regime, when market economic neo-liberal reforms embracing various areas, were drawn up by

economists educated in Chicago (Bellisario, 2007). These ideas and reforms in turn inspired the Thatcher regime in England and Reagan in the USA. Gradually, neo-liberal reforms received a broader response in governmental strategies during the 1980s, underpinned by keywords such as decentralisation, privatisation, deregulation and monetarism (Delanty, 2000; King; 1987).

Pollitt and Bouckaert (2004) argue that management reforms have increasingly become more performance-driven in that public sector organisations focus more on results through measurement and assessment of the impact of their initiatives. In addition, this orientation has led to management control instruments from private business being gradually introduced within health and welfare systems. Funck (2009) has investigated experiences from working with a performance measurement model called the Balanced Scorecard, adopted from the private sector and implemented in Swedish health care sectors. She highlights that this instrument can be used to clarify responsibilities and to make comparisons between different health care organisations, but it could also be used for the purpose of accentuating the importance of one's own agency. Funck concludes that there is a risk that such a control instrument leads to organisations, instead of focusing on processes and action, getting stuck in searching for perfectly measured constructions and results.

Gustafsson (1987) has observed the nature of the development within health services. He found that investigations undertaken to support future developments have been guided by already existing organisational traditions. The formulation of new problems has emerged on the basis of prevailing practical problems within the systems (ibid.). Gustafsson's observation implies that the direction of developments is bound by already prevailing structures. Hall (2007) in turn has drawn a similar conclusion. Based on three case studies of reforms undertaken within different health and social care sectors in Sweden, he argues that NPM reforms within the public sector should primarily be seen as constructions and reconstructions of organisational power. The reforms were legitimated by referring to external processes, for example consumer demands. Hall concludes that the actual underlying aim of the reforms studied was to bring about controllable and self-governing organisations.

However, with regard to the implementation of new organisational reforms or ideas, it could be argued that different forces are in play, pulling in different directions. Blomberg (2004) has explored the implementation of organisational reforms within elderly care in Sweden and asserts that reform proposals are always confronted with different actors, opinions and established traditions. For example, in the implementation process of the purchaser-provider split, ideas became translated, reinterpreted and modified. Blomberg found that throughout the different phases in the implementation process, the resistance became gradually weaker. The reform obtained increased status and turned from having been a debated ideology into a popular and contemporary way of organising.

A reform that indirectly had links to the creation of the networks in the focus of the current research project was *The National action plan for the development of health care*[9], approved by the Swedish Government in the year 2000. In this action plan it became established that primary care instead of hospitals should form the basis of health care (Anell, 2004; The Ministry of Health and Social Affairs, 2000). It was also accentuated that efforts would be made locally to encourage an increased diversity of care providers (Swedish Association of Local Authorities and Regions, 2006). In the action plan, concerns were also highlighted about collaboration between different functions of care and improvement of accessibility without lowering standards of quality (Anell, 2004; The Ministry of Health and Social Affairs, 2000). The *National Action Plan* set out a vision for change, while actual concrete measures to be taken were left to local decision-making (The Swedish Medical Association, 2003). Therefore, all county councils became enjoined to develop local action plans (The National Board of Health and Welfare, 2001). The local response to the *National Action Plan* in *Region Skåne*, the county council in which the current research project is undertaken, will be presented below.

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[9] In Swedish: *Nationell handlingsplan för utveckling av hälso- och sjukvården.*

Local Response to Structural Transitions

Different regions have dealt with *The National Action Plan* (presented in the section above) in varying ways (Swedish Association of Local Authorities and Regions, 2006). The response in *Region Skåne* is formulated in a local policy document approved in 2004, called *Vitality in Skåne – A concept for health care delivery*[10] (The Regional Council, 2004). This policy document, established by *Region Skåne* and *Scania's Association of Local Authorities*[11] provides a framework for a large-scale health care restructuring programme and forms the base for further developments of health care in the region (ibid.). The overall aims emphasised in the policy document was to start out from people's everyday care needs and to improve collaboration between differentiated care-providers, whereby new integrated forms of cooperation were expected to evolve (ibid.). Moreover, private care givers were viewed as important parts to be integrated in the implementation process. In addition, resources were expected to be used as efficiently as possible (ibid.). The new vision of care in *Region Skåne* consisted of four integrated cornerstones: *Integrated Care* (that is of particular interest in this study as it has links to the networks in the focus of this study), specialised emergency treatment, specialised planned treatment and highly specialised treatment (ibid.).

As stated in chapter one, in Swedish the concept *Integrated Care* is a generic label for many different practices and applications and the interpretations of it vary. The literature on *Integrated Care* does not cover a clear and strict definition; rather, its concrete development is more about finding solutions for specific local problems (Swedish Association of Local Authorities and Regions, 2006). However, a shared understanding of *Integrated Care* holds that it concerns patient centredness and care that is common and frequently occurring, likewise that it is reasonable to prosecute seen from an economic aspect (Beställarnätverket, 2001; Ekman et al., 2007; The National Board of Health and Welfare, 2003). In addition, demographic changes and changes in patients' care needs have led to specific attention to the chronically ill and the elderly with multiple health problems, which is why notions

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[10] In Swedish: *Skånsk Livskraft – vård och hälsa.*

[11] *Scania's Association of Local Authorities* is an association representing the interests of the 33 local authorities in *Skåne* (Region Skåne, 2008). In Swedish: *Kommunförbundet Skåne.*

such as nearness, continuity, accessibility, quality and security are usually stressed (Anell, 2004; Swedish Association of Local Authorities and Regions, 2006). *Integrated Care* has been increasingly promoted in Swedish county councils in that it is considered to offer solutions for a deficient overall view and shortcomings of collaboration in different forms, for example between responsible authorities or care providers, as well as regarding competences and resources (Anell, 2004; Edgren & Stenberg, 2006). Also in other countries, for example in Wales, Spain and the Netherlands, there are ways of organising local health care that are reminiscent of Swedish *Integrated Care* development (Edgren & Stenberg, 2006). In these countries, various initiatives have been taken to cross local boundaries and to overcome shortcomings of collaboration (ibid.).

In *Region Skåne, Integrated Care* was established to constitute a linchpin of the new health care restructuring, as it was envisaged as encompassing the main part of people's everyday care needs (The Regional Council, 2004). *Integrated Care* should be underpinned by four aspects; accessibility, participation, care adjusted to needs and a holistic view (ibid). Development groups and working teams from the county council and the municipalities were commissioned to further elucidate, concretise and develop *Integrated Care* in accordance with the aims of *Vitality in Skåne – A concept for health care delivery*, a process that was expected to take place over the long term (ibid.). As will be further described in chapter six, two years after the starting point of the formation of the networks, it was established that the networks should support the development of *Integrated Care*. Edgren and Stenberg (2006) claim that in spite of insufficient knowledge of the value of *Integrated Care* there are great expectations attached to it.

This chapter has presented the health care context in which the networks emerged and within which they function, with specific focus on contemporary health care organisation and its origin. It is asserted that Swedish health care is organised in a vertical structure, characterised by a development towards increased sub-specialisation and fragmentation and a growing identification with science. This organisation structure indicates that boundaries and power dimensions are involved. Moreover, in this chapter it is stated that demographic changes, technical and medical developments and financial constraints are conditions that have

contributed to the enacting of major structural health care sector reforms inspired by market thinking. It is also argued that this market orientation is part of the new public management ideology, which involves increased focus on results through measurement and assessment of the impact of initiatives. Finally in this chapter, a local response to the national structural changes described is presented since this has links to the networks in question.

The next chapter discusses the subjects of evidence-based practice and knowledge transfer as these were areas in the focus of the networks involved in this research project. It also highlights challenges involved in the transfer process and brings to light the voices of critics. Following that, networks and the growing interest in such as a solution to support collaboration and to close the gap between scientifically generated knowledge and practice are discussed.

3. Evidence-Based Practice, Knowledge Transfer and Networks

As will become clear in the empirical chapters (six to nine), most of the participants involved in the networks focused on in the present research project considered evidence-based practice and the transfer of knowledge into practice as important. This chapter deals with the phenomena evidence-based practice (EBP) and knowledge transfer but also with networks and why these are occurring within health care sectors in our time. First in this chapter, the concept evidence-based practice is defined and elaborated on. The next section discusses the implementation of evidence-based practice and the challenges involved, followed by a section on the views of critics. Furthermore, contemporary requests for a broader understanding of the concept evidence-based practice are also highlighted. The final section in this chapter discusses networks and the growing interest in such as a solution to support collaboration, but also as a measure to close the gap between scientifically generated knowledge and practice.

The Current Focus on Evidence-Based Practice

As discussed in chapter two, during the last few decades health care and social services have been subjected to increased pressure and raised demands for cost containment, efficiency and scrutiny of performance (Anell, 2005; Hjortsberg & Ghatnekar, 2001). In parallel, there have been explicit requirements for a more scientifically supported knowledge base in practice (Bergmark & Lundström, 2006). In health and social care services the term evidence-based practice (EBP) is used to describe such claims (Roberts & Yeager, 2004; Sackett et al., 2000; SOU, 2008). A commonly used definition of EBP is: "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients." This means: "integrating individual clinical expertise with the best available external clinical evidence from systematic research." (Sackett et al., 2000 p.246). In recent years, the voices of patients have become included in the definition of EBP as well. This implies that clinical expertise, the best research evidence and patient values should be integrated into the decision-making process for patient care (Haynes et al., 2002).

EBP derives its origin from evidence-based medicine (EBM) (Martinsen & Eriksson, 2009; SOU, 2008). The two concepts EBP and EBM are used basically in the same way (Martinsen & Eriksson, 2009; Trinder, 2000). From Sackett et al.'s (2000) perspective, evidence-based health care "extends the application of the principles of EBM to all professions associated with health care, including purchasing and management." (p.246). EBP and EBM can be traced back to the work of Cochrane from the early 1970s, in which problems with effectiveness and efficiency within the British National Health Service was highlighted (Martinsen & Eriksson, 2009). In this work, a more frequent use of research-derived evidence and controlled scientific treatment methods amongst physicians became stressed (ibid.). It was argued that knowledge of empirical research results, especially from randomised controlled studies (RCT)[12], would contribute to the extension of physicians' expertise and increase their conditions to make more informed decisions (Moos et al., 2005).

In the wake of this new direction, a number of Cochrane Collaboration Centres have been established all over the world, producing and publishing systematic reviews of RCT studies (Horlocker & Brown, 2005; Martinsen & Eriksson, 2009). These reviews are intended to form the basis of evidence-based decisions across a variety of areas within health care (Moos et al., 2005). Since the 1990s, EBP has been increasingly influential not only within medicine and health care, but also in fields such as education, psychology and social work (Bergmark & Lundström, 2006). In the field of social work, a growing number of national and international centres called Campbell Collaboration have been established, producing reviews of evidence-based interventions (ibid.).

Accordingly, scientifically generated evidence is considered to have potential to improve practice as it provides explicit evidence assessed as objective, built up in a systematic and rigorous manner (Hammersley, 2001). Improved decision-making through adoption of EBP is considered to reduce harmful or ineffective treatments in practice, including costs and resources involved (Leach, 2006; Trinder, 2000).

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[12] RCT studies are scientific experiments in which patients or clients are randomly allocated into an experimental group or a control group and followed over time to test the effects of treatments.

This implies that EBP is believed to increase efficiency, lead to better patient outcomes and generally improve the quality of care (Sackett et al., 1996; Tod et al., 2004).

Challenges in Uptake of Evidence-Based Practice

The EBP paradigm has placed new demands on practitioners. One sign of this is that social workers in Sweden were recently exposed to criticism, not only from researchers, but also from politicians, the mass media and citizens because of unclear methods, heavy expenses and a lack of documentation of results (Järvinen, 2002; SOU, 2008). However, from the literature review they undertook, Greenhalgh et al. (2005) claim that practitioners do not generally adopt or assimilate evidence-based knowledge to a great extent. Other researchers have made similar observations. Bahtsevani (2008) in her literature review points at surveys directed towards registered nurses in Swedish psychiatry, showing that few of those who had access to evidence-based literature reported any use of it. From a questionnaire study undertaken within an English health care setting, McColl et al. (1998) found that the level of awareness among general practitioners, as regards extracting journals, reviewing publications and databases, was low. In addition, of those who were aware, many did not use these sources (ibid.).

Moreover, in a Swedish study, undertaken amongst approximately a thousand trained social workers, it was revealed that the social workers only to a very minor extent considered themselves supported by research or guidelines (Svensson, 2008a). When placing different forms of support in order of precedence, colleagues were ranked the highest and research results and guidelines the lowest, far behind support from family or clients (ibid.). Thompson et al. (2001) reached a similar conclusion. In their examination of which sources of information practising nurses found helpful for the uncertainty associated with their clinical decisions, they found that text-based and electronic sources of research knowledge were not regarded useful. Instead, experiences or advice from colleagues who represented a trusted and credible source were reported as most helpful. According to McCaughan et al. (2002), scientifically generated knowledge is experienced by practitioners to be complex and difficult to interpret, having no clinical relevance.

In this respect, in an analysis of two multi-agency Communities of Practice aiming at improving particular aspects of health and social services for older people, Gabbay et al. (2003) found that the groups involved did not follow the conventional procedures of an evidence-based model of practice, regardless of considerable support in terms of facilitation, agenda structuring and library services. Instead, the participants were inclined to rely strongly on tacit, experimental knowledge in the uptake of new knowledge. It emerged that the systematic, rationalist, linear evidence-based model was not reflected by the personal, professional and political agendas in the collective decision-making (ibid.)

A vast body of literature prescribes what is required for practitioners to utilize EBP. For example, Sackett et al. (2000) argue that it is essential that practitioners develop new skills in literature searching and critical appraisal, in addition to the habit of searching for the current best answer as efficiently as possible. To support clinicians' examination of research findings, a hierarchy of evidence is advocated, where the most reliable evidence is normally meta-analyses based on RCT studies, and the least reliable is well-tried experience (Bergmark & Lundström, 2006; Gabbay, 1999; Roberts & Yeager, 2004; Tanenbaum, 2003). In addition, a number of rational procedures of a similar kind have been developed, intended to guide practitioners in the process of searching for best evidence. Upshur and Tracy's (2004) procedure of this kind in five steps will serve as an example; 1) formulating clinical questions 2) searching for the best evidence 3) critically appraising this evidence 4) applying this evidence to patients 5) evaluating the impact of the intervention.

To assist practitioners, McColl et al. (1998) recommend improved access to summaries of evidence. Bahtsevani (2008) in turn argues that dissemination and awareness of evidence-based literature does not promote EBP by itself. Instead, when she explored factors influencing EBP within the field of health care, she found that some sort of receiving system seems to be needed that can receive and transform information into accessible recommendations to be used in everyday care (ibid.). In this respect, Bahtsevani suggests implementation of evidence-based

guidelines, which she argues could be used to reduce inappropriate variations in care efforts.

Knowledge transfer and various Linkage Models

In addition to literature describing the skills that are required of practitioners to utilize EBP, there is a vast body of literature which focuses on the process of implementing research into practice and closing the gap between knowledge producers and users. Numerous terms are used to describe this process, for example knowledge diffusion, knowledge dissemination, knowledge implementation, knowledge transfer and knowledge exchange to mention a few. From a systematic literature review of diffusion of innovations in health service organisations, Greenhalgh et al. (2005) have observed there is a lack of consistency in definitions of the various terms used. The terms are often used interchangeably, although some subtle but important distinctions are noticed (ibid.).

Regarding the definition of the term diffusion, Greenhalgh et al. (2005) draw attention to Rogers' (1995) understanding of it as in substance a passive process of spreading of technical information, abstract ideas or actual practices within a social system. In the context of this understanding, the mechanism for adoption in practice is imitation (Greenhalgh et al., 2005). The next term, dissemination, is explained as concerning active and planned efforts aiming at a deeper level of adoption (ibid.). When defining the term implementation, the authors refer to Mowatt et al.'s (1998) definition, presented as a more active process of dissemination to encourage adoption. More precisely, Mowatt et al. indicate intentional measures and strategies to be taken to transfer and integrate models, routines, ideas or methods into practice and to ensure that they will take effect.

The term knowledge transfer, in turn, bears upon linkage activities in the transferring of knowledge from the knowledge producers to the users (Meyers et al., 1999). Parent et al. (2008) define knowledge transfer as "the effective and sustained exchange between a system's stakeholders (researchers, government, practitioners, etc.); exchanges characterized by significant interactions resulting in the appropriate use of the most recent successful practices and discoveries in the decision making process" (p.95). Yet another term that is frequently used in this

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connection is knowledge exchange, at times having the above described linear linkage model in view (cf. Canadian Health Services Research Foundation, 2009). In this thesis the term knowledge transfer will be used to describe the intentions of the networks involved.

Moreover, as indicated above, writings on knowledge transfer are also concerned with receiving systems that can receive and transform information or mediate across various professional and organisational boundaries (Bahtsevani 2008; Huzzard et al., 2010). For example, to close the gap between knowledge producers and users, it has been suggested that the organisational members or the organisation itself act as knowledge brokers or boundary spanners, which act as facilitators of knowledge transfer and mediators at organisational interfaces (Hargadon, 1998; Huzzard et al., 2010; Ward et al., 2009). Knowledge brokers are engaged in recognising knowledge of value, internalising experience from different actors, linking disconnected knowledge resources and the implementing of knowledge (ibid.). Another term used in this respect is knowledge translators. Characteristic of knowledge transfer models that include knowledge translators is the flow of knowledge from the knowledge producers via translators, who are supposed to adapt the knowledge and transmit it to the probable user, often involving a process of training (fig. 1) (Roy et al., 2003).

Figure 1: A model illustrating the flow of knowledge from knowledge producers to knowledge users via knowledge translators (Roy et al., 2003).

Networks might perform the function of facilitators of knowledge transfer as well as holding the position of knowledge translators within organisations. Networks as facilitators of knowledge transfer and change in practice will be discussed in more detail in the last section in this chapter.

From the perspective of Nutley et al. (2000), there are two principal approaches to dissemination and implementation; macro and micro, or what Mullen (2004) in

other terms calls top-down and bottom-up strategies. Using top-down strategies means providing measures such as manualised interventions or agency directives to assist care practitioners in the best practice. A bottom-up approach presupposes that practitioners engage in a more dynamic process of critical decision-making, including consideration for ethics, professional values as well as different kinds of evidence (ibid.). It is argued that bottom-up strategies based on collaborative models increase the opportunities for evidence-based practice (ibid.). By participating in dialogic processes in which different forms of knowledge are articulated, participants might be able to translate and re-categorise the knowledge given (Nonaka, 1994).

However, knowledge does not start to flow just because meetings between people are arranged (Bate & Robert, 2002). It is asserted that motivation amongst actors concerned is required, which could be reached through arenas for assembling and contact (Blomberg & Åkerlind, 2000; Kalling, 2003). In an action research project undertaken within a Swedish health care region embracing dialogue conferences supported by the researchers, it was demonstrated that building a knowledge base required by the actors involved, calls for commitment and a continuous dialogue (Ekman et al., 2003). By taking an active part in continuous dialogic conferences, the practitioners became empowered to share ideas and good practice and learn from each other (ibid.)[13] Hallin (2009) argues that managers in learning organisations have a responsibility to maintain interest, motivation and self-discipline amongst employees, as these aspects are believed to be the strongest driving force in learning.

Criticism of Evidence-Based Practice

As illustrated above, a great number of researchers express a favourable view of EBP, suggesting measures such as manualised interventions and guidelines to support uptake of evidence-based knowledge in practice (see for example

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[13] As mentioned in chapter one, the empirical part of the present research project is also embedded in an action research approach, intended by means of a dialogical process to support network development. The process undertaken will be described in chapter five and what came out of this process will become clear in the chapters six to nine.

Bahtsevani, 2008; Järvinen, 2002; McColl et al., 1998). EBP is also supported by means of educational efforts and national, regional and local conferences or reports produced by authorities (Lindqvist et al., 2008). Probably no one denies the importance of making efforts to ensure quality within health care services (Delmar, 1999). Likewise, it is obvious that clients and patients should not be exposed to unnecessary, ineffective or harmful treatments (Bohlin, 2009). Striving for best evidence could therefore be seen as an uncontroversial ideal, nevertheless, the EBP paradigm and its various models have been lively debated and criticised.

However, the different concepts of knowledge transfer described above, including the model comprising translators, all imply that information, ideas or scientifically generated knowledge are communicated to stakeholders from a top-down perspective, withholding expectations of adoption in practice. The management of change in health care systems has traditionally been realised by such linear models of implementation, characterised by dissemination of information within a command and control structure (Redfern & Christian, 2003). Yet, as has been discussed in this chapter, these initiatives have had difficulties in reaching desirable results in practice (Argote & Ingram, 2000). Linear models of knowledge transfer are criticised for not taking into consideration the complexity in health and social care services and the many factors that have an influence on the implementation process (Greenhalgh et al., 2004; Petros, 2003). Critics also argue that linear models of knowledge transfer do not provide lasting effects (Lindqvist et al., 2008).

Linear approaches to EBP are largely criticised with the use of constructionist arguments. The critics question the conventional perception of knowledge within the paradigm of medicine, having its roots in positivist philosophy (Sanderson, 2002). From a positivist theory of knowledge, reality is considered to be objective, possible to uncover and reproduce, existing independently of our theories or perceptions of it (Patton, 2002). However, the idea of objectivity is questioned by others, arguing that reality instead is a matter of cultural constructions, coloured by specific times, places and relationships (Johannisson, 1997). Knowledge is constructed and meaning is attributed to it in context (Cook & Brown, 1999). From a socio-cultural perspective on knowledge and learning, the focus is on social and

cultural dimensions, including interaction between the individual and society (Ellström, 1996). Taking a position on the basis of critical theory in addition assumes that reality is shaped by political, economic, ethnic, and gender values (Guba & Lincoln, 2005).

What is argued from a constructionist perspective is that every9day care practices are characterised by complicated interactions between people, which are impossible to foresee or formulate as rules or cause and effect (Moos et al., 2005). It is asserted that essential and unexpected activities in practice dependent on context get lost in technical solutions and the building of causal models (Sanderson, 2002). Moreover, since the extensive field of medicine comprises complex and interacting non-linear systems, it is argued that, for example, RTC studies and meta-analyses can only meet a relatively small part of patient and client problems (Petros, 2003). Focusing on factors that can be measured means that other non-measurable factors run the risk of being disregarded (Tops & Sunesson, 2006; Webb, 2001). In addition, Parent et al. (2008) assert that the difficulties bound up with knowledge transfer do not primarily involve how to make information available or how to transfer data and facts. Information technology could relatively easily serve this purpose as it provides access to databases and facilitates communication of information to recipients. The researchers argue that the real challenge of knowledge transfer is how to capture and transfer knowledge that is quietly created within a person's mind.

Contemporary accentuation on explicit evidence can be traced back to the western rationalisation process during the Age of Enlightenment, in turn receiving its vigour from the philosophy of Kant (Bertilsson, 1999). During this period, the prevailing conception of the world, rooted in scientific ideals from antiquity and the church, changed in favour of a technical knowledge ideal (ibid.). The technical knowledge ideal has since become strengthened and also broadened. Contemporary rational thinking is not just reserved for technology and natural science, but has become a dominant ideal also within social sciences (ibid.).

The development described above implies that a long tradition of relying on experience-based and tacit knowledge is now challenged by explicit and evidence-

based knowledge, considered to be core aspects of being a skilled practitioner (Nutley et al., 2003). Tacit knowledge refers to the internalised subconscious parts of knowledge originating from individual intuition, not possible to be verbally explicated (Nonaka & Takeuchi, 1995; Polanyi, 1966). In contrast, explicit knowledge usually refers to knowledge that is conscious and possible to articulate, that easily and formally could be transmitted from one individual to another (Nonaka & Takeuchi, 1995). As described in this chapter, evidence provided by research is generally considered to be more reliable in improvement of practice as it provides explicit evidence assessed for example by double blind randomised experiments that are considered to be adequate, effective and objective, built up in a systematic and rigorous manner (Hammersley, 2001). In addition, irrespective of the various critical arguments, Bahtsevani et al. (2006) state that it is reasonable to assume that clinical guidelines and other forms of measures aiming to support decision-making in practice will gain increasing importance within health care sectors in the future.

Furthermore, in Sweden, it is the Governmental authorities that have been responsible for promoting and disseminating EBP as a means to develop health and social services' ways of working. For example, the Swedish National Board of Health and Welfare regularly publishes reports that describe deficiencies, and recommend the type of knowledge that should constitute the foundation for better interventions (Lindqvist et al., 2008). It is argued that discussions undertaken at national level on how to support knowledge development stem from requirements for efficiency and cost-consciousness which, as is the case with the reforms discussed in chapter two, is related to ongoing market-oriented changes (Bergmark & Lundström, 2006). In view of such arguments, the leading principles behind the development of EBP are not only to be found in the medicine paradigm, but also in the NPM development that started off in the 1990s (Bergmark & Lundström, 2006; Ferlie et al., 1996; Pollitt & Bouckaert, 2004) (see an account of ongoing structural transitions within public administration and its link to NPM in chapter two). The ongoing developments within the public sector towards increased privatisation and open competition creates the need for measurement and the search for evidence about what works.

Consistent with this development, Sackett et al. (1996) have found from their research critics maintaining that EBP and EBM are used by managers and purchasers as an effective cost-cutting tool within health care sectors, suppressing clinical freedom (Sackett et al., 1996). Related to this, Parsons (2002) argues that EBP represents a mechanistic view of society and its developments, as it emphasises control aspects along with prescribing and managing in detail. Mullen (2004) in turn asserts that the use of top-down strategies expresses the visions of those in authority. There are similarities between these claims and that of Foucault (1977) who studied disciplinary institutions. Foucault has argued that in conformity with disciplinary actions such as torture and execution, contemporary ways of disciplining people come about through different kinds of institutions, for example hospitals and schools, in their application of routines, schedules and compulsory tasks. According to this perspective, it could be argued that the EBP discourse has disciplinary effects in the profession in that it disciplines individuals to behave in accordance with the standard. Other critics argue that the implementation of guidelines, because of its top-down approach, runs the risk of restraining professionals to becoming a performer according to the rules and thus contributing to de-professionalisation (Bergmark & Lundström, 2006).

Inquiries for a Broader Understanding

Given the agreement on Sackett et al.'s (2000) definitions of EBP and EPM (described earlier on in this chapter), the meaning of these concepts is ambiguous. Referring to critics, Sackett et al. (2000) claim there is a misunderstanding regarding the interpretation of EBM. On a closer examination, they argue, it becomes obvious that EBM is neither limited to clinical research nor simply that of advocating a cookbook approach to medicine. Both clinical expertise and patients' values have to be included in the decision-making process. Oscarsson (2006) has made a similar observation, arguing that in Sweden as in other countries, the debate around EBP in social work is infected, as it mainly focuses on whether results from RCT studies and meta-analyses could or should serve as an ideal. He argues that the way EBM is interpreted, both among advocates and critics, differs from the original idea and implies a reduction to a mechanical application (ibid.).

Martinsen and Eriksson (2009) also, assert that the concept of evidence has become narrowed down to the domain of a natural science tradition in which scientific proof is the ideal, arguing that the concept instead should include a broader sense. Eriksson et al. (1999) assert that the original and broader meaning of the term evidence is seeing, insight and making visible. Using this wider scope, evidence refers to something that is valid and possible to ascribe trust to that cannot always be articulated in a rational and technical language (Martinsen & Eriksson, 2009).

However, it is Cochrane Collaboration Centres and RCT-studies that have become the ideal and gained a high degree of hegemony in health and social care sectors at the present time (Martinsen & Eriksson, 2009; Moos et al., 2005). Using a broader understanding of EBP is also criticised as less rigorous studies are presented as evidence-based, as for example case studies, giving rise to ideas of effect, which undermine the essence of EBP (Jenson, 2005). Nevertheless, irrespective of which of the two interpretations of EBP described above is used, implementing EBP in health care settings as discussed in this chapter is regarded as challenging because of its complexity and many factors have an influence on the process (Bahtsevani, 2008; Bate & Robert, 2002; Cox et al., 2006). Still, despite these challenges, a number of health care sectors make a variety of efforts to implement EBP successfully.

Networks as a Vehicle for Change

To deal with complex problems, such as regional and local development and the development of organisations, networks have emerged as a solution (Lindqvist et al., 2008; Svensson & von Otter, 2005). Through a bottom-up approach, networks are suggested to link across traditional organisational and professional boundaries (Goodwin et al., 2004) and support collaboration and long-term learning (Svensson & von Otter, 2005; van Wijngaarden et al., 2006). Bate and Robert (2002) assert that networks are of considerable value for bringing about major transformations within large organisations, for example health providers. Lugon (2003) in turn argues that networks in health care foster innovation and new ways of working by involving a whole health community in the planning and delivery of a service. Moreover, it is asserted that networks facilitate knowledge generation and transfer

better in comparison to hierarchical structures, due to them being less bureaucratic (Bate & Robert, 2002). It is argued that because of their flat structure, networks are more open to knowledge exchange (Bate, 2000; Jones et al., 1997; McDermott & O'Dell, 2001).

Networks have been of importance within human society from time immemorial. For example, in trade relationships in older times, people were dependent on personal contacts for flexibility, facilitating of transactions and credit giving (Aronsson et al., 1999). In recent decades, networks have frequently been referred to in contrast to central management and rational pre-planned solutions (Lindqvist et al., 2008). Rather, networks are associated with visions to become united round a collective commitment amongst those involved (ibid.). Concepts such as engagement, collaboration, spontaneity and flexibility are emphasised in network descriptions as a replacement for words such as authority, control, routines and stability, which are frequently used in accounts of organisations (Ahrne, 1991). From Church et al.'s (2002) perspective, the unique value of networks is their process activities such as linking, coordinating and facilitating.

In our time, networks can be encountered everywhere; for example within culture, politics, science and technology (Boudourides, 2002). Nevertheless, the word network is problematic to define in that it is an ambiguous concept and networks vary considerably in type and function. Usually, networks are explained as a structure of interconnected unities, which could be individuals or organisations, forming a demarcated entirety (Lindqvist et al., 2008). These unities, also called nodes, are bound together in different kinds of relationships that could be weak or strong or more or less bridging, depicted at times by very complex graphs (ibid.). Goodwin et al. (2004) argue that the ways networks are structured and organised could vary in the strength of regulation and integration and level of social cohesion.

Moreover, networks can be regarded as a social process of linking and connecting individuals together, as well as the creation of coalitions or groups to achieve tasks (Hastings, 1993). For example, Swan et al. (1999) draw a distinction between a cognitive network model focusing on information technology and the arrangement

of information, and a community model of network, focusing on dialogue and the creation of meaning. Networks based on relationships facilitate shared space for exchange, development and learning, i.e. capacity building aspects, as they embrace possibilities of seeing the world from the perspective of other actors (Boland & Tenkasi, 1995; Church et al., 2002). For instance, it is argued that network participants through the collaborative process obtain competence in making alterations, i.e. to become skilled in the perception of problems and how to see new possibilities (Philips & Gustafsson, 1994). In an analysis of the development of an integrated network within health care focusing on care givers' ability to cross existing professional and organisational boundaries, van Wijngaarden et al. (2006) highlight the potential of networks in promoting learning. The professionals learned how other professionals and organisations work, likewise to speak each other's language. They also became aware of the limitations of protocols, rules and the standardisation of knowledge in criteria to ensure continuity in care, and have learned to value direct contact in the sharing of knowledge and information (ibid.).

Hastings (1993) stresses both the collective and individual dimensions of networks, arguing that networks exist to achieve something both for the organisations and individuals participating. In addition to collective dimensions such as capacity building mentioned above, an individual aspect of network participation is possibilities for individual support (Åberg, 2002). Alvesson (2004) in turn, points to the outer world, claiming that networks can seldom be seen as entirely a question of obtaining access to knowledge, nor the sharing or utilizing of knowledge; there is also an aspect of image strengthening. The network sends signals to the surrounding world embracing symbolic aspects of interaction and relationships (ibid.).

However, the use of varying network terms within different fields is a puzzling subject. In natural science and engineering for example, labels such as self-organised networks can be discerned, and in social science the term social network is common (Boudourides, 2002). In political science the word policy networks is used and in economics and organisation theory, terms such as networks of innovation and learning networks exist (ibid.). Another term frequently used

within various fields is communities of practice. Communities of practice are specific groups in which the practitioners link across traditional organisational boundaries and develop their own practice (Bate & Robert, 2002; Goodwin et al., 2004; Wenger, 1998). Characteristic is that these groups act from the perspective of the participants and that knowledge is shared horizontally (ibid.) The value of communities of practice lies in their informal, non-hierarchical, self-organising and flexible nature (Canadian Health Services Research Foundation, 2005b). Nevertheless, the common centre of attention in the varying literature on network-like organisational practices is the horizontal patterns of exchange, the interdependent flows of resources and mutual lines of communication (Powell, 1991).

Another confusing circumstance is that different researchers have grouped networks into different categories. For example, Docherty et al. (2003) from a comparative analysis of various learning networks in Europe have identified four distinct network types; strategic networks being formal in character often having an economic rationale, learning networks emphasising learning through formal input or exchanges of experience, transformation networks striving towards transformation across for example organisational boundaries, and professional networks characterised by like-minded professionals focusing on personal development. Goodwin et al. (2004), in turn, from a literature review covering various sectors, have distinguished between three network types; enclave networks having a flat internal structure and high level of equality, individualistic networks developing an association of affiliates, and hierarchical networks having an organisational core and often being controlled by steering groups. However, it is argued that actually observed networks are hybrids formed from two or three of the network types described (Goodwin et al., 2004).

Furthermore, network developments within health and social care delivery often reflect increasing demands for knowledge development and knowledge dissemination (Bate & Robert, 2002). For example, the Canadian Health Services Research Foundation (2005a) has formed a knowledge network, bringing together health system managers, policy makers and researchers from across Canada to advance implementation of primary health care reform. Knowledge networks are

asserted as having a hierarchical structure and are defined as groups of experts working together on a common theme or issue to strengthen their collective knowledge (Canadian Health Services Research Foundation, 2005b). Such networks are permitted to create and share knowledge based on evidence, experience and expertise (ibid.). Objectives of the Canadian knowledge network are to increase the dissemination of scientifically generated evidence and build a capacity for evidence-informed decision-making (ibid.).

So far as networks within health care are concerned, there is a growing interest in clinical networks, and particularly managed clinical networks, which Baker and Lorimer (2000) define as "linked groups of health professionals and organisations from primary, secondary, and tertiary care, working in a coordinated manner that is not constrained by existing organisational or professional boundaries to ensure equitable provision of high quality, clinically effective care". These networks could be grouped regarding specific diseases, a specific speciality or function (ibid.). Meijboom et al. (2004) argue that clinical networks seem to offer important advantages because they allow integration and flexibility within the service being offered, as well as ensuring collaboration between the different groups of professionals and organisations. However, Edwards (2002) states that if clinical networks actually offer better relationships and improve the flow of information, the results could be beneficial, but if it is just a question of structural change it could instead create problems of competing priorities, a lack of connection between the parts and confusion about responsibilities.

Consequently, just because knowledge networks do exist it should not be taken for granted that the desired flow of knowledge actually comes about (Bate & Robert, 2002). Odin (2006) argues that it is the key participants in the networks who obtain increased knowledge, while engagement, experience exchange and learning decrease concurrently with the distance from the centre of the networks. In addition, Odin has observed overconfidence in networks as being the ultimate solution for change, and poses the risk that individual development takes precedence over organisational development. He asserts that knowledge dissemination and transferability only take place when there is a collective identity and a large number of entities involved in networking (ibid.).

As discussed in this chapter, increased demands for a more scientifically supported knowledge base in practice and increased focus on results through measurement and assessment of the impact of initiatives have created a need for new solutions. Networks emerge as a solution to support collaboration and close the gap between scientifically generated knowledge and practice. This chapter has discussed the subjects of evidence-based practice and knowledge transfer including the voices of critics. It has also elaborated on networks as a phenomenon and expectations involved. The next chapter sets out the theoretical framework of the research.

4. Theoretical Framework

This chapter sets out the theoretical framework of the research. This framework is intended to support an exploration of the network coordinators', their facilitator's and the network participants' perspectives on the role of the networks and their ways to work. It is also considered to provide an explanation of these perspectives in relation to the networks as a phenomenon and the context in which they operate, which includes structures, strategies and interactions in play. Firstly, three competing views of knowledge are presented, which are intended as a foundation for further discussions on knowledge transfer and on practitioners' relationship to scientifically generated knowledge in everyday work practice[14]. This section leads to a presentation of Bourdieu´s (1982; 1990a) theory of practice, as I see it providing some insights into a discussion on the relationship between scientifically generated knowledge and how practitioners acquire knowledge in everyday work practices[15].

Next, Bourdieu's theory of social fields is introduced, with particular reference to the notions of reproduction and symbolic violence (Bourdieu, 1988; Bourdieu & Passeron, 1990). This theory and these concepts provide opportunities to discuss structures, strategies and the interactions involved in the field within which the networks function. Following that, I have given a general view of the positions of nursing assistants, registered nurses and physicians as occupational groups in the field of health and social care services since they are central actors within this particular field, or often referred to by the participants in this study. Their positions as occupational groups are considered to constitute reference points in the discussion about the position of the networks. Finally, the rationale of using

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[14] The discussion on practitioners' relationship to scientifically generated knowledge does not imply that practitioner knowledge is non-theoretic or that practitioners cannot be theory-minded. Theories that are generated from practice are here referred to as `naïve´ or `common sense´ theories.

[15] There is a vast body of literature discussing the relationship between scientifically generated knowledge and how practitioners acquire knowledge in every-day work. See for example Schön (1991) who argues that practice in the main is guided by individual knowledge and Kolb's (1984) theory about experimental learning. However, this chapter focuses on Bourdieu's theories on this subject since this constitutes the theoretical framework of the research. Action research and its position in this discussion are explored separately in chapter five.

Bourdieu's theory of practice and his theory of social fields as the analytical framework in this research project is described more in detail.

Competing Types of Knowledge

As discussed in chapter three, there are increasing explicit requirements in society for a more scientifically supported knowledge base in practice. These requirements within health and social care services have been responded to with the support of evidence-based practice (EBP) (cf. Sackett et al., 2000; SOU, 2008). The ongoing discussion on evidence-based practice can be related to Aristotle's three equal, yet competing, types of knowledge, also called intellectual virtues, which are; *episteme*, *techne* and *phronesis* (Aristotle, Nicomachean Ethics, Book VI). *Episteme* refers to an evidence-based and analytic rationale, not taking the context in to consideration. More precisely, this virtue or type of knowledge concerns realities that are considered to be unchangeable, for example the orbit of the stars. The latter two types of knowledge however, are dependent on context, and provide in contrast to the first theoretical type, different aspects of creating or doing (ibid.). To be more explicit, *techne* refers to technical know-how, for example art or craftsmanship, while *phronesis* is developed through action, including situation-driven attention and experience (ibid.). *Phronesis* is a kind of practical wisdom built on insight, moral, reasoning and practical skills, implying that our bodies and desires are permeated with the right attitudes, leading us to acting wisely in practical contexts.

From Aristotle's perspective, none of these three types of knowledge can be omitted in a well-functioning society as they are all integrated. However, Aristotle regards *phronesis* as the crucial and most important virtue in that it carries with it the other two. The extensive focus on outcomes, measurement and efficiency within health care sectors of today indicates that there are higher values attached to *episteme* within these sectors at the expense of *phronesis* (cf. Callewaert, 1999a). What type of knowledge the network coordinators and the network participants emphasise focused on in the current research project will be discussed in chapter ten.

Could Practice be Theory-driven?

As is expounded in chapter three, there seems to be an agreement that a considerable number of decisions that have to be made in day-to-day clinical practice are often routinely resolved here and now (cf. Bahtsevani, 2008; Roy et al., 2003). As also discussed, since this usually is considered problematic, a number of researchers suggest implementation of rules and guidelines into practice that normatively prescribe what practitioners ought to do in different situations (cf. Bahtsevani, 2008; Rosen et al., 2003). However, a vast body of research has concluded that everyday work practices instead of being theory-driven are driven by `naïve´ or `common sense´ theories (see for example Bate & Robert, 2002). `Common sense´ theories refer to a common understanding dependent on personal and social experience. Bourdieu talks about practical mastery (1990a). An example of practical mastery is that of children who learn their native language without knowledge of grammar. At school the children learn the regularity of the language, which is an example of symbolic mastery.

From research, it has been observed that practitioners do not primarily learn theory first and then apply it. For example, Boge (2008) demonstrates empirically and theoretically in her thesis that the washing of patients' bodies, accomplished by registered nurses in practice at a Norwegian nursing home, was not based on theories of hygiene or theories of patients' needs. Instead, it appeared that practice was invented by the nurses in the practical situation and adjusted to existing norms and economic limitations. The theories functioned just as references that existed parallel with practice. Engström (2001) in turn has undertaken a study that aimed to create a clearer picture of what registered nurses are doing in advanced home nursing within a local Swedish health care setting. She observed that it was the dialogue with patients that created and organised their practice, not the scientific knowledge base.

Larsen (1999) has made a similar observation regarding student nurses and learning at hospital wards in Denmark. Through his research he found that nurses in practical training primarily learn through their own incorporated experience, i.e. take advantage of their own life experience. He observed that literature and teacher instructions play a subordinated role in the learning process. Larsen shows that

student nurses' learning is mainly a social and preconscious process, and knowledge transfer closely related to patients and other students as being more experienced people, takes place through practical mastery. Larsen et al. (2002) too, claim that knowledge is not merely transferred from science to practice. Rather, clinical nurses in daily practice learn from the context, and instead of being just recipients of knowledge, they actively generate clinical knowledge themselves. The authors argue that the nurses are following their own practical logic that is dissimilar, however not subordinated, to the logic of theory. Consequently, it could be asserted that the prevailing idea of applied theory within health and social care sectors is built on an incorrect basis since there are no linear paths from theory to application and change in practice (Bourdieu, 1990a; Callewaert, 1999a; Petersen, 2001).

The Role of Habitus and Theory

Bourdieu's theory of practice provides some insights into the further discussion on whether practice could be theory-driven or not[16]. Bourdieu (1990a) asserts that any problems in practice are complex and bound to the situation, which is why practitioners have to invent `best practice´ in every situation (ibid.). Practitioners do what is practicable. Bourdieu and Passeron (1990) argue that practitioners learn what to do from the prevailing culture and definition of the situation, bodily through imitation, i.e. from one person to the other. This learning process takes place throughout life, for example through institutions such as the home environment, school and work, and all other kinds of activities. In other words, learning basically entails acquiring a habitus (ibid.). Habitus is a system of dispositions, formed for example by upbringing, relationships, education and the political situation. The habitus, a cluster of dispositions oriented to different fields of practice, allows individuals to act, think and orient themselves in the social world (Broady, 1998a). Experience becomes accrued and stored in our minds and bodies (Bourdieu, 1982). In essence, habitus is generated by specific contexts and works at a preconscious level, colouring valuations, habits and different actions taken (ibid.). Given this, it is habitus that shapes our practical preconscious

[16] Bourdieu's theory of practice has its origins in his pioneering empirical studies in Algeria during the 1960s (Broady, 1991).

thoughts and actions in everyday work practices. Therefore, Bourdieu argues, we never do as we are told, but as our habitus guides us to do (ibid.). It is habitus that generates practice, and in that sense practice has a logic in its own right (Bourdieu, 1990a).

Yet, two points are to be underscored. Firstly, habitus is not a form of knowledge operating by itself side by side with all other forms of knowledge. Habitus is always operating, but only as an underlying orientation that facilitates and orients one's work with other forms of knowledge. Secondly, this orientation does make practice manageable, but does not make practice and practical knowledge infallible or one hundred per cent adequate. It orientates the practitioner in a given domain. However, its relevance is dependent upon a relatively stable situation, where the context is not drastically changed by external forces, but grows and develops so that even experience and the habitus itself can grow and be developed. Changes that occur can put the practitioner in a new situation where her or his wise way of doing things suddenly does not work out well. In such situations the practitioner comes to a standstill, reflection starts, and different sorts of new knowledge have to be brought to bear on the new situation. Totally adequate new practical knowledge will only begin to work in a habitually incorporated way when modified habitual orientation is in place (Bourdieu, 1990a).

The reasoning above entails that theories, rules and guidelines cannot normatively prescribe what practitioners ought to do in a particular situation. Instead, at the core of all complex human action is the 'feel for the game' (Bourdieu, 1990b). This reasoning also implies that practice comes from practice, or from what Bourdieu (1990a) calls a practical sense. Callewaert (1997) explains practical sense as a sense with its own conditions, constituting the driving force behind rational acting. A practical sense does not follow any proved rules and regulations; instead it is more or less diffuse. A practical sense is incorporated in the individual's life experience, and cannot be derived from or replaced by theories or formulas.

From the assertion above, it could be argued that the role of theory and scientific explanations is not primarily to normatively prescribe what practitioners ought to do, but instead explain why things are as they are or why actions taken evolved as

they did. A practical theory says something about how practitioners usually operate and about procedures and effects in practice, why theories could be regarded as generalised considerations and reconstructions of human action. Petersen (1992) asserts from her interpretation of Bourdieu that theoretical knowledge functions as explanations of the regularity with which under specific conditions practitioners accomplish what they do in practice. A scientific explanation is only one reference of many that exists parallel with practice, and will not have strong impact on practitioners until it is incorporated, i.e. oriented by dispositions and habitus.

None-the-less, an activity in practice could be frozen and turned into an object and observed phenomenon, i.e. being gone through thoroughly through reflexivity. As a consequence, the phenomenon observed could be explained and described, and through that turn into a theory of practice. However, on the basis of what has been discussed above, this theory will not automatically be applied in practice. From Bourdieu's (1990a) perspective, this is because the theory is constructed within a theoretical logic and not considered in a practical logic. As has been discussed, everyday work practices are characterised by a generalised and preconscious sense, which is primarily non-reflexive and not conceptualised.

The Power of Doxa

Another concept of relevance in understanding practitioners' way of acting in everyday work practices is doxa. Bourdieu (1988) uses the term doxa to describe a tacit belief that characterises a field, which is so natural and obvious that it is not even discussed or made explicit. Put in another way, a doxa is an unspoken rule or a doctrine supported by habitus, which for example lies behind the routines and decisions made in everyday work practices within a particular field. The doxa also appears out of for example ideologies, legislations and salaries. It could be argued that practitioners' ways of acting often follow a doxic logic. To exemplify, in Carlhed's (2007) analysis of the field of habilitation services, or more precisely service directed at children and youth with disabilities in Sweden from 1960 to 1980, it is asserted that the paradigm of medicine was established as a doxa. The paradigm of medicine permeated the field in varying ways. The strength of the doxa was identified in the relationship between clients and occupational groups, as well as between medicine and the state.

The Notion of Fields

As is the case with the concepts habitus and doxa, the notion of field is also central in Bourdieu's (1990a) theory of practice. In contrast to archaic societies that are structured on the basis of collective decisions on for example marriages or how the soil should be cultivated, Bourdieu argues that contemporary societies are differentiated, consisting of various fields, for example the fields of science, art, law, economy, politics or medicine (Callewaert, 1999b). Characteristics of fields, as Bourdieu sees it, are that they are relatively autonomous in their character having their specific structures and rules, however dynamic in that they are exposed to both internal and external influences.

Bourdieu distinguishes between fields of production and fields of consumption, which could both be present within the same field (Broady, 1998a). A field of production embraces specialists who create the values and ideas (ibid.). Within the field of medicine, these specialists are represented for example by physicians and scientists, while the field of consumption comprises patients and their relatives. Different fields overlap each other, and a field often embraces different sub-fields. In addition, each individual and institution within a field, by Bourdieu (1988) referred to as agents, occupies a certain position. The agents' positions are related to each other in complex geometric ways. However, the basic differentiation between the agents' positions is claimed as binary; scholars require laymen, managers require subordinates, lawyers require criminals and so on. This means that each position exists in virtue of another and cannot be understood separately.

Bourdieu (1988) claims that all fields embrace relative strengths and hierarchies between the positions held by their agents, which implies that there are always tensions and struggles going on[17]. Such struggles within the field of medicine could concern what will be the best practice or whether patients should be treated in hospital or at home. Struggles are ongoing between different fields too. Taking the question about abortion as an example, clergymen, physicians, lawyers and

[17] In the well-known work *Homo Academius* (1988) that is referred to here, Bourdieu thoroughly describes the struggles in the academic field in Paris. However, the results from this work could be converted to other fields as well.

philosophers might discuss this subject, however from different perspectives. Moreover, there is a hierarchy of positions not only within a field, but also between certain fields. For example, in society in general economics is inclined to be dominant in relationship to other fields such as politics (Broady, 1991). To sum up, Broady (1998b) has in a compressed definition of Bourdieu's notion of a field written that a field is a system of relationships between positions, occupied by individuals and institutions that strive for something they have in common. Struggles that the networks in the focus of the present research project possibly could be involved in will be discussed in chapter ten.

Possession of Capital

To understand Bourdieu's theory of fields, attention has to be paid to his standpoint that the agents' positions are related to their acquisition of capital. Capital can be both symbolic and tangible assets (Broady, 1998a). Agents strive for power through ownership of different kinds of capital that are valid within the specific field. Each autonomous field has its own specific nature of capital, however there are three fundamental types: economic, social and cultural capital (ibid.). Economic capital refers to tangible assets including knowledge of the rules of economy. Social capital refers to friendship and family relations, which can create more favourable conditions. Cultural capital includes cultivated language and familiarity with the so-called highbrow culture and good taste (ibid.).

Other more specific types of capital are education capital and scientific capital, just to mention a few. The different forms of capital are involved in a system of exchange, accumulation and conversion (Broady, 1998a). By way of illustration, both economic and cultural capital can be transferred from one generation to another, which involves reproduction of class. Cultural capital could be acquired through education for example. Cultural capital could also be transferred into economic capital for instance through selling of works of art, and vice versa. Educational capital and titles allow access to certain professions and positions, which in turn generates economic capital and so on. Within a workplace, accumulation of cultural capital could take place through recruitment of adherents (ibid.). This reasoning implies that there exists a market for all kinds of capital.

All capital forms can function as symbolic capital as long as they are assigned value. In the pre-capitalist societies for example, honour gained high symbolic value (Bourdieu, 1982), as is the case with economic and cultural capital in contemporary societies. Symbolic capital amongst social groups is that which is both recognised and gains recognition as valuable (Broady, 1998b). This could for instance be titles, scientific work, a good reputation or art. Additionally, symbolic capital presupposes that there are agents that are predisposed to perceive its value (Broady, 1991). It is through habitus that agents recognize rules and what is at stake in the actual social field (Bourdieu & Wacquant, 1992). It is also through habitus that they acquire symbolic capital that is used to reach higher levels of hierarchy within this field (Bourdieu, 1999a). This reasoning about fields implies that each standpoint regarding the social world derives from a specific position and pre-consciously intends to maintain or increase power (Bourdieu, 1988).

Reproduction of Social Structures

As will be explained, Bourdieu's theory of social reproduction is of particular interest in this study. Bourdieu was interested in why the elite remained in their hierarchical positions within a social field, why he studied how class structures were reproduced within the educational system (Bourdieu & Passeron, 1990). The results from this research can be transferred into other fields as well to explain the reproduction of an established order.

Language is regarded as playing an important role in the reproduction of positions in society as language reflects relative strengths and the culture of what is legitimate within a field (Bourdieu, 1984). Language is linked to hierarchical positions in that it is those who possess symbolic power that have the authority to speak, interrupt, ask questions and are listened to. Within the field of health and social care for instance, it is the physicians who are the most powerful regarding the authority to speak. Moreover, those who possess symbolic power are those who are in control of doxa, and as they have the authority to speak, doxa becomes impressed on other agents too. This competitive and often subconscious feature is what Bourdieu (Bourdieu, 1999b; Bourdieu & Passeron, 1990) calls exertion of symbolic violence. Agents learn from the prevalent definition of the situation and the culture of what is right and wrong from those who define the situation within a

field. Symbolic violence is exerted mainly through communication, for example through recognition. Those who are exposed to symbolic violence gradually apply the dominant perspective, therefore the dominant perspective for the most part comes naturally even to them. In this way doxa slowly becomes incorporated and turned into new habitus, and in turn legitimates those in power. From Bourdieu's perspective, it is in this way the power relations and hierarchy in a field are reproduced (ibid.).

As is apparent from the above, doxa can play a unifying and preserving role, but can also create a distinction between the agents (Bourdieu, 1982). Agents are constructed with particular forms of habitus and bring specific forms of capital to the field, which implies that the doxa is constantly challenged (Bourdieu, 2004). When new opinions and discourses emerge, known as heterodox, these question the existing dominance, i.e. doxa (Bourdieu, 1982). Those who are established within a field, the so-called orthodox, are likely to develop strategies to maintain or improve their positions and the present conditions in the field, i.e. to defend the existing doxa (Bourdieu, 1988). Tensions arise about how to define valid capital, and different investments are made to accumulate capital and have it recognised (ibid.). Within the health and social care sector, such investments could be manifested for example in documents, methods and instruments of various kinds as well as through reputation. Consequently, symbolic capital plays an important role in the ongoing struggles and reproduction of structures in a field. Through exchange of capital amongst those in authority, the capital becomes reproduced and their habitus developed. This assists them in retaining or improving their positions and the present conditions in the field (Bourdieu & Passeron, 1990; Bourdieu, 1993).

The Field of Health and Social Care Services

As stated, the networks of the focus in this research project were established within the field of health and social care services. A characteristic of this field is that care practices performed by nurses have traditionally been bound up with the preferences of physicians and their logic (Melosh, 1982). For example, it has been found that curricula for nursing education have until recently largely been defined by the field of medicine (Petersen & Lundin, 2007). These are circumstances that

make the field of health and social services a sub-field of the field of medicine (Petersen, 1997/8; Lindgren, 1992). The influence of medicine has been observed in other sub-fields within the health and social care sector as well. Within Swedish elderly care, for example, during the time for the purchaser-provider split undertaken in the 1980s (Blomberg, 2004) (see chapter two), occupational groups with a medical competence obtained increasing influence on the assessment of needs of the elderly, an assignment that is usually adherent to educated social workers (ibid.). Carlhed's (2007) analysis of the field of habilitation services, with particular focus on children with disabilities in Sweden from 1960 to 1980, made a similar observation. The struggle in this field concerned appropriate achievements in support of the children. Carlhed concluded that the medical doxa was strong and could function as an obstacle for external agents entering the field.

Accordingly, there is in general a strong impact of medicine within health care practices. In addition, as described in chapter two, the historical development of the medical service in Sweden involved an emergence of two parallel structures; a medical hierarchical and an administrative/economic (Gustafsson, 1987). The medical hierarchy is guided by facts and natural science, while the administrative hierarchy aims at planning, coordination and control. The administrative hierarchy has emerged to create productivity and efficiency within certain economic frameworks (ibid.). Taking the increasing adjustment to market thinking within health care sectors (discussed in chapter two) into consideration, it could be argued that the field of health and social care services has gradually come closer to the position of the economic and administrative fields. An example of such a development is the increased focus on results through measurement and assessment of the impact of various initiatives (Pollitt & Bouckaert, 2004).

Moreover, as stated earlier in this chapter, agents hold certain positions within a field and are connected to each other in what could be described as a geometric system (Bourdieu, 1988). These relationships have a hierarchical dimension, but within the field of care practices could also be linked to an economic and cultural pole (Lindgren, 1992). This means that the economic and cultural capital forms could function as two parameters in a continuum in analyses of the field. Hospitals, primary care and care provided by municipalities for instance, hold different

positions within this range. Hospitals tend to have more resources and better technology, which bring them closer to the economic pole, while primary care and care provided by municipalities have a higher degree of a caring rationale, which brings them closer to the cultural pole. These poles could be important in discussions on the relative strengths within the field.

Regarding the different occupational groups within the field of health and social care, they have different status and conditions for success, which could be related to the history of the respective group's professional development (Anell, 2004). On looking at the European physicians, this group gained a central position in the field of medicine during the late 18th century in that medicine at the time became an instrument to supervise the individual body (Foucault, 1975; Johannisson, 1997) (a matter elaborated on in chapter two). During the late 19th century, physicians became both scientists and officials, which entailed a more patriarchal attitude (ibid.). As a group they established the preferential right of interpretation, and their language became permeated with authority. It is argued that the physicians now became the new clergy (Johannisson, 1997). In Sweden, increased status amongst the physicians also led to increased allocation of economic resources (Andersson, 2009).

Running parallel with the progress of the medical profession described above, in the Scandinavian countries the whole of health care services expanded. This development took place rapidly and implied that it was difficult to keep up the pace regarding human resources (Boge, 2008). In the wake of this progress, during the second half of the 19th century an intensified professionalisation process occurred (Johannisson, 1997). It was during this expansion phase that the nursing profession instead of being a mission in life turned into educated labour (Boge, 2008; Gustafsson, 1987). The nurses gained higher status through development of a theoretical knowledge base, internal control and demarcation towards other professions (Boge, 2008).

It could be argued that the relationship between different professions within the field of health and social care services is characterised by competition (Anell, 2004). Lindgren's (1992) analysis of the different cultures of physicians, registered

nurses and nursing assistants contributes to an understanding of this matter. The nursing assistants in her analysis are described as a homogeneous group. They act in the background and have strong identification with each other and patients. Nursing assistants originate mainly from the working class. Taking the registered nurses into consideration, their position is in the middle of the hierarchy; they serve the higher levels within the hierarchy and supervise the lower. Lindgren describes them as a subordinated group who seek to negotiate for better conditions. The nurses are also described as a heterogeneous group recruited from all classes; however, they become a more homogeneous group in practice. In comparison, Heyman (1995) in her thesis has undertaken a meta-analysis of 65 doctoral dissertations in Sweden, written by nurses. The thesis explored the development of nursing science as an autonomous field. By using the concepts habitus and capital as analytical tools she found that the hereditary capital within this group was subordinated to capital obtained from education programmes. The physicians in turn are those who work in the forefront (Lindgren, 1992). They function in an elitist environment and are mainly recruited from the upper class (ibid.). Lindgren's and Heyman's analyses support an understanding of the positions of the network participants involved in this study. These positions will be discussed in chapter ten.

Analytical Tools

As stated, one of the intentions of this thesis is to explore the network coordinators', their facilitator's and network participants' perspective of knowledge transfer, and thereafter bring it into a wider context. In this respect, Bourdieu's (1982; 1990a) theory of practice is used as a theoretical framework as potentially it can provide some insights into the discussion about the relationship between scientifically generated knowledge and practice, and how practitioners acquire knowledge in everyday work practices. Moreover, the thesis seeks to analyse the networks as a phenomenon and to explain structures, strategies and interactions involved. For this purpose, Bourdieu's theory of social fields is applied (Bourdieu, 1988; Bourdieu & Passeron, 1990). However, instead of drawing on the

prosopographical approach[18] often used by Bourdieu and his followers in their analysis of fields, I strive to conduct a line of reasoning in which I outline the networks in a field of relative strengths between two poles: the discourse of evidence-based practice (EBP) versus the logic of actual practice. Making such a theoretical reconstruction provides opportunities to understand the network coordinators' and network participants' perspectives and to discuss power structures involved. In this respect, the concepts reproduction and symbolic violence are used as a theoretical lens (ibid.). For example, it could be assumed that the network coordinators and network participants use certain strategies to increase their possession of capital for the purpose of maintaining or improving their own and the networks' position within the field and to substantiate their legitimacy.

In this chapter, Bourdieu's theory of practice has been presented along with his theory of social fields (Bourdieu, 1982; Bourdieu, 1988; Bourdieu, 1990a; Bourdieu & Passeron, 1990). Particular attention has been paid to the concepts reproduction and symbolic violence. The next chapter presents my research position and my own approach to knowledge, along with the action research approach and collaborative inquiry process involved. It also presents the participants in the study, the methods used and how the analysis was undertaken. The chapter concludes with a discussion on trustworthiness.

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[18] Prosopography in the sense that is developed by Bourdieu and colleagues implies development of a specific a kind of collective biography. A comprehensive amount of data concerning habitus and different forms of capital is collected from people who belong to a specific field. These data could for example be used to map the distribution of different kinds of capital or to analyse strategies when individuals or groups are entering a field. In the latter example, it is the history and structure of the field that is in focus rather than the individuals themselves (Broady et al., 1998a).

5. Research Methodology

As described in chapter one, the social practice at the centre of the present research project is nine research and development (R&D) networks, operating in a local health and social care setting in the north-east district under the county council *Region Skåne* in Sweden. Empirically, the thesis focuses on the network coordinators', their facilitator's and network participants' perspectives on the networks. This empirical phase of the research is embedded in a collaborative process of inquiry. Theoretically, the thesis seeks to bring aspects that emerged from the empirical phase into a wider context. (The aims are described more in detail in chapter one and the theoretical lens is elucidated in chapter four.) This chapter sets out the epistemological and methodological framework of the thesis. First, my research position and approach to knowledge is presented. Next, the participants involved in the study are introduced. After that, I shall describe the action research methodology underpinning the research project, followed by the collaborative inquiry process accomplished. Following that, I shall present the data collection methods used and how the analysis was undertaken. This chapter concludes with a discussion on trustworthiness.

Positioning

The way in which a researcher obtains knowledge within a certain field is concerned with the researcher's assumptions about reality and knowledge. This thesis is located within social science theory, implying that I consider reality to be constructed by one's own consciousness, and knowledge is thereby associated with interpretation, meaning and illumination (Usher, 1996). I also believe that knowledge is constructed and shaped by social, institutional, political, cultural and economic contexts that not only affect what we do, but is also affected by what we do (Guba & Linclon, 2005; Zeichner & Liston, 1996). Moreover, from my perspective, participation in dialogue and joint work involves opportunities for learning and change (Lundberg & Starrin, 2001). Knowledge might become more profound and enriched when it is co-created in a process embedded in practice (ibid.).

In addition, I sympathize with Bourdieu et al.'s (1991) perspective of social practices. From this perspective, knowledge is socially constructed and conditioned by a social and historical context which cannot be ignored[19]. This implies that research is not entirely about presenting people's subjective perceived experiences. Researchers within their social practices encounter people's perceptions on what is regarded as the essence of the object. However, people are not fully transparent regarding their ideas, which is why it is as a researcher important to break with common-sense and the prevailing perceptions instead of reproducing pre-constructed objects (ibid.). By conscious reflection, the researcher as an outsider reveals and reconstructs the ideas and ideologies that are subconscious or hidden from the eyes of the individuals. The idea is that these subjective perceived experiences should be reconstructed with regard to *genesis* and *structure* (ibid.). From this outlook, the purpose of research undertaken in social practices is to describe practice, and next, break with common-sense and spontaneous thinking through reconstruction, for example by use of specific concepts functioning as analytical tools (ibid.).

Bourdieu argues that by breaking with the conditions under which the constructions take place, it is possible to establish a core that for the present is true[20]. It is asserted that it is a part of the research work to develop a meta-discourse above the discourse, i.e. hypotheses or theories about practice; however, the reality and the reconstruction of it should not be confused (Bourdieu, 1988). Spontaneous constructions do always exist, preconsciously and embedded in language (Bourdieu et al., 1991). Language is a symbolic construction that is organised from a certain position that expresses meanings and relative strengths (Bourdieu, 1988; Heyman, 1999). It implies that it is important to take into

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[19]Bourdieu's theory of science is referred to as praxeology, placed within the field of historical epistemology. Praxeology attempts to unite social phenomenology and structuralism by considering both experiences of the individuals and structural frames (Bourdieu et al, 1992). From his own fieldwork experience of social practices, Bourdieu tried to exceed this classic subjective-objective antinomy.

[20] From my understanding, this is the point where Bourdieu's theory of constructions differs from social constructionism as Berger and Luckmann (1966) explain it. Within social constructionism, everything is considered as relative, and it is regarded as impossible to reach an objective truth. Within Bourdieu's theory of constructions it is possible to break with the constructions and establish a nucleus that for the present is true.

consideration positions from which the individuals talk and the power structures involved (Bourdieu et al., 1991).

The data obtained in this study are interpreted and analysed in a way that drew inspiration from Bourdieu's understanding of social practices described above. It implies that I first intend to describe the network participants' subjective perspectives and perceived experiences in relation to the networks, and next, break with their spontaneous thinking through reconstruction of the scientific object. As a part of this epistemological break, Bourdieu´s (1982; 1990a) theory of practice is used as a research framework, as it potentially can provide some insights into the discussion on the relationship between scientifically generated knowledge and practice, and as to how practitioners acquire knowledge in their everyday work practices. To further analyse and explain the networks as a phenomenon and the structures, strategies and interactions in play, I draw on Bourdieu's theory of social fields (Bourdieu, 1988; Bourdieu & Passeron, 1990). Through this lens, the networks can be outlined in a field of tensions between two poles: the discourse of evidence-based practice (EBP) versus the logic of actual practice. Here, I will use the concepts reproduction and symbolic violence as analytical tools (ibid.), described in more detail in the previous chapter.

As mentioned above, I believe that knowledge is socially constructed and shaped by contexts. This position includes the view that data are always constructed and interpreted in the light of the researcher's personal, cultural, ideological and linguistic frames of reference (Alvesson & Sköldberg, 2009; Johannisson, 1997). In other words, aspects such as power, selective perception and social conventions permeate research in complicated ways (ibid.). From Bourdieu's perspective, the researcher too is affected by habitus and positions, bringing about particular dispositions influencing choices that are made (Bourdieu & Wacquant, 1992). Social science is regarded as being a social construction of a social construction (Bourdieu, 2004). Therefore, an epistemological break always involves two dimensions; a break with the spontaneous, as well as with the scientific construction work. My own frames of reference that might have influenced the research project are outlined in chapter one. My specific role in the collaborative process of inquiry is elucidated further on in this chapter.

As already stated, the empirical part of the research process is embedded in an action research approach, described in more detail in sections below. This approach implied that the establishment of research questions and study design were an evolving process, coming out in gradual stages in pace with the progress of the collaborative inquiry process (Dadds & Hart, 2001). The intention was to be open-minded and adjust to what emerged during the collaborative process. In line with this approach, it was the initial analysis undertaken that formed the basis for the theoretical lens to come. How I reconcile the action research approach with theoretical lens adopted will be further discussed in chapter eleven.

Participants in the Study

The key participants in the collaborative inquiry process have been the coordinators of the nine R&D networks (the networks are presented more in detail in chapter six). Each network was led by one, and in one case two, coordinators, which made them ten in all. However, in the course of the collaborative process undertaken, two coordinators were replaced (for natural reasons), and as their successors also became engaged in the research project, twelve coordinators were involved in total. In addition, the facilitator of the meta-network, linking the coordinators of the nine networks together, has been engaged as well.

Other participants involved were the network participants of the networks Pain, Discharge Planning and Psychiatric Rehabilitation. The three networks were selected as a result of the collaborative process undertaken, given the diversity in their way of working. This diversity was considered to be an advantage in that it could potentially provide a deeper understanding of the network participants' perspectives and inform the forthcoming process. I also met the network participants from the other networks included in the network formation during development days arranged by the meta-network, however they never became directly involved in the research project. The nine networks consisted of between eleven and fifty practitioners each and approximately 200 in total, and encompassed a wide range of workplaces and professions. The organisational belonging, along with the type of workplaces and professions involved amongst

the different participant groups directly involved in the research project are described in more detail in chapter six.

Furthermore, the networks were connected with a steering group, whose participants have partly been involved in the research project. The steering group participated in the final feedback and dialogue sessions (described in chapter nine), which primarily were directed towards the coordinators of the networks and their facilitator. Table 1 provides an overview of the number of participants involved in the current research project.

Table 1 An overview of the number of participants involved in the research project

Participant groups	No of participants
The coordinators of the networks (i.e. the meta-network)	12
The facilitator of the meta-network	1
The steering group	6
The participants of the Pain network	ca. 50*
The participants of the Psychiatric Rehabilitation network	ca. 18*
The participants of the Discharge Planning network	ca. 12*
Total	ca. 99

* The number of network participants varied over time. In this table, it is the estimated average number of participants during the collaborative process that is accounted for.

Action Research

The Action Research Methodology

As described in chapter one, it was decided within the research group I was part of that action research (AR) should provide a common approach for the research projects undertaken. AR has traditions from the 1940s and Kurt Lewin's community action research projects in the United States (Kemmis, 1981). Based on the growing criticism of Taylorism and its principles of hierarchy and bureaucracy within industries, Lewin in his theory of AR considered it essential to start out from problem solving in real-life situations (Herr & Anderson, 2005). The epistemology that underpins AR is that knowledge is constructed in interaction with other people through action (Reason & Torbert, 2001). AR has come to embrace areas such as organisational development, education, social work and public health, to name a few (ibid.). Research projects that emphasise participation are also increasingly used in health care settings (Cornwall & Jewkes, 1995;

Hughes, 2008). A particular challenge associated with AR is both to facilitate social development processes located in practice, and to contribute to the field of research (Greenwood & Levin, 2007). It could be argued that collaborative inquiry is as much an issue of engagement from both the researcher and those involved as the research itself. This particular dilemma along with critical reflections on the AR project element as a whole is discussed in chapter eleven.

AR involves different kinds of research orientations, and several terms are used, for example, action science, appreciative inquiry and participatory action research (PAR), to describe different purposes, epistemologies and research traditions (Herr & Anderson, 2005; Shani et al., 2004). AR projects can, for example, endeavour to enhance the organisation's efficiency and effectiveness (Shani et al., 2004). These kinds of projects can also include more critical and emancipatory approaches and politically activist supported social movements (Carr & Kemmis, 1986). In addition, as indicated above, AR involves more or less participative approaches; from the practitioners' involvement in the whole research process to the researcher remaining in control (Greenwood & Levin, 2007). The purpose of the collaborative process undertaken in the present research project and the degree of participant involvement will be described in the following two sections.

Across the different purposes and approaches that can be found, AR also includes common features. Characteristic of AR is the involvement of both researcher and participants in processes of participation, dialogue, reflexivity and democracy (Greenwood & Levin, 2007; Gustavsen, 1992). An essential feature is also that researchers and practitioners work together in particular cycles of activities. The current research process was supported by a cycle of observation, reflection and action (Stringer & Genat, 2004). Observation refers to the building of an overall view of the situation including data collection, reflection refers to the analysis of data and the dialogue sessions undertaken, and action refers to what emerged from the process as a whole (ibid). However, this cycle also contained smaller cycles, undertaken within the meta-network as well as within three of the networks. However, the lines between these phases were not absolute; instead the different phases were interwoven. The cycles aimed at promotion of the network development, and the reflective processes were meant to create conditions for it

(Stringer, 1999). It is argued that a reflective process continually encourages participants to challenge their own frames as well as to look outwards at the world (Marshall, 2001).

Using an AR approach means specific ethical challenges because of its unpredictable nature (Greenwood & Levin, 2007; Stringer, 1999). This implies that the participants are expected to give consent to a process that could not be described in detail in advance (Löfman et al., 2004). In this study, the coordinators of the networks and their facilitator gave both verbal and written consent to participate in the collaborative inquiry process as a whole. They were provided with information about the overall purpose of the study, which was vague at the time, and the unpredictable nature of AR projects. They were also informed that participation was on a voluntary basis and that they had the right to withdraw at any time without prejudice. Moreover, they were informed that data collected would be used just for research purposes. As to the network participants of the three selected networks, they were given verbal consent to take part in the research project. The information they were provided with when I first met them embraced the same components as those described above. In addition to the overall consent, all who were interviewed gave a specific written consent shortly before the interviews took place. The current research project was undertaken in accordance with Swedish legislation (The Swedish Research Council, 2002) and has been fully approved by the Ethics Committee, Liverpool John Moores University.

The Collaborative Process

As stated above, those who were directly involved in the collaborative research process were the coordinators of the networks and their facilitator, as well as the participants of the networks Pain, Psychiatric Rehabilitation and Discharge Planning. However, it was the coordinators of the networks who were of specific interest in this study. The purpose of the collaborative process was to support network development by means of dialogical processes, encouraging the coordinators and their facilitator to reflect on their own perspectives. The dialogical processes were intended to raise consciousness around a subject that emerged from the network coordinators' and facilitator's own interest, which

possibly could initiate a process of development and change of their practice. The collaborative part of the research lasted for four years.

The collaborative process evolved to encompass three stages. Stage one focused the coordinators of the networks and their facilitator, stage two focused the participants of the networks Pain, Psychiatric Rehabilitation and Discharge Planning, and stage three included the coordinators once more. The three stages did not take place in a straight linear way, but were to some extent overlapping. Next, the three stages of the collaborative process are presented in more detail. What came out of the process will be described in chapters seven, eight and nine.

Stage one:

As mentioned in chapter one, it was decided that the projects undertaken within the research group I was a part of should emerge from inquiries from practice. In the present research project, the initiative started from the coordinators of the networks and their facilitator, who contacted the research group approximately two years after the start of the network coalition. Their initial interest was to be engaged in a research project focusing on the development process of the networks. As a PhD-student, I became involved in further discussions on launching such a project, which shortly afterwards led to a continuation. With the intention of narrowing down their request into an inquiry of interest and relevance to all the coordinators, an agreement was made that I for a start should participate during meta-network meetings and that I should undertake interviews with the coordinators. The data collection intended to shed light upon the coordinators' perspectives on the networks' relationship to *Integrated Care,* their views of the role of the networks and their ideas on how to achieve their vision. In addition, it intended to elucidate their reflections on how the networks' achievements work, on their role as coordinators and what they considered as strengths and limitations.

The results from the data collection were fed back to the coordinators and the facilitator, followed by dialogue sessions about a pattern that had emerged, which was their endeavours to transfer knowledge into practice by means of a linear top-down approach. To support network development and their further understanding of the complex area of knowledge transfer, an agreement was made between the

coordinators, their facilitator and me. This agreement implied that I should continue the process together with the network participants of the networks Pain, Psychiatric Rehabilitation and Discharge Planning.

Stage two:

As stated, stage two included the networks Pain, Psychiatric Rehabilitation and Discharge Planning, and was undertaken as a consequence of the collaborative process along with the coordinators and their facilitator. The intention of this second stage was primarily that I should collect data to inform the coordinators' increased interest in the complexity of knowledge transfer, and by doing so support the coordinators in the network development. However, the collaborative process intended also to inform the three networks' internal development processes for the period our interaction continued. As stated in this chapter, the three networks were selected given the diversity in their way of working. This diversity was considered to be an advantage in that potentially it could provide a deeper understanding of the network participants' perspectives of knowledge transfer and inform the forthcoming process. The coordinators of the networks had inquired into the network participants' interest in participating in the collaborative process in advance.

Initially, I attended the three networks' respective network meetings to present the purpose of the process and to make an agreement on a continuation of the process myself. During the first meetings with each of the three networks, the purpose of the research project and rationale for using an AR approach was presented, and following that, an agreement was made on a continuation. The processes within the three networks ran side by side. Observations and interviews were undertaken to explore what the network participants considered the value of the networks and their experience of knowledge transfer and implementation in practice. In addition, the participants of the networks Pain and Psychiatric Rehabilitation wrote reflexive notes[21]. This second stage of the research also involved feedback and dialogical processes within each of the three networks with the purpose of initiating a

[21] The reasons why the participants within the Discharge Planning network did not write reflexive notes is described in the section "Reflexive Notes" in this chapter.

dialogue on the subject of knowledge transfer that possibly could generate ideas around their own continuing development work.

In parallel with the processes undertaken amongst the three selected networks, the coordinators wrote reflexive notes on two occasions. The purpose was to obtain additional data about what the coordinators regarded as challenges and which aspects they regarded as having encouraged the network development. In addition, I continued to participate during meta-network meetings to follow the coordinators' internal discussions and further developments. The results from the data collection amongst the three networks, including the reflexive notes written by the coordinators and the observations undertaken during meta-network meetings, were used in a final feedback and dialogue process with the coordinators and their facilitator (stage three).

Stage three:
During the third stage of the collaborative research process, the focus was on the group of coordinators and their facilitator once more. Participants of the steering group also participated during this stage of the research. Results from stage one and stage two taken together, along with joint reflections on challenges associated with linear processes of knowledge transfer, formed the basis for final feedback and dialogue sessions. Since the intention of the whole process was to support network development and further understanding of the complex area of knowledge transfer, this stage of the research was seen as a phase with potential. It was hoped that the dialogue sessions would lead to a continuation of the process and development of their practice.

Later on, results from the collaborative process along with my theoretical reconstruction were fed back during a local conference directed towards practitioners, to which the participants of the meta-network were specifically invited. The facilitator and some of the coordinators attended the conference and took an active part in the subsequent opportunity for questions and dialogue. Finally, an interview with the facilitator of the meta-network was undertaken to obtain her perspective and concluding statements on how the networks worked.

The intention was to increase the understanding of the networks as a phenomenon. Table 2 presents an overview of the whole collaborative process undertaken:

Table 2 An Overview of the Collaborative Research Process Undertaken

STAGE ONE:
Amongst the coordinators of the networks
-Agreement on adopting an AR approach and initial discussions on the subject of research
-Data collection: Interviews, observations and document review
-Analysis of obtained data
-Feedback and dialogue sessions

STAGE TWO:
Amongst the participants of the networks Pain, Psychiatric Rehab and Discharge Planning
-Initial discussions on the subject of research within each of the three networks
-Data collection: Interviews, observations and reflexive notes
-Analysis of obtained data
-Feedback and dialogue sessions within each of the three networks

Amongst the coordinators of the networks
-Reflexive notes kept by the coordinators of the networks

STAGE THREE:
Amongst the coordinators of the networks once more
-Overall analysis of data from stage one and two taken together
-Feedback and dialogue sessions on stage one and two taken together
-Concluding reflexive notes
-Concluding statements from the facilitator of the coordinators

Our Roles

As brought up in this chapter, characteristic of AR is the involvement of practitioners in the research process. However, there are different degrees of involvement; from the practitioners' involvement in the whole research process, to the researcher remaining in control (Greenwood & Levin, 2007). In the current research process, an agreement was made with the coordinators and their facilitator on the direction of the process. The coordinators and the facilitator were also engaged in defining an issue of interest for them to explore. However, it was agreed that I should accomplish the data collection and analysis. For natural reasons, the coordinators and the facilitator took an active part in the following feedback and dialogue sessions, which concerned their common emphasis on a linear top-down model of knowledge transfer. My role during these sessions was to make explicit their perspectives and facilitate a dialogue around their practice.

Due to the difficulties they had experienced in the process of knowledge transfer, we also made an agreement to challenge their view of knowledge transfer collectively. The purpose was to broaden their perspective around this complex area and possibly initiate a process of change. By challenging routine-like ideas and ways of working it was hoped that reflection and developmental learning should be supported (Ellström, 1996). In practice, it was I who held the role as catalyst and challenger, implying encouraging the participants in reflection on their own perspectives on knowledge transfer. However, I left it to the coordinators and the facilitator to take responsibility for possible actions to be taken (Stringer, 1999).

The participants of the networks Pain, Psychiatric Rehabilitation and Discharge Planning were also engaged in feedback and dialogue sessions, i.e. in bringing their own frameworks and perspectives on knowledge transfer to a learning community. As was the case within the meta-network, my role was to facilitate these sessions. As stated above, the direction of the overall collaborative process was agreed upon together with the coordinators of the networks and their facilitator. In addition, specific research tasks such as data collection, interpretation and writing were not accomplished collaboratively with the network participants. For reasons that will be discussed in chapter eleven, the involvement of the coordinators and their facilitator and the network participants in the research process was less collaborative than the ideal outlined the literature (see for example Greenwood & Levin, 2007; Heron & Reason, 2001).

Methods and Analysis

The data collection was based on a combination of sources: interviews (with the coordinators, their facilitator and network participants), observations (during meta-network meetings and meetings within the networks Pain, Psychiatric Rehabilitation and Discharge Planning), reflections in writing (from the coordinators and network participants) and document review (of newsletters distributed by the network coordinators and their facilitator, internal network documents and meeting memoranda from meta-network meetings and meetings with the three selected networks). The dialogical relationship provided me with

data as well. An advantage of using a multi-method approach is the possibility to cross-check findings. The weaknesses with a specific method can be compensated through use of another (Patton, 2002).

Moreover, Polkinghorne (2006) argues that the quality of results does not depend on the strict adherence to a series of steps or the application of techniques advocated by a particular method. Rather than being method-centred, the conduct of qualitative research is problem-centred. In this research project, the data collection responded to the particular collaborative inquiry process undertaken, which implied that the specific tools and samples were chosen and developed during the course of the research project. In addition, as the number of network meetings was limited and participants in general were very busy, it was important to be flexible and not interfere in the networks' process more than what was required. The following five sections in this chapter describe the data collection methods used and are followed by a section describing the analysis procedure.

Document Review

Written documents can provide a great deal of information about the context of the research. However, documents of all kinds are socially constructed, influenced by the authors' perspectives and motives (Stringer & Genat, 2004). Therefore, it is important to deconstruct the texts and strive to understand how and why they were produced (Miller, 1997). As preparatory work and a supplement to the fieldwork, I reviewed newsletters distributed by the network coordinators and their facilitator, internal network documents, and meeting memoranda from meta-network meetings and meetings with the three selected networks. The purpose was to reveal visions and desired development directions that could not be observed (Patton, 2002). I also strived to get behind what was written and understand intended meanings, as well as placing what was communicated in the texts in a wider context. Important questions were: What was emphasised in these documents? What were the underlying intentions? How could the documents be related to the wider context, as for example the health care services in general and their surrounding influences?

Interviews

The strengths of interviews are their possibilities of capturing thoughts, intentions and how people have organised the world, which are aspects that cannot be observed (Patton, 2002). A limitation of interviews, however, is that those who are interviewed may create a meaningful context when they present their thoughts and experiences, and perhaps also put themselves and what they carry out in a favourable light. In addition, the person who tells her story always makes a selection, i.e. the censoring or sorting out of pieces of information (ibid.). Accordingly, language expressions do not represent an objective reality. Bourdieu (1986) argues that as an interviewer it is easy to be seduced by the immediacy of the narratives since, if they are un-reflected, they might seem as if they are factual. Moreover, it is important to be aware of the results of the interaction with the interviewees and the power relations that are in play within the interview episode rather than just look upon the results from the interviews as being natural data.

As already established, the interviews in this research project were undertaken as a part of the collaborative inquiry process, and were considered by the coordinators of the network and their facilitator to constitute an appropriate foundation for dialogue and decisions about future steps to be taken. From a research point of view, the intention was to capture perspectives and experiences of the participants, and next, describe and explain. As to interview data limitations, such as personal bias and self-serving responses described above, these are aspects that are difficult to avoid, both concerning the interviewer and the interviewees (Patton, 2002). However, what I aspired to achieve was to create familiarity and trust in the interview situation, as these aspects influence how the story is portrayed (Bourdieu, 1986). The interaction is important for what emerges from the interviews, both as to the content and how it is structured (ibid.).

As to the meta-network, all the network coordinators, including their facilitator, were interviewed. The network participants of the three selected networks were asked during ordinary network meetings to participate in interviews on a voluntary basis. Those who were interested came to me during coffee breaks and announced their interest. A total of 39 interviews were accomplished amongst the network

coordinators, their facilitator and the network participants. Table 3 provides an overview of the number of interviews undertaken within each participant group.

Table 3 The number of interviews undertaken

Participant groups	Number
The coordinators of the networks	12
The facilitator of the meta-network	1
Participants of the Ps. Rehab. Network*	9
Participants of the Pain network	8
Participants of the Discharge Pl. network	9
Total	39

* All the network participants within the Psychiatric Rehabilitation networks except one were drawn from the health and social care sector. The network participant who was not was a representative of a client association.

All the interviews were semi-structured and open-ended, which implied that the three interview guides used (one for each group, i.e. the coordinators, the facilitator and network participants, see Appendix 3) covered a few pre-determinated questions that the respondents were encouraged to answer in their own terms and without feeling constrained by a standardized order (May, 1997). The questions asked were chosen to obtain an overview of how they viewed the role of the networks, what they were doing and their experiences of their efforts. Follow-up questions were asked to make the respondents clarify or further develop their answers (Kvale & Brinkmann, 2008). The interviews lasted for 40 to 75 minutes. All interviews were tape-recorded and transcribed verbatim. Finally, when quotes are presented as a dialogue between me as interviewer and the interviewees in the chapters of results (chapter six to nine), I use the acronym *I* for the interviewer and *R* for the respondents.

Observations

Our values are reflected not only in what we say, but also in our actions, which motivates use of observations as an additional data collection method. In addition, a combination of data obtained from interviews and observations offer possibilities of cross-checking findings (Silverman, 2006). Moreover, observations could be seen as a strength when using collaborative research approaches as collaboration might entail difficulties for the researcher in dissociating himself or herself from

the participants' outlook (Patton, 2002). Observations offer a way for the researcher to change perspective and objectify the participants or the situation by asking questions such as: "What is really going on here?". However, a weakness with observations is that people or situations might be affected by the observer in ways that are not possible to fully anticipate or identify. Another weakness could be limitations in the researcher's selective ability (ibid.).

As was the case with the interviews accomplished, the coordinators and the facilitator thought that data from observations undertaken during network meetings could contribute to forthcoming discussions and decisions about steps to be taken. My intention as a researcher was to obtain data about what the participants actually did in a 'naturally occurring' context rather than upon what they thought about what they did (Silverman, 2006). With the purpose of minimizing the weaknesses associated with observations, I strived to be thoughtful about the interconnections between me and the participants (Patton, 2002). It implied that I aspired to be aware of my role and how it affected the participants, as well as of how the participants affected me (Bourdieu, 1982). During the observation sessions, I considered it important not to interfere in their meetings if it was not requested, so that they were given opportunities to talk and act as naturally as possible.

Observations were undertaken during meta-network meetings, and at a later stage during the three selected networks' meetings as well. I attended 36 network meetings in total. The networks held meetings two to five times per year, and each meeting lasted between three and six hours. The observations within the meta-network extended over a period of four years, and the observations within the three selected networks lasted for 14 to 26 months. During the observation sessions I took notes concerning what the participants talked about, including potential implicit meanings (Kvale & Brinkmann, 2008). The notes were unstructured in that I, at a least for a while, did not stick to any specific themes or activities. However, in gradual stages, the notes became a bit more structured and focused on the subject of knowledge transfer. I noted down both main points and longer paragraphs freely without use of schedules. My role during the observation sessions has been of a diverse nature; from active involvement in planning and dialogue to being in possession of a more peripheral role as an observer and

informal discussion partner. The participants were aware that they were observed and for what purpose. Table 4 provides an overview of the number of network meetings I attended within each participant group. The table also draws a distinction between the meetings where I had an active versus more passive role.

Table 4 An overview of the number of network meetings that I attended, and the nature of the research activities

	Meta-netw	Disch Pl netw	Psyc netw	Pain netw
Meetings where time was set aside on the agenda for mutual planning, feedback, dialogue, reflection and evaluation:	8	3	4	3
Meetings where my role was less prominent, comprising observations, contribution to discussions and collection of additional information:	8	8*	-	2
Total network meetings attended:	16	11	4	5

* The Discharge Planning network became involved in another AR project facilitated by a colleague. The network participants also held some meetings together with the Documentation network. I attended these meetings as I was interested in what came out of them. However, these circumstances implied that I attended more meetings by comparison with the Pain and Psychiatric Rehabilitation networks, and also that my role during these meetings was of a more peripheral nature.

Reflexive Notes

The coordinators of the networks wrote reflexive notes during meta-network meetings on two occasions, in parallel with the processes undertaken with the network participants (stage two). In these notes, the coordinators reflected upon two areas: challenges and aspects regarded as having encouraged the network development. The purpose was to obtain additional data to inform the coming feedback and dialogue sessions with the coordinators. In addition, the coordinators wrote concluding reflexive notes (stage three) about what they learnt from the collaborative process they were involved in. It could be argued that this data collection method has certain similarities to participant diaries, although in a minimised and simplified form. Jacelon (2005) used solicited participant diaries guided by a number of open-ended questions to encourage participants to reflect on daily activities. Participant diaries in combination with interviews are regarded by Jacelon as a useful source of data that has not been noticed enough within qualitative research.

In addition, the network participants of the networks Pain and Psychiatric Rehabilitation networks wrote reflexive notes on one occasion each. The subjects they reflected on were what they considered as strengths and challenges as to their engagement in knowledge development and knowledge transfer. The participants of the Pain network were also asked to reflect upon their experiences of the story dialogue method (explained in chapter eight), which they had been trained in and were expected to use as a tool for the transfer of knowledge into practice. As to the Pain network, I received notes from the 20 network participants who were present at the actual network meeting. Regarding the Psychiatric Rehabilitation network, I received notes from nine network participants, which was everyone who was present at the network meeting concerned.

The primary reason for the use of reflexive notes as a data collection method amongst the network participants was to obtain supplementary data to inform their internal development processes, and also to inform the coming feedback and dialogue sessions with the coordinators. The reason why the participants of the Discharge Planning network did not write reflexive notes was that they become involved in yet another action research project, and I did not want to put too much workload on them. As I attended the Discharge Planning network's meetings more often (see table 4 above) I considered this as compensation for that.

Dialogue Sessions

The dialogical elements that characterized the three stages of the collaborative inquiry process were primarily undertaken to support network development, but were also a part of the data collection. Dialogue is encouraged in several action research projects focusing on organisational development (see for example Gustavsen, 1992). As stated previously, the dialogue sessions in the present research project mainly concerned the subject of knowledge transfer. The reason for this was that the earlier completed data collection and feedback processes led to an agreement that together we should challenge the network coordinators' linear top-down model of knowledge transfer. My role during the sessions was to make explicit their perspectives and facilitate a dialogue around their practice. Essential aspects on the subject of knowledge transfer that came out of our shared dialogue

sessions were written down by me briefly during the sessions, and were supplemented immediately after each meeting. What I noted was the content in our discussions as well as changes in relation to their initial perspective of the subject of knowledge transfer. In all, eighteen dialogue sessions were accomplished. The analysis process undertaken is described below.

Analysis

As described earlier in this chapter, the data collection was based on a combination of data sources. All material was analysed by use of qualitative methods, not following any standard method. Instead, the analysis evolved in gradual stages, involving an interplay of different approaches. According to Kvale and Brinkmann (2008), such an ad hoc use of different analysis approaches is widespread. The researcher may for example alternate between reading the interviews, making deeper interpretations and developing metaphors in a way that comes naturally to capture relationships and structures that may be relevant to the research project.

Initially, the interview transcripts from the interviews with the network coordinators, notes from the observations undertaken during meta-network meetings and internal network documents (newsletters, meeting memoranda and other network documents) were read several times to get a sense of the whole (Patton, 2002). At this stage, I focused on the network coordinators' perspectives. What were the coordinators' experiences related to the networks? What meaning did they assign to the networks and their achievements? Data was concentrated and organised into four categories, intended to reflect the essential content of the data obtained:

-The unclear link to Integrated Care
-The quest for knowledge transfer and evidence-based practice
-Concerns about how knowledge transfer worked in practice
-Expert guidance

The presentation of results from this stage of research (see chapter seven) is basically a descriptive presentation that is sorted into these categories. However, this initial analysis and the following feedback and dialogue sessions also revealed that the transfer and implementation of knowledge into practice was regarded by

the coordinators and their facilitator to be an urgent matter for the networks to handle. This circumstance guided the next stage of the analysis, which was the analysis of data from the three selected networks. As was the case with the initial analysis undertaken, interview transcripts from the interviews with the network participants, notes from observations during network meetings and the internal network documents (meeting memoranda) were read several times to get a sense of the whole (Patton, 2002). The networks were first analysed separately and then taken together. The main focus in the analysis was now directed towards the subjects of knowledge development and knowledge transfer. In accordance with the focus of the analysis, data was concentrated and organised into the following two categories, intended to reflect the perspectives of the network participants (these results are presented in chapter eight):

-Focus on internal knowledge development
-Difficulties with knowledge transfer

The analysis continued by analysing all data obtained: data from the two stages described above, including data from the interview with the facilitator of the meta-network, from the reflexive notes and the dialogue sessions undertaken. This stage of the analysis intended to describe a broader picture and develop a theoretical understanding, originating from what had emerged (Kvale & Brinkmann, 2008). As discussed in this chapter, I saw it as important to break with common-sense and the prevailing perceptions that always exist and not just reproduce pre-constructed objects (Bourdieu et al., 1991). My social science lens guided me in the interpretation process to focus on overall social structures and tensions that were not in full view of those involved. The theoretical tools used (described in chapter four) were chosen for the interpretative reading and analysis, and as way of understanding the empirical story line. The theoretical lens also responded to the initial analysis undertaken, which indicated that knowledge transfer did not work out satisfactorily. At this stage of the analysis, I endeavoured to reconstruct the object of the research by conscious reflection on the participants' perspectives as well as structures and a wider context (ibid.).

The analysis as a whole was not undertaken as a linear process; rather the various analytical steps overlapped one another. The analysis involved an interaction between reading of units and lengthy parts from the collected data, versus the theoretical reconstruction work. In other words, this process comprised an interaction between close reading and reflections. The following themes (further developed in chapter ten) emerged from this final stage of the analysis:

-The idea of knowledge transfer
-Dissonance between idea and experiences
-The vertically informed networks
-Reproduction of structures
-Tensions in the field
-Legitimacy and strategies to improve positions
-The symbolic value of the networks

Research Trustworthiness

The interest within qualitative research is to understand more fully cases embedded within a particular context (Patton, 2002). This is a matter that makes discussions about the truth of our observations complex. To respond to this complexity and address the trustworthiness in qualitative research, Lincoln and Guba (1986) suggest the use of four criteria: credibility, transferability, dependability and confirmability. Their suggestion is developed as an alternative to the following criteria used within traditional quantitative research in its striving to estimate a true picture of a phenomenon: internal validity, external validity, reliability and objectivity (Miles & Huberman, 1994).

Credibility (analogous to internal validity) refers to whether results are credible to the participants involved in the study. Since qualitative research strives to describe the phenomena concerned from the perspective of the participants, they may also approve whether the findings represent a true picture (Stringer et al., 2004). In this study, a number of measures were taken to enhance the credibility. First, follow-up questions were asked during the interviews with the intention to encourage in-depth responses and avoid ambiguity (Kvale & Brinkmann, 2008). Next, I offered the participants possibilities to read their own interview transcripts with the purpose of clarifying possible misinterpretations. Furthermore, the participants were engaged in recurrent feedback and dialogue sessions, which naturally

involved requests for comments on the results and interpretations. I also presented results from the research project at a local conference, in which the facilitator of the meta-network and a number of the network coordinators participated. During the time for dialogue that followed this presentation, a number of them affirmed that they recognized what was presented.

In all, my judgment is that the results and interpretations were recognized by the participants involved in the study. However, since the theoretical analysis was not fully developed at the end of the collaborative process, there is some uncertainty about their views on the very latest conclusions. There is a risk that not all would agree on or approve the final conclusions since these evolved to include a more critical angle. However, on the issue of ontology and constructionist arguments, saying that the way we describe reality is dependent on our perceptions of it, it could be argued that it is not necessary that all interpretations made by the researcher are in accordance with the actors' involved. As I see it, the multiple data collection methods used and the prolonged engagement with the field supported the credibility of the work. In addition, regular PhD seminars and supervision informed critical reflections on credibility throughout the entire research process.

The transferability criterion (analogous to external validity) involves the matter of to what extent results can be transferred to other contexts (Stringer et al., 2004). Judgments of the transferability of research require close presentations of both contexts and methods (Lincoln & Guba, 1985). However, crucial elements associated with qualitative research are both the specific contexts and its evolving nature, which makes the matter of transferability complicated. In this study, attempts have been made to describe adequately and thoroughly the context of the R&D networks, the collaborative process and methods used, along with the results and theoretical framework. Whether the results can be transferred to other health care contexts is discussed in chapter eleven, but is primarily an assessment for the reader to make (Lincoln & Guba, 1985).

Dependability (analogous to reliability) concerns to what extent the same results could be reached if the study was replicated (Stringer et al., 2004). However, the challenge in qualitative research is that the phenomenon under study is embedded

within a particular context and process, which entails that it is not achievable to observe exactly the same repeatedly. Lincoln and Guba (1985) suggest the use of an "inquiry audit" as a measure for enhancing dependability in qualitative research. The purpose of an audit is to examine and verify both the research process and its findings. To enhance consistency in this study, I discussed the research process and findings regularly during PhD seminars and with my supervisors. I also strived to present clearly the research design and process, including methodology, results, and the theoretical lens adopted. However, worth noting in discussions on dependability is that seen from a constructionist perspective, dependent on the lens of the researcher, researchers are likely to make divergent interpretations of the same data. And instead of being a disadvantage, this might be assumed as enriching the body of research. Yet, it could be argued that the structures in which the observed networks in this study are embedded are rather firm, which implies that researchers might make similar interpretations such as the issue of hierarchies and positions.

Finally, confirmability (analogous to objectivity) involves the researcher's relative neutrality and to what extent the results and interpretations made can be derived from their original sources (Stringer et al., 2004). To reduce the biases of the researcher, Lincoln and Guba (1985) suggest the writing of reflexive notes, triangulation across both methods and investigators, and the use of an audit. In order to establish transparency in this study, attempts have been made to present the case under study, including the analytical procedure, with carefulness. To demonstrate from where the interpretations have been arrived at, a large amount of quotations from the interview transcripts were presented. In addition, the multi-method approach used provided opportunities to compare information from different sources. Moreover, in addition to traditional supervision and PhD-seminars where the subject of neutrality was discussed, a co-researcher participated in the feedback and dialogue sessions undertaken during stage one, holding a role as observer and sounding board for my reflections and interpretations. However, researchers always bring certain values to their research, and this is why it could be argued that value neutrality is not possible to achieve. To increase my consciousness around my own values and support judgments of confirmability in this study, the pre-understanding I brought to the study is presented in chapter one.

This chapter has described the epistemological and methodological framework of the thesis, including the collaborative inquiry process undertaken. It has also has presented the participants involved in the study in addition to the data collection methods used and how the analysis undertaken. The chapter was concluded with a discussion on the issue of trustworthiness. The following four chapters (six to nine) present the results of the empirical phase of the research.

6. The Networks – Background, Aims and Meta-Network Activities

This and the following three chapters present the results of the current research project, following the three stages that came out of the collaborative inquiry process undertaken (described in chapter five). The present chapter embraces an introductory overview of the nine networks concerned and why they were formed. First, an overview of the networks is given, followed by the overall aims of the networks. Next, the facilitator of the meta-network's perspective of the network formation is presented since she was the initiator of the network coalition and led the continuing build-up phase.

An Overview of the Networks

The nine[22] research and development (R&D) networks in the focus of this research project have been established within the north-east district of the county council *Region Skåne* in Sweden across the three tiers of care: hospital care, primary care and care provided by municipalities[23]. The subject areas of the networks were: Palliative Care, Documentation, Drugs & Elderly, Ulcer, Nutrition & Eating, Psychiatric Rehabilitation, Pain, Hygiene and Discharge Planning (fig. 2).

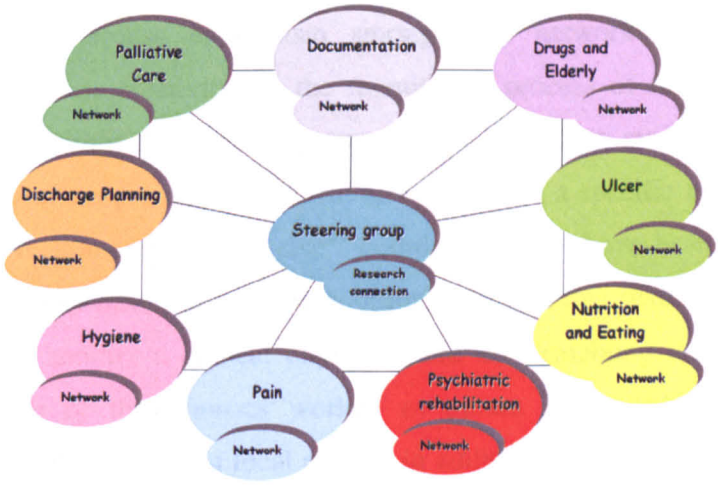

Figure 2: The nine R&D networks included in the research project. The figure was established by the steering group linked to the networks.

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[22] When the empirical phase of research was almost completed, two new networks were formed; Rehabilitation and Prevention & Health, which at the time of writing makes them eleven in all. However, neither of these two new networks became actively involved in the research project.

[23] The six municipalities concerned were; *Bromölla, Hässleholm, Kristianstad, Osby, Perstorp* and *Östra Göinge*. These municipalities comprised approximately 7000 to 70 000 inhabitants.

The network coalition had its starting point in 2002. The networks Palliative Care, Documentation, Ulcer and Pain existed independently before the start and were the first to become involved, while new networks took shape in gradual stages. When this research project was launched, eight networks had been established. The ninth network, Psychiatric Rehabilitation, was set up and became involved in the research project shortly afterwards. As mentioned in chapter five, the networks each consisted of between eleven and fifty practitioners, that is approximately 200 in total. The networks had network meetings from two to six times a year, lasting from two to six hours on each occasion. All network participants participated in these meetings during working hours.

As also mentioned in chapter five, each network was led by one, and in one case two, coordinators. The coordinators had the overall responsibility for the network development. It was decided by the participants within the steering group (presented below) and the facilitator of the meta-network (also presented below) that each network should be managed by highly qualified people, who could stimulate and arouse enthusiasm amongst the network participants without suppressing their creativity. In the recruitment process of the coordinators, the participants within the steering group and the facilitator made use of their own knowledge of people with a specific competence in a specific network area. The fields of work amongst the twelve[24] coordinators that have been involved in the research project have varied. One coordinator was a line manager within care of the elderly, another a clinical physician and the remaining ten were registered nurses. Five of these nurses worked as nurses in everyday work practices, sometimes with a role of a local adviser in addition. Another was a district nurse. Two were researchers, one a project leader and one served an administrative function. Three of the coordinators were male and nine female. The responsible organisations that the coordinators were attached to in their everyday work are presented in table 5.

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[24] As described in chapter five, twelve coordinators in total became involved due to shared responsibility between two coordinators within one of the networks and the replacement of two coordinators during the research process.

Table 5 The organisational affiliation of the coordinators of the networks

Responsible organisations	No of Coordinators	Networks
Municipalities	3	Discharge Planning*, Drugs & Elderly**
Primary care	1	Palliative Care
Psychiatry	1	Psychiatric Rehabilitation
Hospital care	6	Ulcer***, Hygiene, Documentation, Pain, Drugs & Elderly**, Nutrition & Eating
The local University	1	Ulcer***
Total	12	

* The Discharge Planning network had its coordinator replaced during the research process, and both coordinators were drawn from the municipalities.
** During a certain period, the Drugs & Elderly network had a shared responsibility between two coordinators; one drawn from hospital care and another from municipal care.
*** The Ulcer network also had its coordinator replaced during the research process; the first coordinator was drawn from hospital care and the second from the local University.

As stated in chapter five, the coordinators of the networks were interconnected in their own meta-network, linking the nine networks together. The meta-network was led by a facilitator, i.e. a coordinator of the coordinators. It was the facilitator of the meta-network who was the initiator of the network coalition and the driving force in their continuing development work. The facilitator had a background in nursing and held positions such as clinical department supervisor. However, later on in her career she became an administrator. In her present position she was part of the managerial group at the central hospital in the area and had an overall responsibility for the hospital's collaboration with primary care and the six municipalities in the area. From this position, she has also been involved in major change processes, for example a local retrenchment programme called Strategy - 99, in which several reorganisational measures were taken with the aim to save 450 million SEK in the region. Her role as facilitator of the meta-network involved the responsibility of facilitating the meta-network meetings and of supporting the coordinators and the network development.

The participants of the nine networks concerned were practitioners from the north-east district of *Skåne*, an area which roughly speaking embraces 10 000 health-care practitioners in total (an estimation made by the facilitator of the meta-network). The network participants had their workplaces at the two hospitals in the area,

within primary care (care centres and qualified homecare services[25]), psychiatry, care of the elderly (special forms of housing and ordinary housing) and care of physically disabled patients. The participants also held a variety of professions. The majority were registered nurses, including district nurses, nurses responsible for discharge planning at the hospitals, nurses with a specific overall medical responsibility in relation to nursing within a municipality[26], and nurses working as coordinators of hospital sickbeds. Other occupational groups were involved, including nursing assistants, line managers within care of the elderly and psychiatry, administrators of means-tested home help services[27] for the elderly, officials in charge of functional impairments[28], occupational therapists, physiotherapists, dieticians, pharmacists, local advisers, coordinators within psychiatry, municipal diet and restaurant managers and secretaries for staff matters. The Psychiatric Rehabilitation network was the only network that involved a participant from a client association.

Generally, new network participants were recruited by the coordinators of the networks or by network participants already involved. Practitioners who were recruited to the networks were those having a specific competence or interest in a specific network area, which required knowledge of people. In addition to the network participants already mentioned, the majority of the networks included teachers from the local university, having specific knowledge of the network areas concerned. These representatives were expected to constitute a link between scientifically generated knowledge and practice.

Furthermore, a steering group was linked to the networks consisting of between six and ten participants (the number varied over time), most of whom were registered nurses with a specific overall medical responsibility in relation to nursing within municipal care, or as in one case, pursuing development work at one of the hospitals. The steering group participated in coordinator meetings approximately three times a year, and their role during these meetings was to contribute to

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[25] In Swedish: Kvalificerad vård i hemmet (KVH).
[26] In Swedish: Medicinskt ansvarig sjuksköterska (MAS)
[27] In Swedish: Biståndshandläggare
[28] In Swedish: LSS-handläggare

discussions, prioritise-activities and to encourage and oversee the development of the networks. In addition, the steering group made efforts to pave the way for the networks in different ways. For example, they took the opportunity at times to establish different ideas arising from coordinator meetings and suggested measures to be taken during meetings with their own colleagues. Negligible resources have been allocated by the county council to support their achievement. These primarily were used to purchase low-cost items such as coffee and books, and occasionally field trips and conference fees.

The Overall Aims of the Networks

The overall aims of the networks were formulated by the steering group linked to the networks. One of the aims was to promote a professional approach to care and strengthen the collaboration between health care sectors. Through increasing the ability to co-operate across the sectors, it was hoped that there would be an increasing exchange of knowledge and consequently a further development of competence. Another aim was to follow the development of knowledge within each network area and to create a consensus on strategies to be taken, bearing the needs of patients in mind. Commitment was to be encouraged as well as views from different client groups. Yet another aim was the transfer and implementation of methods and strategies, based on clinical research and good practice. The work of the networks would be based on two elements; on the one hand, research and development (R&D), on the other, dissemination.

As to the research component, the idea was that the work accomplished should start out from clinical research, not necessarily that the networks should do research themselves. It was also expounded that experts from hospital care, primary care, municipal care and the local university should be linked to the networks. Moreover, it was decided that each network should create specific aims for their own networks (unpublished network document, 2002). In addition, it was agreed that the networks should have a specific focus on the elderly as this group often has complex care needs that appear simultaneously within different parts of the care-chain (Forskningsplattformen för utveckling av Närsjukvård, 2005).

Furthermore, two years after the starting point of the formation of the networks, i.e. in 2004, it was established that the networks should support a local health care restructuring programme called *Integrated Care*[29] (Forskningsplattformen för utveckling av Närsjukvård, 2005). In the local region concerned, the politicians had shortly before this laid down that *Integrated Care* should constitute a linchpin of a new large-scale health care restructuring programme (explained in chapter two) (The Regional Council, 2004). As described in chapter two, *Integrated Care* has been increasingly promoted in Swedish county councils in that it has been considered to offer solutions for a deficient overall view and shortcomings of collaboration in different forms (Anell, 2004; Edgren & Stenberg, 2006).

Meta-Network Activities

The meta-network meetings took place from three to five times a year (a higher number of meetings in the beginning) and lasted in most cases half a day. The facilitator of the meta-network usually started off the meetings by letting the coordinators of the networks in turn present the respective network achievements accomplished since their last meeting. The facilitator also usually highlighted new national guiding principles or tendencies and local directives she had come across, for example from her participation in managerial meetings. The remaining time normally was spent on the sharing of experiences between them and discussions on future network development and measures to be taken. On certain occasions, lecturers were invited to the meta-network meetings to present experiences or methods that were of general interest amongst the coordinators. On one such occasion, the coordinators were trained in three practice-oriented dialogical methods in which patient cases constituted the starting point to support learning. The idea behind such occasions was to inspire the coordinators in their development work within their own networks.

From meta-network meetings it became obvious that the facilitator and the coordinators of the networks put efforts into advertising the networks in different ways. The newsletters produced are such an example. The newsletters held a

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[29] As stated in chapter one, in this thesis I use the term *Integrated Care* instead of the Swedish term *Närsjukvård* (Huzzard et al., 2010).

preamble written by the facilitator, and summations on network achievements written by each coordinator, and were distributed twice a year to politicians, employers and employees concerned with care in the north-east district of the county council. In addition, the networks have been presented at the website of the largest hospital in the area, accessible to the public. Furthermore, several oral presentations on the network coalition, their purpose and course of action have been given by the facilitator and the coordinators of the networks. For example, such a presentation was held by some of the coordinators at a local research and development day, directed towards line managers and politicians in the area. For this event, a poster was developed, describing the aims and the expected usefulness of the networks. The poster was afterwards circulated between various municipal health care workplaces. Another oral presentation regarding the networks was held by the facilitator and some of the coordinators at a national conference called *Vårdstämman* (In English: The National Care Assembly) in Stockholm.

The coordinators also accomplished network activities collectively. For example, network participants from all the networks were invited to a development day named "To create dialogue and engagement". The purpose of this day was to motivate both coordinators and network participants in their roles and support them in their development work. The person invited to be in charge that day was an experienced lecturer and course-leader. She discussed pitfalls in dialogues with the use of illustrative examples and playful practices, meant to be adopted and used by those present in their roles of coordinators and network participants. Slightly more than 100 people participated during the development day and the event was well evaluated[30]. As the development day was considered successful, a second development day was arranged later on with a focus on communication. From discussions during network meetings some time afterwards, it turned out in fact that the network participants considered the days as inspiring, however, no one had practised the ideas from the days themselves. It was argued that they had not yet had the time to do so.

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[30] The facilitator of the meta-network used a linear scale to evaluate the day, in which nil was equal to bad and ten was equal to very good. The lowest result marked on this scale was four, the highest nine and the median was seven.

Moreover, certain agreements were made between the participants within the meta-network and the steering group that were intended to pave the way for network participants in different ways. For example, to back up the network participants, the meta-network and the steering group agreed to develop a document containing an account of the assignments of the network participants. The purpose of the document was primarily to inform municipal line managers in order to increase their understanding of the networks and hopefully allow network participants time off to participate in network meetings and undertake development work in practice to a greater extent.

In this document specifying the assignments of the network participants, it was stated that the networks were an important part of the development of *Integrated Care* in the area. Likewise, it was established that it was a problem that patients did not always receive care based on the latest findings. The reason for this problem was considered to be that knowledge was not disseminated in a sufficiently active way. It was claimed that the networks were a means to handle this problem, which implied that the network participants needed support from their line managers. On the role and function of the network participants, it was laid down in the document that the network participants should work for national and regional guiding principles to be put into practice and that guiding principles were to be developed and established at workplaces and amongst the management. The network participants should also create their own networks at their workplaces.

Moreover, it was expressed in this document that the network participants should be given opportunities to actively take part in network meetings, to acquire advanced knowledge, and be given opportunities through courses and conferences to follow developments within their specific subject areas. In addition, it was stated that the network participants should continuously evaluate guiding principles and guarantee their quality. They should also take responsibility for their own needs of training and the dissemination of knowledge, and continuously pass on information about innovations and encourage others in dissemination and the search for new knowledge (unpublished network document, 2007). The facilitator of the meta-network presented this new document at a meeting with the registered

nurses with a specific overall medical responsibility in relation to nursing, and at a meeting with heads of administration, both held within the municipalities. She also asked the participants in the meetings to distribute the document to municipal line managers at a local level. The facilitator asserted that the document was met with a positive response.

The Facilitator of the Meta-Network's Perspective

As mentioned above, it was the facilitator of the meta-network who was the initiator of the networks. It was in her professional role which entailed a responsibility for the hospital's collaboration with the municipalities that she had identified a need locally for increased collaboration between sectors. In addition, she had recognised that the municipalities due to a faster throughput of patients at the hospital now had to take care of patients at an earlier stage in the care chain. The facilitator argued that this circumstance involved a need to communicate research and development between the two care providers. In the facilitator's own words:

> *I have a specific responsibility for the* [hospital's] *collaboration with primary care and municipal care; it is one of my main assignments. And I saw the need from the position I have. The throughput* [at the hospital] *increased, the hospital beds became fewer and technological advances occurred faster and faster. We operated more quickly, and more work was carried out on an outpatient basis. Patients who had been here for weeks now went home after three to five days. Anyhow, I saw a need to create some opportunities between hospital care and municipal care where we could communicate about research and development with each other and explain why we works in a certain way and so on. And in 2002 we created the networks. (The facilitator of the meta-network)*

The facilitator argued that the need for increased collaboration that she identified had links to the implementation of the *Community Care Reform* in 1992 (described in chapter two). Through this reform the responsibility for long-term in-patient health care and social services regarding the elderly and disabled, including payment of costs, was transferred from the county councils to the municipalities (Edebalk, 2008; Hjortsberg & Ghatnekar, 2001; The National Board of Health and Welfare, 2007). As the facilitator put it:

> *Around 1991 I was asked by the hospital to take responsibility for the implementation of the Community Care Reform, which was this huge upheaval in which the municipalities took over a completely different responsibility. I established contact with the municipalities in order to bring this change to such a successful conclusion as possible. In this implementation process I saw the need to do something that made the municipalities get a better chance to nurse the patients. Together we saw that something was missing and began to reflect on how we could help to bridge the gap between us. (The facilitator of the meta-network)*

The facilitator explained that there was a need to transfer medical competence from the hospital to the municipalities, but she also emphasised that the transfer was intended to take place in both directions. She described her thoughts on this as follows:

> *It was mostly about transfer of medical competence, but it was not just about transfer from the hospital to the municipalities, it also took place in the opposite direction. It was also about the understanding of what it is like to be in a specific context, the understanding of why you are exposed in different ways when working alone as a nurse within the municipalities and so on. So, as I said, I got the mission to be the hospital's representative in implementing the Community Care Reform. And as I am a fairly practical person, I tried to build bridges to the nurses with a specific overall medical responsibility in relation to nursing within municipal care and to other strategically important persons. After a while we saw that it became more and more complex. I thought that we must build something that makes the daily routines and the reporting of information between us work. And then I thought that we needed to find something that allowed us to help each other, which led to these networks. That is how it started. But of course, there was quite a lot of preparatory work and not so many networks from the start. (The facilitator of the meta-network)*

The facilitator of the meta-network did not just bring forth the idea of creating the networks, she was also the driving force in the build-up phase and in the continuing development work. At an early stage, she assembled representatives from the three tiers of care, i.e. from hospital care, primary care and municipal care, which became a preliminary steering group. After initial discussions, this group formulated the overall aims of the networks (presented above) and identified suitable network areas that to a great extent were based upon problems that the representatives from the municipalities had experienced. As the facilitator expressed it:

> *I brought together representatives from the municipalities, primary care* [refers to qualified homecare services] *and the senior consultant from the*

> *hospital. You could say that it was the embryo of the steering group. We discussed what we should do, and it was in this process we laid the foundation of the overall aims of the networks. Then we started to identify subject areas that we thought were particularly urgent. The representatives from the municipalities had to say what they thought they had problems with. Well, it was Nutrition. Patients were malnourished, they were dehydrated, all those things. And so it was Ulcer. There were many problems with leg ulcers too. And then it was Pain, chronic pain and existential pain amongst the elderly. It was Palliative Care. We had just launched qualified home care services, and this meant that the municipalities had to nurse more patients in palliative care out there. And documentation. Then we had Hygiene. Hygiene issues became more and more urgent within the municipalities and I considered it to be a strategic area in which the municipalities needed a lot of support. Therefore, we put a hygiene nurse from the hospital to lead this network. Next were Drugs and Elderly, because we had a lot of problems with the elderly getting too many drugs and all that. And after a couple of years we also included Psychiatric Rehabilitation as the municipalities had a lot of problems with it. Mostly it has been the municipalities that have brought forward subject areas that they did not think worked well. (The facilitator of the meta-network)*

On the issue of the recruitment of network coordinators, the facilitator described that she had been anxious that the coordinators should be recruited not only from the hospitals, but also from the municipalities. However, above all it was those with competence and willingness who were of interest. She described her thoughts on the recruitment process as follows:

> *I have been anxious that not all networks should be managed from the hospital. But of course, Palliative care needs to be managed from the palliative unit* [i.e. the hospital] *because they are the one who have most knowledge of it, and I do not think there is anyone else who wants to lead it. And we put the responsibility for the Hygiene network on our hygiene nurse, because we thought that she needed to lead it, and so on. It is about where the competence is and where there is someone who is willing. After all, it requires that you should follow research and development and that you have the energy to catch up research issues and such things. A good person is very important. If it is a person who understands all this, maybe it is not necessary to know everything about the specific subject area. (The facilitator of the meta-network)*

As stated, the majority of the networks included teachers from the local university, who were expected to constitute a link between scientifically generated knowledge and practice. The facilitator had encouraged this idea as she considered the university teachers to be important in supporting research activities. In her own words:

> *I have been arguing that people from the university should be part of the networks. I thought they could support research activities, review articles, search for new research and so on. With the force of their competence they can be a support in this respect. (The facilitator of the meta-network)*

As to the resources devoted to the networks, the facilitator argued that she had good possibilities of supporting the network coordinators if they wanted to. She reasoned as follows:

> *We from the steering group have never placed financial obstacles in the coordinators' way. If the coordinators considered there was a need to do things or to go somewhere, it has been practicable. In the beginning I got 100.000 SEK as a disposable sum from the politicians, or 200.000, I cannot remember which. But the money lasted for quite a long time. So I have paid for some books, study tours and conferences and things like that. And in recent years I have been able to support them again because I am responsible for governmental funds consisting of some millions of SEK. Well, I cannot support them with large sums of money, but if I would like to add 50.000 to 100.000 SEK one year, I can do it. So next, I will try to collect money for a study tour to Denmark for the coordinators. (The facilitator of the meta-network)*

Moreover, as described above, the facilitator role involved the responsibility for facilitating the meta-network meetings and for supporting the coordinators and the network development. The facilitator described her role as follows:

> *The networks' processes need to be nourished and supported, and I have been an engine in that process. My role is to listen as well as to find forums where they could be nurtured and supported. During each meeting, everybody* [i.e. the coordinators] *gives an account of what they have done since our last meeting, if they have any problems and so on. (The facilitator of the meta-network)*

She argued that the facilitator role also included looking for national guiding principles and to be updated on what was going on within the field of care for the purpose of supporting the coordinators of the networks. She explained it in this way:

> *My role is also to look for things: "What is going on within the field of care today? What will come next?" There are plenty of national guiding principles coming regarding all kinds of care, for example stroke, and the coordinators have to know that these exist and use them to back them up in their work. I copied this one today: "Your duty to inform and make the*

> *patient involved. Handbook for health care providers, operation managers and practitioners." I will bring it up when we meet next time. (The facilitator of the meta-network)*

In addition, the facilitator considered it important to make use of her own contacts with the intention of advertising the networks, which appears from the following extract from the interview with her:

> *R: Since I am responsible for the hospital's collaboration with the municipalities and with primary care, I lead lots of other meetings as well, for example meetings with senior consultants and nurses with a specific overall medical responsibility in relation to nursing within municipal care. For example, every time I have meetings with the heads of administration within the municipalities, they are six in number, I bring up the networks and declare how important it is that they support them. I also ask them to bring the networks up for discussion when they in turn meet their business managers.*
> *I: Do you think it leads anywhere?*
> *R: They are very positive when I bring it up: "Yes, of course we want this." The nurses with a specific overall medical responsibility always participate in these meetings, and one of them is always very good at laying stress upon the value of the networks and how the municipalities benefit from it.*
> *I: So you use these opportunities to...*
> *R: You bet I do! I have the channels. It is about seeing the context and understanding the value of it. (The facilitator of the meta-network)*

This chapter has addressed an introductory overview of the nine networks involved in the present research project, including the overall aims of the networks. It has also presented the facilitator of the meta-network's perspective of the network formation and the continuing build-up phase. The next chapter presents the perspectives of the coordinators of the networks on the role of the networks and their ways of working.

7. The Network Coordinators' Perspectives –Stage One

The present chapter embraces stage one of the collaborative inquiry process undertaken (the whole process is described in chapter five), which contains the perspectives of the coordinators of the networks on the role of the networks and their ways of working. The chapter is divided up into four sections based categories intended to reflect the essential content of the data obtained. These categories, empirically grounded as explained in chapter five, are:

-The Unclear Link to Integrated Care
-The Quest for Knowledge Transfer and Evidence-based Practice
-Concerns about how Knowledge Transfer Worked in Practice
-Expert Guidance

The last section in this chapter embraces the feedback and dialogue sessions undertaken as a part of the collaborative inquiry process during this first stage of the research, and what emerged from these.

The Unclear Link to Integrated Care

As stated in the previous chapter, two years after the starting point of the network coalition it was established that the networks should support the development of the local health care restructuring programme called *Integrated Care* (described in chapter two). The coordinators of the networks were asked during the interviews about their ideas on the relationship between the networks and *Integrated Care*, as their ideas on this relationship might have influenced the networks' development. It turned out that most of the coordinators had an unclear idea of the tenor of this health care restructuring programme. One of the coordinators reasoned as follows:

> *Well..., I think it is very difficult to tell, I must say... I do not even believe that those who decided on it* [i.e. on the implementation of Integrated Care] *know yet what it means themselves... (Coordinator no. 3)*

And in another coordinator's words:

> *I remember that we were asked during a meta-network meeting to relate integrated care to our work within the networks, but I am not sure whether*

> *we succeeded... I think integrated care means different things to different people. (Coordinator no. 2)*

It appeared that a majority of the coordinators considered that the programme *Integrated Care* had a subordinated role in the networks' achievements. As explained by one coordinator:

> *We do not chiefly support or even think of Integrated Care within the network, above all we work for a third party, i.e. the patients. (Coordinator no. 5)*

However, in spite of a general uncertainty of the tenor of this programme and its relation to the networks amongst the coordinators, they had varying opinions of it, some of which were sceptical. For example, one of the coordinators argued that *Integrated Care* was just a way for the county council to transmit responsibility from hospitals to municipal care, and instead of being a matter of quality was an economy measure:

> *From my point of view, Integrated Care does not start out from a vision to produce qualitatively better care, but from a wish to make care cheaper. The municipalities will have to take care of tasks they do not have resources for today, and will not be allocated extra resources for it either. The emperor's new clothes, that's what it is all is about. (Coordinator no.8)*

On the other hand, another coordinator seemed to be more convinced of its relevance. Without being detailed, she regarded the networks as a response to ongoing discussions in society about networks and *Integrated Care*, which the following extract from the interview illustrates:

> *R: This* [i.e. the networks] *really emerged as something that is characteristic of the times!*
> *I: What do you mean more precisely?*
> *R: Just that one has begun to talk about these things in society, networks and Integrated Care and all this, and you can see these networks as a part of that. (Coordinator no.4)*

The relationship between the networks and the health care restructuring programme *Integrated Care* was very occasionally brought up for discussion during the meta-network meetings, yet, this relationship was highlighted in other ways. For instance, a while after the decision to link the networks to the

development of this programme, the facilitator wrote in a newsletter[31] that the networks were now well established in their important roles as development agents of *Integrated Care*. However, apparently, as to the coordinators, they seemed to have relatively vague ideas of the meaning of this programme and of its link to the networks. Underlying explanations why the networks were linked to *Integrated Care* will be discussed in chapter ten.

The Quest for Knowledge Transfer and Evidence-based Practice

The coordinators generally described the transfer of knowledge into practice as the most important aim of the networks, principally since it was believed to increase the level of knowledge amongst practitioners and be of benefit to the patients. In one of the coordinator's words:

> *What we aim at is that knowledge is transferred to different levels within the municipalities, to hospital wards... and that patients and clients will benefit from it. The fact is that this is the way one would wish it to work. (Coordinator no.12)*

Another coordinator expressed a similar view in this way:

> *Working in networks provides possibilities of developing different issues, getting it established in a way, and communicate it to actors in the different arenas. It's like circles on the water. The networks' achievements give more dignity and weight to this process, which is valuable. (Coordinator no.11)*

However, it was commonly believed among the coordinators that they first and foremost had to increase the level of knowledge within the networks and thereafter continue with the transfer of knowledge. As one of them expressed it:

> *First of all, we want to increase competence within the group and then share it with all the others. When we meet we try to discuss patient cases and pictures and so on, and if someone has been away* [refers to conferences etc.], *we share research results and new ways of thinking. We inform each other of our experiences, I bring the latest news from The National Board of Health and Welfare, we hand out material and have acquired some textbooks. And we have taken part in courses and so on. So*

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[31] As stated in chapter six, the newsletters have been written by the facilitator and the coordinators of the network and have been focusing on the networks' achievements. The newsletters have been distributed twice a year to politicians, employers and employees concerned with care in the area.

> *what we do is to create a core group who feel that our subject area is a topic we can handle. And the network is a way to spread this, preferably far out. (Coordinator no.2)*

Yet another coordinator stated that the low level of knowledge within her network had surprised her, which she considered as an argument for focusing on internal knowledge development as a first step in the process of knowledge transfer. She explained:

> *I thought that the level of knowledge was higher than it was within the network, and such things take time to build up. Those who participate in the network are trained nurses* [refers to municipal nurses], *and it ought to be part of their training to know such things, basic stuff, because that is what it is about. And it has surprised me that they have nothing* [knowledge of the subject area]. *Therefore, we strive to raise their level of knowledge, and then maybe we can start to look at what more we should do. So I look upon this as a very long-term process. (Coordinator no.3)*

Accordingly, the coordinators considered it important to invest a great deal of time and energy in internal knowledge development. A common way to realise this intention was through the arrangement of lectures. Most of the networks invited lecturers to their network meetings on a regular basis who were experts on a specific topic. Those who were invited could be for example researchers, physicians or practitioners with specific experience. It was generally considered to be an advantage to invite lecturers who had a PhD, as their ability to analyse and answer questions from a researcher's point of view was regarded to be of a high standard. However, the coordinators considered it important not only to increase their own competence, but also increase competence in practice. It was frequently argued during meta-network meetings that the level of knowledge varied a great deal amongst front-line health care workers. However, the standard was generally considered by the coordinators to be lower within the municipalities in comparison with the hospitals. To increase competence within the municipalities, some of the coordinators wished that they themselves or their network participants could function as local advisers, which appears from the following quotation:

> *Almost all of it is about increasing the competence of everybody who works with the subject area our network focuses on, and that we have a good communication. Practitioners should have the possibility to call me or one of the network participants and ask: "Hey, now it's like this, do you have*

> *any ideas?" Maybe then I can strengthen them in their way of thinking or present a new angle. I believe that this kind of communication is really important, so that they don't stand there within the municipalities and feel insecure and think: "Well, I'll do it in this way then". (Coordinator no.7)*

The same coordinator was convinced that if they increased competence in practice and took advantages of research findings, it would be of benefit to both patients and health care economy. In her own words:

> *I'm convinced that this* [i.e. the networks] *is a very good thing both for the patients and for the health care sector as it can spare the patients suffering and one can save money in addition. Partly by taking advantage of research results, partly by increasing competence amongst everybody out there. (Coordinator no.7)*

A number of the networks chose to develop files with facts and instructions, intended for knowledge development in practice. The Hygiene network for example, developed a file named "Methods for hygiene-procedures", which included instructions for basic personal hygiene routines, methods for how to handle resistant bacteria and instructions on how to handle cuts without transmission of infections. These instructions already existed in a computer-based variant, but as not all places of work had access to computers, this project was in demand by the network participants. The Drugs & Elderly network and the Ulcer network developed files containing information about their specific subject areas as well, intended for use in practice. One of the coordinators described the purpose of the file that her network had developed as follows:

> *The intention of the file is to increase competence out there, so that the practitioners can very easily get information: "Okay, now I have this particular problem, what does the file say about it?" (Coordinator no.7)*

Moreover, it was regarded by most of the coordinators as advantageous to knowledge transfer if the network participants created their own sub-networks at their workplaces. As one asserted:

> *My vision is that they* [the network participants] *should have networks at their local workplaces to spread..., well, whatever it is, measures to be implemented or such things. And my network has such a network at the hospital. For example, ideas that emerge from that network could be addressed in the overall network, and the other way round. It may be things*

> *we have worked with in the overall network that I bring down to the network at the hospital. (Coordinator no.9)*

The facilitator and most of the coordinators looked upon national policies and guidelines as standards for quality and reliable sources of information. It was considered as an important role of the networks to scrutinise and concretise such policies and guidelines and transfer the results of this work into practice. In addition, one of the coordinators stressed the importance of striving for standardisation between the responsible organisations. In the coordinator's words:

> *One of the most important measures as I see it is that we try to establish uniform routines within the hospitals and the municipalities. For me as a coordinator, it has the first priority. (Coordinator no.9)*

Furthermore, it was generally considered favourable to the networks' development to involve teachers from the local university in the networks. For example, it was argued that the teachers could provide the networks with research findings that the network participants in turn could transfer into practice. As one coordinator asserted:

> *We have representatives from the university within our network, and they are supposed to contribute with research reports and the latest findings and things like that. What I mean is that they can contribute with new information, and the network participants can convey it further to nurses and nursing assistants in practice. (Coordinator no.5)*

Most of the coordinators asserted that the networks' connection to the local university provided more weight to their achievements. As explained by one coordinator:

> *The fact that we now have participants from the local university to assist us and help us a little bit with the newest on the research front and so on gives more weight to our work. (Coordinator no.6)*

Moreover, the facilitator of the meta-network highlighted the networks' connection to the local university as well. In one of the newsletters she wrote that the networks

had an important collaboration with a research group at the local university[32], which she claimed increased the possibilities for the networks to hold research in focus. It was generally emphasised by both the facilitator and the coordinators that their various efforts should be grounded on research findings instead of on their own ideas on the best practice. For example, in the abstract to the presentation held by the facilitator and some of the coordinators at the national care assembly (mentioned in chapter six), the presenters stated that methods and ideas on good ways to act that were implemented into practice should be in line with research evidence and thoroughly tested experience. The importance of scientifically based knowledge was also stressed in the interviews with the coordinators, which the following quotation demonstrates:

> *It has been fun, as the network participants have been so enormously enthusiastic, their eyes have really been shining with enthusiasm. And there is one who has written to me: "I learn so much, this is fun" and so on. But sometimes they become too impulsive. It is important that it is scientifically based, instead of:" I consider it to be best in this way." But the network participants receive lots of information from me, articles and so on, and on up-to-date methods. (Coordinator no.3)*

Another coordinator phrased the importance of starting out from research findings as follows:

> *For me as a coordinator, I consider it important that measures and things we strive to implement have a scientific base. For instance, there are new national guidelines on our subject area that are based on research, and the criteria we* [within our network] *now implement are adjusted to these guidelines. They are evidence-based, basically. (Coordinator no.9)*

The two coordinators who were researchers regarded it important to use their competence to undertake large-scale research projects in collaboration with network participants and practitioners at hospital wards and special forms of housing for the elderly. For example, the coordinator of the Nutrition & Eating network accomplished such a large-scale research project on the weight of the elderly with the purpose of determining nutritional problems. The coordinator of

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[32] The facilitator referred to the cross-disciplinary research group at *Kristianstad University* that I was a part of.

the Ulcer network accomplished a research project in collaboration with the Hygiene network on consumption of hand-washing liquid in hospital wards. Both coordinators who were researchers were convinced that such studies would lead to better care and increase the level of knowledge at workplaces. As one of them stated:

> *I believe that research plays an enormously important role within the networks. And I think that the way in which we have worked, i.e. through collection of a large amount of data and accomplishment of surveys in which many people have been engaged, has been successful actually. It has led to a kind of play down of research. It is not just something you work with in a chamber, it is everyday research that leads to better care. And everyone is involved. Every living soul on every ward, in principle, is aware of these studies and they work with us in different ways so to speak. I think that is important. (Coordinator no.12)*

The other coordinator who was a researcher planned a large-scale survey and following that, implementation of guiding principles for measures to be taken in practice. As voiced by the coordinator:

> *The roadmap for our network is actually divided into two stages. The first stage is that virtually all patients should be assessed. The second stage will be to create guiding principles for measures to be taken when they* [the practitioners] *find patients who do not meet up with the criteria. If we implement these guiding principles and have fixed criteria for measures to be taken... I am convinced that it will be of benefit to the patients. (Coordinator no.9)*

An argument used for the accomplishment of large-scale research studies was that these could bring forth facts that could be used to put economic pressure on politicians:

> *All managers are under pressure today when it comes to economy, but if we can demonstrate in any way that by use of this kind of network you can provide the agencies with something, it will finally provide the managers with financial incentives. But to influence politicians you need facts, and that is what we have started with, not least in the study that will be accomplished this autumn, which will be very important. (Coordinator no.12)*

The network participants and practitioners had primarily the role of data collectors in the research studies mentioned above, but were also involved in dialogue sessions facilitated by the researchers concerning the research results. One of the

coordinators emphasized the importance of the involvement of network participants in the extensive research work as follows:

> *Our last meeting was much of an information meeting, because we are facing this large study, and they* [the network participants] *have to help with it. But they are very interested in getting involved. So therefore we discussed a lot about it, and very good viewpoints emerged as well. (Coordinator no.12)*

The research projects mentioned above were widely acclaimed in contexts in which the networks were presented, for example in the newsletters produced. The facilitator of the meta-network pointed out in one of these newsletters the fact that two of the coordinators were researchers, which she established was advantageous to all networks. In this connection, she also wrote that patients and their relatives had the right to require that care was based on research findings and thoroughly tested experience.

Consequently, knowledge generated from research was generally highlighted in different contexts. However, by contrast with the other coordinators, one argued that she kept a lower profile on research within her network, at least for the time being. In the coordinator's words:

> *We have not yet discussed how research will get involved in this network. In our network we are more interested in the practical sides of our subject area. As I see it, the network should emphasis development more than research at the moment. (Coordinator no.11)*

The reason for this particular network keeping a lower profile on research was that they focused on ethical values, which the coordinator considered a difficult subject to concretise:

> *It is the ethical and moral matters that have formed the basis for our approach and, above all, respect for patients' needs. It is soft prestige words that are so difficult to grasp. The next step for us to deal with could be: "How do we get there?" and "What do we do to keep this subject constantly alive?" (Coordinator no.11)*

The same coordinator claimed that ethical values could be interpreted as being a bit fuzzy as they did not fit into measurable frames:

> *I think it is important that you constantly get trained in ethics and morals and soft issues, because the technical issues take place all the time anyway. One difficulty is that they* [ethics and morals] *do not have a clear framework but instead slightly permeate everything. It can sometimes be perceived as a bit fuzzy. It is not a square you lift from one place and put into another. It is not a connection you put into another connection, right? (Coordinator no.11)*

To sum up, the main features in this category were that the coordinators primarily regarded the networks as the transferrer of knowledge into practice. Their strategy was first to increase the level of knowledge within the networks and then continue with knowledge transfer, for example through the creation of sub-networks in practice. In addition, most of the coordinators considered it important that their achievements started out from knowledge generated from research.

Concerns about how Knowledge Transfer Worked in Practice

From the interviews, it appeared that the coordinators expected the network participants to transfer knowledge into practice. However, it turned out in fact that not all network participants had yet started. Some of the coordinators described that they had brought this matter up for discussion during network meetings within their own networks since they considered it a problem. In one coordinator's words:

> *Some network participants had made more progress than others, some had not yet really started* [to transfer knowledge]. *I brought it up for discussion last time we met, and I have planned to bring it up again when we meet next time, because it is very important that what comes up here in this network... that it does not just stay between us. It is better if they find representatives at the different workplaces and spread what is important to them. (Coordinator no.4)*

And in another coordinator's words:

> *I have told them* [the participants of the networks]*: "You must arrange it and do it as you wish. You have the responsibility for it* [the knowledge] *to reach your areas. That is your responsibility." (Coordinator no.7)*

In fact, several coordinators had concerns about whether knowledge was actually transferred into practice or not, which is demonstrated by the following extract from an interview:

> *I: Do you know anything about how the network participants are working in their turn? Do they transfer what you have dealt with in the network in any way?*
> *R: Yes, I hope so, but I feel that this is an area I need to know more about.*
> *I: You don't really know how they work then?*
> *R: No, I don't. That's a question one can raise within the network: "How do you transfer information?" (Coordinator no.11)*

Another coordinator admitted that she was not conversant with what the network participants actually did in this respect outside the network meetings, but argued that she had to have confidence in them being active:

> *As a coordinator you have to rely upon the participants of your network; that they transfer knowledge to their colleagues, to nursing assistants, to everyone. (Coordinator no.1)*

It was argued that each participant within the networks had to take responsibility and not stand back or remain passive:

> *I believe in our way of working, I really do. But everybody who is part of the network does have a responsibility. I think it is something that should be put forward a bit more, not least from a central level. The network is not something you just go to and think is nice and learn some new things from. And take part in discussions and present your own opinions... This is something that you are responsible for, to carry it further. (Coordinator no.12)*

In another coordinator's words:

> *It is important that everyone tries to prioritize the network. During the last meta-network meeting signals came from all coordinators that the network participants have to prioritize this and set aside time in their everyday work. (Coordinator no.11)*

In addition, it turned out to be the case that some of the coordinators felt frustrated about the passivity amongst the network participants. As one of them asserted:

> *I feel that some of the network participants come to the network meetings just to get things served in some way, that they just come to get training without giving much back. That is what I find hard sometimes. (Coordinator no.6)*

The same coordinator sometimes felt that she would like to put more pressure upon the network participants:

> *Sometimes I feel that one cannot be too nice ... sometimes I would like to put more pressure upon them* [i.e. the network participants]*: "Now you have to perform something out there too." But I know what it is like within the municipalities, they are under pressure and have simply not time enough. (Coordinator no.6)*

The wish to put more pressure upon the network participants was expressed by another coordinator as well:

> *Perhaps you should tighten the reins and say something like: "Now you have to ..." I mean steer a bit more so that something actually happens after the meetings. That is what I think. And maybe you should consider if there are the right persons within the network, who are prepared to accomplish the extra work that is needed as well. (Coordinator no.12)*

Besides, it appeared that there was also an uncertainty amongst some of the coordinators about what was needed for the knowledge transfer to have an impact in practice, which the following extract from one of the interviews demonstrates:

> *I: How do you look upon the possibilities for your network to have an influence on practice?*
> *R: I think it's possible, but it will take time and require a lot of work.*
> *I: Do you believe in this way of working?*
> *R: Yes I do, but I'm afraid that instead it will just be a lot of meetings. That it's comfortable to get a break from work and think: "This was really exciting." But, it also requires that things will be implemented so that there will be an effect of the whole thing. It's a process, but processes most move forward. I'm a bit critical as you can hear.*
> *I: Yes. What is needed to get an effect then?*
> *R: Well... what is needed? Well, if I knew, it would only be to do it. (Coordinator no.3)*

However, a problem that was recurrently brought up for discussion during meta-network meetings was that the network participants had insufficient time, space and resources to take action at their own workplaces on knowledge transfer. Considered most problematic was the municipal line managers' lack of understanding of the value of the networks and their lack of support for network participants in their fulfilment of the networks' mission. As one of the coordinators claimed:

> *If something really is to happen at the workplaces, it is very important that you have managers who understand what this is about. And I would almost say that above all, it is most important that they understand and are willing to support and facilitate the network participants. It is very important that the network participants have mandate at their workplaces and that someone is asking for what they bring up and what they want to change. And this is a matter we have not yet really solved... (Coordinator no.12)*

And as voiced by another coordinator:

> *There are some network participants who say that they have difficulties in getting time off from their workplaces to attend our meetings. And I think it is a pity, because then maybe their managers have not understood the point of it. We have problems with this, and it's not just in our network. There are other networks who say this too that they do not quite understand what we do. (Coordinator no.5)*

An explanation that some of the coordinators saw for the problems described above was that several municipal line managers were not trained in nursing. The coordinators felt that this circumstance implied that the managers had a lack of understanding of the whole network idea. One of them expressed this viewpoint as follows:

> *It is not just that we should say hello, have coffee and go through what we have done and so on during our network meetings. The network participants must have opportunities to do things out there too. And this is a problem. When it comes to the municipalities, it is not certain that the line managers have medical training, which means that they do not understand what this will be good for. (Coordinator no.3)*

Furthermore, another concern regarding the transfer of knowledge brought up for discussion during a meta-network meeting was the difficulty to form a link between theoretical knowledge generated from research and practice. During this meeting, one of the coordinators argued that her experience was that practitioners learn much more from situations connected with practice, such as discussions about patient cases (cf. Boge, 2008; Engström, 2001; Larsen, 1999). During the ensuing discussion, other coordinators argued that practitioners do not have the opportunities to adopt research findings themselves. Finally, it was concluded that the role of the networks had to be to sorted out and transfer research findings into usable practice. A similar standpoint was given during one of the interviews:

> *That is the reality. They* [practitioners] *are not able to absorb all this material* [research findings], *and well, they do not have to either. There must be others who extract and filter the knowledge that is needed. (Coordinator no.12)*

Yet another coordinator argued that knowledge generated from practice was useful, but not as valuable as knowledge generated from research (cf. Callewaert, 1999a). Therefore, she argued that it was important to find ways to reach out with the knowledge that is needed in practice. In her own words:

> *But that does not mean that there is not very much important knowledge that is generated close to the patients. But that is more of case description character, which must be related to larger studies that present tendencies and how to respond to these. As a practitioner you maybe just treat a few patients a year, compared to research results that maybe elucidate 500. But you cannot expect that people that are up to their ears in handling things in their practical work concerning the patients also should sit down in the evenings and read specialist literature from all over the world. They cannot. So that is why one must try to find ways to reach out with the knowledge that is needed at the different care levels. (Coordinator no.12)*

One of the coordinators had implicitly pointed out that knowledge had to be given meaning in context (see for example Cook & Brown, 1999), and be incorporated to make sense (see for example Bourdieu,1990a; Callewaert, 1997):

> *If they* [practitioners] *do not have the understanding themselves they just do what they are told to when they are watched. They have to understand it and it must come from themselves. (Coordinator no.3)*

In conclusion, the main concern amongst the coordinators was whether knowledge was actually transferred into practice, which included doubts about what the network participants actually did in this respect. In addition, a certain extent of uncertainty emerged of what was needed to make the process of knowledge transfer work. A limitation that was experienced was municipal line managers' lack of understanding of the whole network idea. It was also considered a challenge to link theoretical knowledge generated from research to practice. The coordinators' linear approach to knowledge transfer and their concerns about how it worked out was dealt with during the feedback and dialogue process described in the last section in this chapter and will be further discussed in chapter ten.

Expert Guidance

The coordinators' view of their own role of being coordinators of the networks was in general seen as being supportive to network participants in their training. It was argued as important to make the network participants feel that their efforts were valuable and led to increased knowledge and progress. As explained by one of the coordinators:

> *Well... it is to keep up interest... to encourage the actors within the network so that they feel that this is fun and important, and that they might see themselves as becoming more skilled. That they can see that it actually leads somewhere. Because this requires real enthusiasts, or those who have a specific competence or a specific interest so to speak. What I can do is to stimulate and support them and encourage them to go on. (Coordinator no.7)*

Another coordinator described herself as a catalyst, inspirer and guarantor for quality within her network. In her own words:

> *Well, a kind of a catalyst and someone who inspires, that is what I am, I guess. I feel that a network is quite dependent on there being a person who leads and inspires. Because this kind of network can easily be a backwater if you do not supply it from without and open it up to bigger watercourses so to speak, and that's what I think I can do. (Coordinator no.12)*

It also emerged that the coordinators generally felt strong individual responsibility for the networks and what came out of them. One comment on this was as follows:

> *I feel it is very dependent on me that something good will come out of this network. (Coordinator no.7)*

Another coordinator put it in this way:

> *It is a lot of work indeed. It means planning, and I keep most of it together myself. Sometimes we have external lecturers, or maybe I have been away on training, and then I put it all together and talk about it at our meetings, and then we discuss it... (Coordinator no.6)*

Some of them argued that their role was to be responsible for their network's efforts being scientifically based. One expressed this viewpoint in the following way:

> *I would describe my role in the network as a convener and the one who keeps it together and maybe the person who sometimes straightens out things. I have to take responsibility for the information within the network so that it remains within reasonable limits, so that they* [the network participants] *do not turn to websites as the students do sometimes. It must be scientifically proved. (Coordinator no.3)*

Furthermore, several coordinators described their role as being a knowledge resource for their networks. One of them stated:

> *I feel very much that what I contribute to this network is... well, knowledge. (Coordinator no.2)*

In this respect, based on a question about which professional groups that were missing within the networks, it appeared that one of the coordinators did not miss anyone, but instead felt confident in her own competence as a researcher. This standpoint is illustrated in the following extract from the interview:

> *I: Is there any profession you lack within the network?*
> *R: Maybe a physician, but... I'm not entirely sure whether that is necessary. It may be that you need to consult them, but I feel that it works very well anyhow. Also, with my experience as a researcher, I think that I have quite a lot of knowledge myself to contribute to the network, so... (Coordinator no.9)*

However, based on the same question, several coordinators stated that they lacked physicians in their networks as it would back up their achievements. As one coordinator explained:

> *A recommendation receives far more weight when it comes from a doctor. (Coordinator no.1)*

Nevertheless, regardless of the coordinators' confidence in their own and other experts' competence, it was evident that most of them made efforts to combine expert guidance with the network participants' participation in the decision making processes, which the following quotation illustrates:

> *Well, my role as coordinator... of course, I have to benefit from the knowledge that I have, but I want the others to be in the boat too. I could have told them: "Let's do this and that", but I don't want it to be like that.*

> *Instead, I say something like: "There are national guidelines that have been developed. What do you think of these guidelines?" In that way I try to get them on board. (Coordinator no.9)*

Because of some uncertainty they felt at times in their roles and regarding the networks' direction, most of them considered that the meta-network meetings were valuable. These meetings offered possibilities for them to discuss problems and learn from each other and also to gain recognition for what they did. In one of the coordinator's words:

> *It is stimulating to meet everyone* [within the meta-network] *and get fresh ideas about how to continue and receive confirmation that you are on the right track. I think it is useful instead of just keep on working in silence. You need to get together and reflect on how to proceed, make a point of departure, take a break and then have another go at it. It is worthwhile, even if everyone has a tight schedule. (Coordinator no.10)*

The coordinators' contact with the steering group that was bound to the networks was also generally appreciated as they felt they gained feedback and support regarding new ideas or when they met with difficulties. The steering group suggested strategies and activities to be taken, which was seen as valuable. One of the coordinators described that she considered that the steering group lent more weight to their work. She expressed these viewpoints as follows:

> *The steering group provides us with the feeling that we have mandate and a mission to accomplish. We have someone behind us to bandy ideas with, and I think that we need that support. I believe that the support from the steering group lends more weight to our work. (Coordinator no.7)*

In conclusion, in this category the coordinators looked upon themselves as facilitators within their networks as well as knowledge resources. They also looked upon themselves as the ones who were responsible for that the networks' efforts were scientifically based. This implied that they tried to combine an expert guidance with the network participants' participation in the different decision-making processes. In addition, the coordinators regarded the meta-network meetings and the support from the steering group as advantageous as it helped them to reflect and it also lent more weight to their achievements.

The Feedback and Dialogue Process within the Meta-Network

From interviews and observations, it turned out in fact that the transfer of knowledge into practice was regarded by the coordinators and their facilitator to be an urgent matter for the networks to handle. It appeared that their idea of how to achieve this vision was mainly built upon a linear top-down approach. In broad outline, their theory of knowledge transfer was that scientifically generated knowledge could be transferred into practice by means of various activities, for example lectures and educational efforts, and thereby leads to desirable changes. However, it also turned out in fact that the knowledge transfer and implementation did not work out as hoped. The coordinators expressed a feeling of frustration that knowledge to a great extent remained within the networks.

These results were fed back to the coordinators during a coordinator meeting, backed up by quotations from the interviews. Following that, a model (fig. 3) was presented that had emerged from the initial analysis. The model was a simplified illustration of the coordinators' theory of knowledge transfer and how to bring about changes in practice: Scientifically based knowledge percolating from the networks, through organisations and their practitioners, finally of benefit to patients and clients. The alternative approach referred to in network and communities of practice literature is that of sharing knowledge horizontally (Bate & Robert, 2002; Goodwin et al., 2004). The intention of presenting the model was to encourage dialogue and reflection round the subject of knowledge transfer. The idea was that engagement in a dialogical process could possibly support further network development (Greenwood & Levin, 2007; Gustavsen, 1992).

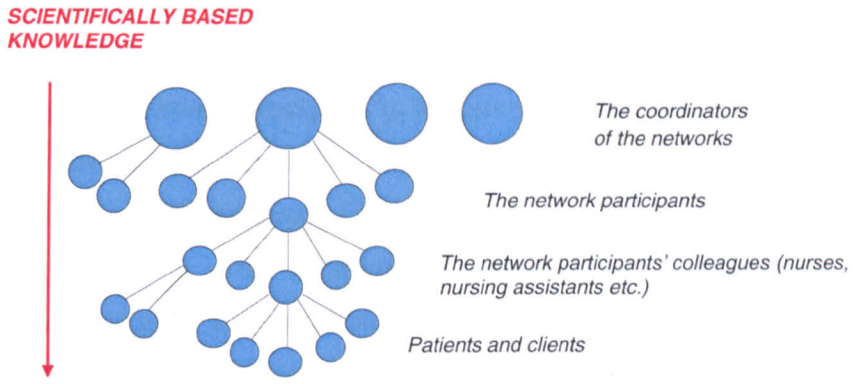

Figure 3: A model generated from the initial analysis of observations and interviews undertaken amongst the coordinators of the networks. The model is a simplification of the coordinators' theory of knowledge transfer and was intended to support dialogue and reflection and further network development.

The model served as a trigger of a dialogical process as was intended. Initially, the model was met with recognition. The coordinators stated that it corresponded to their prevailing theory of knowledge transfer, which was that scientifically generated knowledge could be transferred into practice, built upon a linear top-down approach. They still also considered this to be the best way to bring about changes in practice. However, due to the difficulties they had experienced in this respect, we made an agreement to challenge this view collectively. By challenging routine-like ideas and ways of working it was hoped that reflection and developmental learning would be supported (Ellström, 1996).

Next, more dialogical space was created. During the following meta-network meeting, the coordinators discussed their views of knowledge transfer in small groups and following that in the group as a whole. At this stage, they asserted that people do not learn just from information, they also learn by doing, from discussions with colleagues and from their own experiences (cf. for example Dewey's (1944) emphasis on learning by doing). The coordinators also talked about knowledge in terms of tacit knowledge in contrast to explicit knowledge (cf. Nonaka & Takeuchi, 1995). My contribution to the dialogue was to raise questions about whether knowledge was an object that could simply be transferred, or whether meaning and context was attributed to it (Cook & Brown, 1999). Later on, it was evident that the coordinators started out from the perspective of the

practitioners more clearly during the dialogue sessions than during the observations and interviews undertaken. For example, they suggested that to a greater extent they should support network participants in the use of case descriptions in practice. Gradually, the discussion led to a more multifaceted model of knowledge transfer, implying that the one-way direction of knowledge they emphasised earlier on now became multi-directional. The coordinators' assumptions of knowledge and learning seemed now to be less hierarchical and closer to the sharing ideal outlined in the network and communities of practice literature (Bate & Robert, 2002; Goodwin et al., 2004).

In conclusion, the issue of knowledge transfer was problematized and discussed during two dialogue sessions. In these discussions, the subject of learning in practice emerged. As a consequence, the coordinators asked for a workshop on the subject of learning and its complexity, which was arranged by a senior lecturer from the local university. During the workshop, the coordinators discussed good and bad examples from their own experiences of learning. They also paid attention to different concepts, for example information transfer, knowledge development, dialogue, reflection, context, competence and participation. Issues brought up for the discussions were whether practice could be applied theory or not, and possibilities of learning by doing and relating to theory afterwards. The lecturer focused on knowledge and learning from a socio-cultural perspective, in which the centre of attention is on social and cultural dimensions, including interaction between the individual and society (Ellström, 1996). The coordinators considered the workshop to be interesting and a constructive start for their ideas to practise case descriptions more frequently.

Finally, at this stage of the collaborative process an agreement was made between the coordinators and myself on a continuation of the process amongst the networks Pain, Psychiatric Rehabilitation and Discharge Planning. Focusing on network participants' perspectives on the issue of knowledge transfer was considered to be a move towards an increased understanding of the networks' course of action and support for the coordinators in their understanding of the complex area of knowledge transfer.

In sum, the following emerged from the feedback and dialogue sessions undertaken during stage one of the collaborative inquiry process:

-An agreement was made between the coordinators and myself to challenge the coordinators' prevailing theory of knowledge transfer into practice.

-During the dialogical process, the coordinators' original theory of knowledge transfer was problematised and discussed in a broader way, implying that they highlighted the perspective of the practitioners more explicitly compared to what was the case during the observations and interviews that were undertaken.

-Suggestions emerged to support network participants in the use of case descriptions amongst practitioners.

-A workshop on the subject of learning was arranged at the request of the coordinators.

-An agreement was made on a continuation of the collaborative process amongst three selected networks.

This chapter has presented the network coordinators' perspectives on the role of the networks and their ways of working. It has also described the collaborative inquiry process undertaken during this first stage of the research and what emerged from it. The next chapter focuses on the networks Pain, Psychiatric Rehabilitation and Discharge Planning and its network participants' perspectives on the issue of knowledge transfer. It also includes the collaborative process of inquiry undertaken during this second research stage.

8. The Network Participants' Perspectives – Stage Two

This chapter embraces the results of stage two of the collaborative inquiry process (described in chapter five). This stage involves the network participants of the networks Pain, Psychiatric Rehabilitation and Discharge Planning. As described in chapter seven, stage two was a continuation of the collaborative process with the coordinators and their facilitator in which the complexity of knowledge transfer was highlighted. Focusing on the network participants' perspectives on knowledge transfer was considered as supporting the respective network's development processes, as well as informing the coordinators on the forthcoming process. Exploring the three networks' diverse approaches to knowledge transfer was considered an advantage to the coordinators' understanding of the complex area of knowledge transfer, which after the final feedback and dialogue process during stage three was hoped to be of benefit to the development process of all networks.

The first three sections in this chapter contain a presentation of the results of the data collection within the networks Pain, Psychiatric Rehabilitation and Discharge Planning. Each of these three sections embraces a short background and an account of the aims of the respective network, along with the network participants' perspectives on knowledge development and knowledge transfer. Next, an account is given of the feedback and dialogue sessions undertaken within the three networks. After that, results are presented from the reflexive notes written by the coordinators in parallel with the data collection and collaborative process undertaken with the network participants.

The Pain Network

Background

The Pain network started in 2002 and consisted of approximately fifty network participants. The number of participants varied over time. The network participants were drawn from hospital care, primary care and municipal care. The majority were registered nurses, but other occupational groups were involved including district nurses, physiotherapists, occupational therapists, nursing assistants and social welfare officers. In addition, three teachers from Kristianstad University

were connected with the network to constitute links to research. The network held meetings twice a year, lasting for three hours on each occasion. During these meetings, the coordinator informed about new pain assessment methods for example, and solutions for pain relief that she had come across. She also enlightened the participants on the network's progress. In addition, the network participants presented eventual network achievements accomplished at their workplaces since their last meeting. The remaining time was normally spent at lectures or training, followed by free scope for dialogue.

Pain is a complex area full of nuances. For example, it embraces post-operative pain dealt with at hospitals, pain amongst the elderly living in special forms of housing, pain amongst people suffering from dementia, children's pain and prolonged pain from benign tumours. The participants of the Pain network considered the elderly with multiple diagnoses and complex treatment methods as an urgent target group for their efforts. One of their aims was to promote conditions for competence development and knowledge sharing amongst practitioners along the care chain. The network also aimed to overcome bureaucratic obstacles occurring in relation to pain treatment. In addition, it was established that that the level of knowledge among practitioners on the assessment of pain had to increase. Yet another aim was to strengthen collaboration between health care sectors. It was also established that the network should develop strategies, methods and tools for pain assessment, as well as guidelines for treatment. Knowledge of pain, pain assessment and treatment should be transferred along the care chain to be of benefit to the patients. In addition, in their aims it was stated that treatment of pain should start out from an evidence-based foundation. Finally, the network participants were also expected to acquire evidence-based knowledge and follow developments within the area of pain (unpublished network document, 2004).

Focus on Internal Knowledge Development

The Pain network devoted much energy to internal knowledge development. The coordinator of the network had observed that the level of knowledge amongst the network participants varied and had to be improved, so that they in turn would be able to train practitioners at their own places of work. After a period of exchange

of ideas between the coordinator and network participants on how to handle the matter of knowledge development, the coordinator came into contact with a project managed from one of the hospitals in the area, embracing opportunities to take part in a web-based learning exercise. This contact led to the initial line of development now being included in a pilot project. As a consequence, a web-based course on the subject of pain was developed, initially directed towards network participants, and as a next step towards nurses within municipal care.

Within this web-based course, theoretical aspects were complemented with more dialogical aspects. For example, a lecture held by a reader from Lund University was filmed and placed on the Web. Within the framework of the course, the participants were also obliged to assemble a group of colleagues at their workplace and discuss a concrete patient case together. Those who had completed all stages and tests associated with the course online became certificated. The majority of the network participants completed the course, and an in-house evaluation demonstrated that it was evaluated positively. An advantage that emerged from the evaluation was that people could take part in the course wherever and whenever they wanted and at their own pace. It was also considered an advantage for people to practise and repeat its content as much as they wanted. From the start, the course focused on the elderly and pain, but the coordinator asserted that the web-based learning exercise could easily be extended into more modules.

Not many outside the network had yet begun the course at the time of data collection. However, as it was a part of the plan, some of the network participants had started to think about this. One of the network participants described her plans of introducing the course to her colleagues. However, she had concerns that they should not give priority to it because she had already noticed that they rather called her than logging in themselves. In her own words:

> *I have done the test and received the certificate. And soon I will meet my colleagues* [i.e. municipal nurses] *in a computer room and go through the training so that everyone knows what to do. Then it is their own responsibility. But I know they are really bad at logging in. They have got the web address, and everybody knows what it is about, but there is not enough time for it. So instead of logging in and searching themselves, they call me. I have become the one who can give some answers. (Pain no.4)*

Furthermore, after a while it also became possible for those who had access to the web-based learning exercise to search for factual scientific data and suggestions for treatment regarding pain. All material was collected and scrutinised by people with varying competence, however mostly physicians. Moreover, a web-based forum was developed on which it was possible to address questions about pain that pain nurses from most of the pain units at the hospitals within the county council answered. At a later stage, physicians were linked to this forum as well. As to the web-based forum, most of the network participants argued that they appreciated the possibility to post questions on it, which the following quotation from an interview demonstrates:

> *I appreciate that we have others who can answer our questions at the forum and give their viewpoints when for example you ask: "Do you have any experiences of this problem?" (Pain no.6)*

However, even though the web-based forum was appreciated, it turned out that not many network participants had taken advantage of the opportunity to post questions about pain on it at the time when the interviews were undertaken. One of them had once, which the following extract from an interview illustrates:

> *R: And if it is anything special, I can post a question at the forum. There are several others who can read and reply and give advice.*
> *I: Have you tried it at some point?*
> *R: Yes once. (Pain no.7)*

Nevertheless, even if most of the network participants were satisfied with the whole web-based learning exercise with its various elements and potential for development, not everyone appreciated that the launching of this project was decided on without their involvement. One of the network participants expressed her criticism as follows:

> *In the beginning everything was very vague. We did not quite know what we should do. Should we make files in order to transfer knowledge to others? Should our efforts be addressed to our colleagues? There were a lot of questions like that. But suddenly we were summoned to a network meeting, and then they had more or less made this web-based learning exercise. We had not been involved in that process, so it felt a bit strange that they*

presented an already completed concept. But of course, it has turned out very good. I think I have learnt a lot from it. (Pain no.4)

Apart from the development of the web-based learning exercise, for a period of time the Pain network directed efforts towards learning the story dialogue method (Labonte & Feather, 1996). In brief, this method is built on stories from one's own experience of a specific topic or problem, starting out from one's own interests. The story is shared within a group and followed by jointly performed and well-structured dialogue and reflections. The intention of learning this method within the network was that the network participants could use it as a tool to involve practitioners in dialogue and learning at their own places of work. A lecturer from Kristianstad University who was linked to the network was responsible for the training. From network meetings it became obvious that only one of the network participants had practised the method outside the network so far. The person concerned was a nurse who had practised the method amongst nursing assistants at her own place of work, which was a special form of housing for the elderly. Her endeavours were contained within a local municipal project. She described the underlying causes of practising the story dialogue method and her experiences of it in the following way:

I was commissioned by the municipality to go through training to become a supervisor of study circles[33]. Following that, it was in my assignment to start a number of study circles. And as I worked with pain within this network, I built on that. I used already existing study material from Vårdalsinstitutet (The Swedish Institute for Health Sciences) called "Living with Pain" and transformed it into my own model and included the story dialogue method with excellent results. It has been much appreciated. The nursing assistants come with their cases and we started out from these. There have been very good discussions. They are not obliged to participate, but still each study circle is fully booked, which shows that people want to learn even if they work a long way out in home care services. There is a hunger for knowledge and it is such fun! It is important to highlight the knowledge embodied in each one. It is about providing them with tools. They have vastly much more knowledge than I thought. (Pain no.1)

Follow-up focus group interviews undertaken within the framework of a master thesis have demonstrated that their use of the story dialogue method has resulted in

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[33] A study circle is a group of people who with the assistance of a facilitator meet during a number of occasions to explore together a specific issue and increase their knowledge (Larsson, 2001).

increased understanding of the elderly with pain amongst those who participated (Bertilsson & Jönsson, 2008). This example, with the nurse who had practised the story dialogue method, has on many occasions been presented to politicians and managers in the area, used as a good example of knowledge development in practice. The network participant quoted above described that practising the story dialogue method had influenced her own way of working in practice and made her more sensitive to the nursing assistants' knowledge and viewpoints. In her own words:

> *I have changed my own way of working too. Before, I took over much more and decided much more by myself. Now, I take a lot more help from the nursing assistants when it comes to problems with pain amongst the elderly. We have started a dialogue and we do take advantage of each other's knowledge much more. And my nurse colleagues and I have learnt that we must become better at providing the staff with feedback. So the study circles have brought much good with it, not just increased knowledge about pain. (Pain no.1)*

The same network participant considered the story dialogue method to be more suitable for the nursing assistants as this method starts out from their everyday practice, and the web-based course described earlier in this section was thought to be well adapted for nurses as they are used to doing independent work. She expressed this standpoint as follows:

> *The web-based course is better for the nurses because they are used to working independently and finding out things by themselves. For them this training is absolutely perfect. But the nursing assistants are not used to working in that way and maybe not used to working with computers that much, so for them it gives much more to use the story dialogue method as one starts out from their reality. (Pain no.1)*

From the reflexive notes that the network participants wrote as a part of our collaborative process, it appeared that those who had not practised the story dialogue method argued that they had not yet had enough time for it. However, they asserted that they had the ambition and a positive attitude to it, which the following statements from these notes show:

> *-I have not yet had the opportunity to practise the story dialogue method, but I think it works well and is easy to perform.*

> *-I have just done the training here. I shall try to do it at our next nurse-meeting.*
>
> *-I have not practised it because of time constraints, but I will try to obtain understanding of the benefits of the method at my workplace.*

Besides, to increase their internal level of knowledge, the network coordinator invited lecturers on a regular basis to the network meetings. For example, on one occasion a nurse was invited to give a lecture on post-operative pain, and on another occasion a physiotherapist was invited to give a lecture on physical activity and pain amongst the elderly. Each lecture was followed by a session for questions and dialogue. All the network participants appreciated these lectures as it helped them to keep abreast with developments on the subject of pain. In one of the network participants' words:

> *You have, what can I say... the opportunity to be updated through our recurrent meetings with different lecturers invited. It is physicians that are experts on pain and other lecturers that have knowledge about different kinds of pain. (Pain no.6)*

As to the network meetings, most of the network participants asserted that their meetings helped them to establish contacts across sectors. Some of the network participants argued that getting to know each other made it easier for them to consult each other in their everyday work practice. As the network participant quoted above stated:

> *The biggest gain with the network is that people meet and that we know about each other. You get familiar with the faces within the group. I can discuss patients with other care givers, give them a call, get advice, and send referrals for help and so on. (Pain no.6)*

It was also argued amongst some of the network participants that their participation in the network endowed their statements in practice with more weight. In one of the network participants' words:

> *Above all, I think I am in a better position to convey what I know about pain now as I have this extra weight behind me. And my colleagues are aware that I am a participant in the pain network too. (Pain no.7)*

Difficulties with Knowledge Transfer

From the interviews it emerged that some of the network participants considered what was learnt within the network was to some extent of benefit to patients. For example, one of the network participants argued that she, thanks to what she learnt within the network, could actively take additional measures when she met patients. In her own words:

> *My participation within the network does also bring something to the patients I meet. I can help them in a different way. Due to the knowledge I have acquired within the network, I can actively do something when I am out there with the patient. (Pain no.6)*

As to if there was anyone but the network participants themselves and the patients they met who could benefit from what they learnt within the network, most of them argued that it principally was just their nearest colleagues. As the network participant quoted above explained:

> *I: Is there anyone else who benefits from what you have learnt within the network?*
> *R: Well, it is mostly my nearest colleagues if I may say so... When we are working with a patient who you can see is not helped by the pain relief, then of course you discuss it and bandy ideas. (Pain no.6)*

However, a number of the network participants desired a higher degree of knowledge exchange between the Pain network and practice. One of them voiced this as follows:

> *I would like to see that the information constantly moved back and forth between the network and practice. Exchange of knowledge is, I think, extremely important, because then I can present my network and get many perspectives back, and bring it back to the network. There are always situations you have not been in yourself or have not thought of. (Pain no.7)*

Another network participant had created a group of contact persons intended to serve as links between the network and practice. Similarly to the network participant quoted above, she wished that the degree of knowledge exchange between the network and the contact persons had been higher. In her own words:

> *I have a group consisting of about ten to fifteen contact persons that I meet one or two times every term. But they are too few. This is due to our difficulties with dissemination. I wish we had a contact person at each special form of housing and in each home care service group, and that everybody had the responsibility to liaise with the network and that the information flowed between us. (Pain no.1)*

It appeared that several of the network participants regarded ordinary workplace meetings in practice as an adequate arena for transfer of information and knowledge. However most of them also considered it to be difficult to present network matters during such workplace meetings due to constant time constraints. As one stated:

> *I have not mentioned anything about the network at our workplace meetings actually. The nurses meet every fifth week, and there is too much time between our meetings I think. And when we meet we have so much to deal with and talk about. But it is decided that those who have been at network meetings and training should give information about the most important items. I think we should have workplace meetings more often. The time constraints are a barrier, it is indeed. (Pain no.5)*

One of the network participants argued that the strictly regulated workplace meetings entailed that knowledge remained within the networks and made the networks isolated. In her own words:

> *I would so much like to show a specific DVD about pain for my nurse colleagues during a workplace meeting, but unfortunately I cannot. Nowadays our meetings are so tightly controlled by statistics and stuff, so there is no room for open discussions in any way as there was a few years ago. It turns the networks into isolated bubbles as there are too few ways out from them. The networks are still on the same spot, just as a threshing machine. (Pain no.7)*

Yet another network participant was convinced that knowledge transfer best could be realised during the nursing assistants' workplace meetings, as so many were assembled in one place on these occasions. However, after having tried this way of working, she concluded that occasional attendance at these meetings was not enough. She explained her experience as follows:

> *If I had had enough time and resources, I think the best way for me to work on would have been to invite myself to the nursing assistants' workplace meetings where people are assembled. I have tried that, but the problem is that you might get half an hour as a maximum. And you cannot do much on*

> *only one occasion. You may need to meet each group several times, and there are many different groups too, for example home care services groups and groups at special forms of housing. (Pain no.4)*

It was also regarded as a problem in the process of knowledge transfer that there were so many ongoing projects at the workplaces competing for space, which led to the network being given lower priority. As the network participants quoted above explained:

> *Time is a problem, both for us* [the network participants] *and those who are to receive the knowledge. It feels that there are always so many other things that are given priority. Everybody has their groups and networks and everybody wants space. Here within our municipality we have a lot of EU-projects, and right now they focus a lot on people with dementia. There is so much else going on, which means that the network ends up far down on the priority list. (Pain no.4)*

Another barrier to knowledge transfer referred to by most of the network participants was the lack of support from line managers. As one argued:

> *It depends a lot upon those who are part of the network getting conditions to do something. That our participation in the network is supported by the managers and that they understand that it is something important. (Pain no.3)*

Some of the network participants suggested that the network should be presented at management meetings to increase the managers' understanding of the network and enhance the conditions for the networks to reach out. As one of them put it:

> *It is also an obstacle that our nearest managers do not prioritize our work in the networks. Therefore, the networks should be presented at management meetings. We need help in reaching out, and if the support does not come from our managers, we are not established. (Pain no.1)*

As shown above, the network participants considered their mission to transfer knowledge from the network into practice to be difficult for various reasons. One aspect highlighted was the large geographical area they were expected to cover. In one of the network participant's words:

> *I am the only nurse from this municipality within the network, and we are about 150 nurses in total. It is too large an area geographically for one person, if you are expected to transfer knowledge to everyone. (Pain no.1)*

Another network participant regarded their mission to transfer knowledge into practice to be unrealistic due to similar reasons; the high amount of workplaces and the different occupational groups involved. She expressed her view on this as follows:

> *Knowledge transfer is difficult. Within primary care there are about 20 care centres and different occupational groups in the area, and we are just two representatives from primary care within the network. It feels like too big a mission. I can attend network meetings and eventually try to get together a group within primary care who I can meet occasionally. But it is totally unrealistic to give information at all care centres. And then we have private primary care where we have no representation at all. At my workplace we have workplace meetings once a month, and there is always some space to talk briefly about a course or a meeting you have attended. So here it is possible, but the intention of the network is more than that. (Pain no.2)*

The network participant quoted above also considered it to be a challenge to find a common ground within the network as the different care providers involved had different patients and treatment strategies. She argued that such a big network could lead to improved collaboration, but she had also concerns that it would instead make the network weaker. She reasoned in the following way:

> *The network must work from on a more overall level. Pain is such a broad issue and we have different kinds of patients, and also different treatment strategies. For example, within primary care we have lot of patients with chronic pain, post traumatic stress disorders, and pain combined with anxiety or depression. Within this broad network it is not possible to focus on development work within primary care, hospital care or the municipalities. That has to be done within each sector. Within primary care we have other networks that deal with pain that is specific to primary care. It is there we are established. But at the same time, we have also to collaborate with the hospital and the municipality. And I can imagine that this kind of network leads to collaboration between us being improved. It is a hard aim to reach, but I think it might be so. There may be advantages to assemble it all in one network, but it can also become a bit watered down. A challenge is to find a common ground. (Pain no.2)*

During the interviews undertaken, several of the network participants tried to come up with solutions to the problem of knowledge transfer. One of them felt at first that practitioners ought to contact them when they encounter problems with

patients suffering from pain. However, after a while she reminded herself that she never contacts other network participants herself. In her own words:

> *But practitioners are perhaps not good at contacting each other. I do not contact other network participants myself. If I for example encounter a patient with a problematic ulcer, I do not call a representative from the ulcer network, who quite likely should have experience and knowledge of bandaging and so on. (Pain no.6)*

One more suggestion that emerged on the problem of knowledge transfer concerned the accomplishment of research projects. One of the network participants argued that in addition to useful outcomes, accomplishment of research projects would probably also bring about that the network would be paid more attention to, as was the case with for example the Ulcer network. This is how she reasoned:

> *I wish that we could accomplish some research, just as was done within the Ulcer network for example. We could take some students to assist us, and our network could support them. One could make some sort of documentation of how much analgesic we are using, of which ages that are involved, and how many pain plasters that are used. It is a huge job, of course, but then I think someone would care about what we do. It would be noticed. Everybody, including the nursing assistants, could get involved, depending on how it had been organised. I think that it would have been both fun and good. (Pain no.4)*

As apparent from the examples above, the difficulty of transferring knowledge from the network into practice was highlighted in different ways. The network participant quoted above was not optimistic on finding ways out of this problem. Her apprehension about the future was that the network would primarily serve an inner circle and not reach practice. In her own words:

> *I think that it will be we who are closest to the network that will keep us up to date and keep it all running. But I think everyone else in the organisations, our colleagues, the nursing assistants, they will never get there. It would have been useful to see how others solve the problem with dissemination. (Pain no.4)*

The network participants' views of knowledge development and knowledge transfer that are presented in the sections above were in accordance with the statements that emerged from the reflexive notes they wrote. The following

statements show the spectrum of the contents in these notes made on what they considered strengths:

-The network meetings are fun, inspiring and developing.
-I get a good training.
-It is very useful to meet colleagues and share experiences.
-You meet people with other experiences and other patient groups than you do normally.
-I look upon my role as a link in a long chain.
-It is a strength that I can influence the work as regards pain at our hospital ward.

The statements below from the reflexive notes demonstrate the spectrum of what the network participants considered challenges:

-I have no time to read and disseminate knowledge in working hours.
-It is difficult to reach out because of time constraints and the lack of energy amongst colleagues when it comes to receiving more information.
-It is negative that it takes such a long time for our managers to understand that basic knowledge of pain is a prerequisite of a qualified treatment.
-Sometimes this work feels like nagging and carping.

The statements from the reflexive notes above illuminate the value that was assigned to their own training and the sharing of experiences, and the difficulties associated with knowledge transfer.

Summation:
Initiatives undertaken within the Pain Network:
-One of the major initiatives undertaken within the Pain network was the development and launching of a web-based learning exercise.
-Accomplishment of internal training in the use of the story dialogue method.
-Invitation of lecturers into network meetings.

The following emerged:

-The network participants appreciated the network as an arena for training and establishing of contacts across sectors.

-The network participants considered their participation in the network to lend more weight to their statements in practice.

-The network participants considered knowledge transfer to be difficult due to time constraints, the amount of workplaces and occupational groups concerned, the too many ongoing projects in practice and a lack of support from line managers.

-The network participants made inquiries about increased knowledge exchange and accomplishment of research projects.

-Misgivings emerged on whether the network would be able to serve more than an inner circle.

The Psychiatric Rehabilitation Network

Background

The Psychiatric Rehabilitation network started up in 2004 and was the last network launched amongst the nine networks involved in this research project. The network consisted of about eighteen participants drawn from hospital care and municipal care. The network participants held professions such as registered nurses, municipal line managers, keepers, trained social workers, and officials in charge of functional impairments. One of the network participants held an overall coordinating role within psychiatry. The Psychiatric Rehabilitation network also involved a representative of the client associations. In addition, the network maintained contact with three teachers from Kristianstad University to constitute links to research. The participants of the network held meetings about four times a year, lasting for six hours on each occasion.

The term psychiatric rehabilitation refers to improvements of the capacity of individuals with psychiatric illness, and reduction of the impact of the illness, preferably in natural situations (Ekstam et al., 2005). Within the Psychiatric Rehabilitation network, recovery from psychiatric illness was considered an urgent subject for their efforts. From the specific aims of the network it appeared that their efforts should embrace support of individuals with psychiatric illness to develop their skills. The network should also work to overcome bureaucratic obstacles in

relation to psychiatric rehabilitation. Another aim of the network was to develop guidelines, methods and ways of working in relation to psychiatric rehabilitation. Moreover, it was established that psychiatric rehabilitation should start out from an evidence-based foundation. In addition, it was also agreed that the level of knowledge on the assessment of clients' needs had to increase amongst practitioners. Yet another aim was to transfer knowledge about psychiatric rehabilitation within the chain of care to be of benefit to the patients (unpublished network document, 2004).

Focus on Internal Knowledge Development

As was the case within the Pain network, the participants of the Psychiatric Rehabilitation network focused largely upon internal knowledge development. For that purpose they invited lecturers to their network meetings on a regular basis. The lecturers were chosen in relationship to specific themes they had decided on in advance. One such theme has been women who have been subjected to violence. During this particular theme, the network invited a woman who was used to giving lectures to tell her story of having been exposed to violence in her everyday life. During another meeting linked to the same theme, representatives from both the victim support organisation[34] and the association of women's shelters[35] described their practice, including what kind of help they could offer. During yet another meeting on the same theme, one of the teachers that the network collaborated with from Kristianstad University presented a paper on violence against women within psychiatry.

The lectures held were in general followed by lively discussions and the sharing of one's own experiences amongst the network participants. For example, on the theme mentioned above the network participants shared experience of working with women who have been subjected to violence, and tried to find patterns and strategies that could be helpful in the women's rehabilitation process. From the interviews it appeared that all the network participants appreciated the lectures given. One asserted that the lectures had increased her level of knowledge. She

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[34] In Swedish: Brottsofferjouren
[35] In Swedish: Kvinnojouren

also highlighted that their meetings were like a vitamin injection to her. She put her view of the lectures and meetings as follows:

> *For me, the lectures that are held within the network function as refilling of knowledge. The network meetings are like a vitamin injection, you get a lot of insight. For example, the lecture held by the victim support organisation really aroused thoughts, feelings and reflection. It was so alive. (Ps Rehab no.7)*

The representative of the client associations argued that the lectures held helped the network participants to gain clearer insight into other agencies, which in turn helped them to avoid blindness and increase the possibilities for collaboration. These thoughts were expressed in the following way:

> *Use of lectures is a great way to work. You get insight into other agencies and can avoid blindness. We talk a lot about collaboration, but it is very difficult if you do not know what others have to offer. (Ps Rehab no.8)*

On a question about the role of the network, several of the network participants considered the network primarily to be a forum for discussions. In one of the network participants' words:

> *This network has a conversational character, it has functioned as a way to get to know each other. We simply exchange knowledge and increase the level of knowledge by use of our themes and the invitation of lecturers. Our work has not been particularly concrete, but the network has been a forum where we can talk freely. (Ps Rehab no.5)*

Moreover, most of the network participants attached great value to the network as a forum for establishment of contacts with network participants from other workplaces. As one of them stated:

> *The most important point, I feel, is to meet other people from other municipalities. Other people that are in the same situation. (Ps Rehab no.6)*

And in another network participant's words:

> *An advantage is the sharing of knowledge and ideas between us and that we have got to know each other across the various agencies. We can talk a bit more informally and compare our activities to see how others have solved their problems, and give each other tips about things. (Ps Rehab no.2)*

One of the network participants looked upon the network as a build-up of a knowledge bank. In her words:

> *The network picks up what is happening within the municipalities and the county council. It is a forum for development. You enter deeply into certain areas, learn from each other's experiences and ways to work, and build up a knowledge bank. (Ps Rehab no.4)*

Increasing the level of knowledge was generally argued to be of benefit to the clients as knowledge helped them to become more secure in their professional roles. As one explained:

> *All knowledge makes a difference for the client. The more we know, the more secure we become, the better our work will be done. We use ourselves as tools, and to sharpen this tool, we have to learn more. (Ps Rehab no.5)*

Besides, on the issue of the clients, most of the network participants regarded it a strength to have a representative of the client organisations within the network as it promoted dialogue and helped them to avoid misunderstandings. As one of them stated:

> *We try to take a client focus. Just the fact that we have a representative from a client organisation within the network gives us an opportunity to bandy ideas and discuss and get a perspective from the client organisations. (Ps Rehab no.2)*

However, one of the network participants claimed that even if the perspective of the clients was important, it should not be exaggerated. This network participant asserted that a client perspective must not have precedence over specialist knowledge. The network participant argued in the following terms:

> *The perspective of clients is important, but it should not be exaggerated. You feel that the clients should bring a greater truth with them. They give us their inner picture, but it must be taken with a grain of salt, otherwise you could be misled. One life story does not represent everyone. I believe a lot in specialist knowledge but of course, you must have a dialogue with those whom it concerns all the time, one cannot evade that. (Ps Rehab no.5)*

The discussions during network meetings often involved the subject of recovery from a psychiatric illness. These discussions usually embraced a dialogue about empowerment, which concerns the transformation of power from experts to clients and how such a process could be supported. In this respect, the participants of the network paid particular attention to a working model called case management. The case management model concerns clients with complex mental illness, and starts out from the strengths and needs of the clients (Onyett, 1998). A case manager is a professional who takes the responsibility for the assessment, planning, implementation, monitoring and reviewing of services and outcomes, all in collaboration with the client (ibid.).

The discussions on case management within the network were coloured by a governmental report of the state of Swedish psychiatric care, also comprising suggestions for improvements, referred to as the Milton investigation (SOU 2006:100). In this report the client perspective and the notion of empowerment was highlighted. This investigation has had great impact on the debate on Swedish psychiatry, and due to addressed government grants, also on national and local projects undertaken. In the wake of the Milton investigation and owing to government grants, it was established that psychiatry providers within the two municipalities Kristianstad and Hässleholm[36] should get involved in a national project aiming at implementation of the case management model.

In her professional role, the coordinator of the network was involved in the implementation of the case management model locally, which was a circumstance that influenced the focus of the network. For example, one of the network meetings was combined with a full day of information about the implementation of case management directed towards practitioners within psychiatry. Since the coordinator was involved in several other national and local projects, these projects were partly interwoven with network activities as well. For instance, when the psychiatric clinical departments at the local hospitals and the local client organisations together organised a full day of lectures directed towards

[36] Kristianstad and Hässleholm are two of the six municipalities within the area that the networks cover.

practitioners, the network participants took part in the marketing of this event. However, one of the network participants considered the network to be just an embryo in comparison to the major changes going on as a result of the Milton investigation. In the network participant's words:

> *The issues that Milton is talking about are big. In this case, resources and political decisions start out from a national level, so there we are talking about major changes. This small network cannot contribute to such big things. There are so many other factors also playing a part. But the network that does exist today is perhaps the embryo of something that is consistent with the greater things going on. (Ps Rehab no.1)*

Difficulties with Knowledge Transfer

Most of the network participants found it difficult to know for certain if clients benefited from what they had learnt themselves within the network. The reason why it was difficult to know it was argued was that psychiatry was largely connected with attitudes and behaviours. As explained by one of the network participants:

> *I cannot come up with any specific example where what I have learnt within the network has been of benefit to the clients. There are some lectures that have remained in my memory. Next step is about how I can handle it in relationship to the clients. Within our sector, it is much about our attitudes and behaviours. (Ps Rehab no.3)*

Another network participant argued that the clients they met probably could benefit from the knowledge they had obtained, but probably no one in wider circles. In her own words:

> *We who are participants of the network..., the clients we meet can probably benefit from our knowledge. But otherwise it is difficult, which I think is unfortunate. (Ps Rehab no.1)*

Yet another network participant asserted that she had noticed that attitudes and behaviours had changed amongst some of her colleagues, and that it possibly could be ascribed to the network. She reasoned in the following way:

> *I benefit from what I learn within the network, and I have also seen that attitudes and behaviors have changed amongst some colleagues. The network can be a part of it, but I do not know for certain. (Ps Rehab no.7)*

On the issue of knowledge transfer, some of the network participants claimed that they never shared knowledge and experiences obtained from the network meetings during meetings at their own places of work. Instead they usually share it with colleagues in more informal ways. As one stated:

> *I do not pass on information about the network at the various meetings I participate in, I do it in more informal ways. (Ps Rehab no.5)*

And in another networks participant's words:

> *During our meetings, there is no room to talk about the network. What I do instead is to impart information about the network to the colleagues I work most closely with. (Ps Rehab no.3)*

As to obstacles to knowledge transfer, it was argued that there were not always conditions for knowledge transfer within the organisations. Examples of such obstacles mentioned by most of the network participants were the lack of time, the lack of opportunities for meetings and the economy. As one of them asserted:

> *There must be a foundation for knowledge transfer. Everybody is short of time and we do not have so many opportunities for meetings. Economy and how much attention the municipalities pay to psychiatry are barriers to knowledge transfer too. (Ps Rehab no.7)*

Apart from various organisational barriers, one of the network participants stated that knowledge transfer was also a matter of personal commitment:

> *How knowledge transfer works must be placed on an organisational level, but it also requires a personal commitment. (Ps Rehab no.5)*

Yet some other network participants considered the different cultures and perspectives of the client that existed within psychiatry to be obstacles to the transfer of knowledge. One expressed her viewpoint as follows:

> *One obstacle to knowledge transfer is that there exist different views within psychiatry. Some are so focused on symptoms and treatment and others are more focused on the impairments and what opportunities there are to overcome these, despite the illness. We have difficulties to meet since we have different perspectives. (Ps Rehab no.3)*

And:

> *I share what I learn with my closest colleagues, but it is more difficult to share it with other groups since we speak different languages. (Ps Rehab no.7)*

A few network participants highlighted that the focus should be not only on those who are expected to transfer knowledge, but also on practitioners. For example, one of them stated that colleagues were not always interested in listening:

> *It is not just about those who try to transfer knowledge, it is about the recipients too. I guess it is as with protocols, it is not self-evident that everybody reads them. (Ps Rehab no.9)*

The representative of the client organisations pointed out the same problem, arguing that no matter what efforts they made within the network, it would not help if the practitioners were not willing to receive the knowledge:

> *All of us within the network are in agreement, it is quite clear, but then comes the big problem. I do not know how big it is, but it is about the transfer of knowledge into practice. It does not matter how much we agree within the network about how one is going to work. If the practitioners do not want to, it will be quite difficult anyway. (Ps Rehab no.8)*

Some of the network participants considered research as valuable when informing others. One of them asserted:

> *Well, of course, research is worth more when you inform other about different things. (Ps Rehab no.3)*

However, one of the network participants pointed out the difficulties united with results from research as it requires knowledge of how to use it. In her words:

> *Research is always important, it always makes a contribution in some way. But one should also have the knowledge of how to use it. (Ps Rehab no.9)*

Without being specific about how, one of the network participants considered dialogue as the best way to overcome barriers associated with the transfer of knowledge:

> *Dialogue is the only way I know to overcome problems with the transfer of knowledge. (Ps Rehab no.3)*

Another network participant argued that the best way to support knowledge transfer was to allow practitioners to participate in network meetings since it provided them with more details. In the network participant's words:

> *Actually, I see nothing else for it but to let practitioners from various workplaces attend our meetings themselves. You can never get all details if you have not been there yourself. (Ps Rehab no.9)*

To overcome problems associated with knowledge transfer, the representative of the client organisations suggested that they might make plans for visiting activities, dialogue meetings and information folders:

> *The network could visit the different agencies and talk about what we do. Visiting activities, dialogue meetings and information folders about the network could be a task for the network, at least partly. (Ps Rehab no.8)*

However, the majority of the network participants was optimistic on the future of the network and considered their work to be a slow process that would yield results in the long term. As one of them put it:

> *This is a process, so you have to see it in the long run. It is often the small steps that are the good steps. It is about implanting seeds in as many people as possible. (Ps Rehab no.1)*

The network participants' views of knowledge development and knowledge transfer that are described in the sections above corresponded with the statements in the reflexive notes they wrote. The following statements from these notes demonstrate the spectrum of what were considered as strengths in this respect:

> *-I learn new things each time we meet.*

-I have gained greater understanding of how one works within other agencies.

-I have created new contacts both within the county council and other municipalities.

-It has been invigorating for my professional practice to meet "like-minded" and get feedback on my own way to think and act.

-I bring the discussions we have back to some of my colleagues.

-Client perspective and client participation is important.

-The view that recovery is possible – it is on this point that the network can exert influence.

Furthermore, the statements from the reflexive notes that are presented below illustrate the spectrum of the answers on the question to what they considered as challenges on the subjects of knowledge development and knowledge transfer. These notes consisted mainly of new questions, but also of a number of suggestions:

-How does the implementation into practice work in reality?

-Can we do things differently?

-Maybe study circles?

-We need to evaluate what we have done and what we do.

-Invite managers and politicians so that we can highlight and elucidate the network.

-It is important to solve the problem with knowledge transfer.

The statements from the reflexive notes above indicate the value that was assigned to learning and the sharing of experiences, and the difficulties associated with knowledge transfer.

Summation:

Initiatives undertaken within the Psychiatric Rehabilitation Network:

-Invitation of lecturers into network meetings.

-Involvement in external projects led by the coordinator of the network.

The following emerged:

-The major focus during network meetings within the Psychiatric Rehabilitation network was on recovery from psychiatric illness and the case management model.

-The network participants appreciated the network as an arena for training, discussions and establishing of contacts across sectors.

-Some of network participants considered research to lend more weight when informing others, however, one pointed out that it also required knowledge of how to use results from research.

-It was associated with difficulties in disseminating knowledge outside the network due to time constraints, too few workplace meetings, economic limitations, a lack of interest amongst practitioners and the different perspectives concerning clients that existed within the field of Psychiatry.

-The network participants requested dialogue meetings, visiting activities, information folders and practitioners' participation at lectures during network meetings.

-The network participants were optimistic about the future of the network and believed that their work would yield results in the long run.

The Discharge Planning Network

Background

The Discharge Planning network started in 2003 and consisted of around twelve participants. The number fluctuated over time. The network participants were drawn from hospital care, primary care and municipal care. Most of them held professions such as registered nurses, of which some were responsible for discharge planning at the hospitals, and other worked as coordinators of hospital sickbeds, and yet another few were nurses within municipal care. Amongst the latter group, one was a nurse with a specific overall medical responsibility in relationship to nursing within municipal care. Another nurse belonged to primary care and was a consultant within qualified home care services. Other professions included were keepers within psychiatry and municipal administrators of means-tested home-help services for the elderly. Moreover, the network maintained contact with one university teacher. The purpose of this contact was to create a link between scientifically generated knowledge and the network's achievements. The network meetings were held five times a year and lasted for three hours on each

occasion. These meetings were to a great extent characterised by internal dialogue concerning how to overcome problems associated with discharge planning.

Discharge planning refers to the transition of care of the elderly from hospital to municipal care. When elderly patients are discharged from the hospital, discharge planning meetings are held linking representatives of the two care providers involved. The purpose of these meetings is to facilitate this transition and to transfer relevant information and to ensure continuity of care. Usually, a nurse from hospital care and an administrator of means-tested home-help services for the elderly from municipal care, along with a municipal district nurse, are those who are involved in the discharge planning meetings. Other occupational groups that could be involved are, for example, physiotherapists and occupational therapists. The patient concerned also takes part in these meetings, in most cases along with a relative. Discharge planning is a complex process that makes heavy demands on collaboration between the care providers concerned. For example, there is a risk that patients fall between two stools due to failure in transfer of information (The National Board of Health and Welfare, 2007). The overall idea of the network was to contribute to improvements and development in relation to discharge planning in practice.

Focus on Internal Knowledge Development

The Discharge Planning network had a fumbling start. For a period of time, the network participants and their coordinator had difficulties in establishing the overall aims of the networks and in coming to an agreement on what they should focus on. During this period, they were engaged in lively discussions about what their centre of attention should be. In one of the newsletters[37], the coordinator highlighted the feelings that were circulating at this stage: "Can you imagine how many feelings the subject of discharge planning awake? When we started, there were many opinions on what we should do and how." One of the network

[37] As described in previous chapters, the newsletters were written by the facilitator and the coordinators of the nine networks and focused on the networks' achievements. The newsletters were distributed twice a year to politicians, employers and employees concerned with care in the area (i.e. in the north-east district of the county council *Region Skåne*).

participants described the initial phase of the Discharge Planning network as follows:

> *From the beginning the idea was that we should search for possibilities and areas for collaboration. People from the hospitals had their views and we* [from the municipalities] *had our views, and these should be linked to a whole in some way. And above all, we should put the patient at the centre. But a reason why we had a slow and fumbling start was that our remit was too vague. (Disch Pl no.9)*

In order to move forward, they decided to identify each network participant's view of discharge planning. From this process it appeared that the main problems were considered to be a lack of common attitudes and behaviours in practice and a lack of trust amongst the representatives of the two care providers. For the purpose of reaching high-quality discharge planning meetings with the focus on the needs of the patients, it was agreed within the network to concentrate on ethical principles as well as on increased understanding and improved communication between the care providers involved. However, from this stage in the network's process, the network had a pause for six months due to a delay in the exchange of a network coordinator. At the restart, the internal discussions continued where they had ended. Gradually, their discussions led to development of a number of criteria of what the network participants considered should characterise a good discharge planning meeting, and of what they felt were areas for improvements. These criteria, intended as guiding principles in their work, were:

> *-A holistic approach with specific focus on health oriented aspects*
> *-A humanistic outlook on people*
> *-Respect*
> *-Paying attention to the gender perspective (women' and men's different social and cultural situations)*
> *-Consensus among the care providers involved*
> *-Handing over of the already existing information leaflet on discharge planning to patients and their relatives before the discharge planning meeting takes place*
> *-Preparatory meetings between the representatives of the two care providers before the discharge planning meeting takes place*
> *-A physician should be available for any questions before the discharge planning meeting takes place*
> *-A clear documentation*

The discussions about what should characterise high-quality discharge planning meetings continued. However, it appeared that the network participants had

tendencies to focus on problems in relationship to discharge planning, and frequently gave examples of various negative experiences from practice. Some of the network participants considered that their continuing focus on problems within the network resulted in stagnation of the network's development. As one put it:

> *I think we are stagnating. We begin all over again and again, but still we end up with difficulties in relationship to the hospitals, difficulties in relationship to the municipalities, and our different experiences of it. I feel that it is just that we are discussing all the time. We have not come far at all, we are getting nowhere. (Disch Pl no.6)*

Moreover, the network participant quoted above stated that there had been too much focus within the network on the perspective of the representatives of the hospitals. She argued that the network needed more representatives from the municipalities to get the balance right. As she expressed it:

> *It is not surprising that discharge planning is not functioning properly in practice when we cannot get it to work when we sit down together and discuss problems within the network. We actually disagree quite a bit on some things, I feel. There has been much focus on how people from the hospital experience problems within the municipalities. We have poor understanding of each other. We should have more representatives from the municipalities to get more balance. (Disch Pl no.6)*

Another network participant pointed out an additional kind of one-sidedness, which in this case concerned the network's internal representation. She considered that there were too many nurses within the network and made inquiries for additional professional categories to provide further perspectives. In her own words:

> *It is quite important to have representatives from different professional categories, but that has not been the case I think. There have been mostly nurses, and that is not good. You need to see things from different angles. (Disch Pl no.1)*

It was argued that the imbalance between the two care providers that existed within the network also existed in practice. One of the network participants maintained that it was the hospitals that dictated the conditions for the collaboration between the hospitals and the municipalities in the discharge planning process. She also asserted that this was an increasing dilemma. As she put it:

> *It is the municipalities and primary care that have the primary responsibility, but somehow there is still a focus on the hospitals. It is the hospitals that dictate the conditions for our collaboration: "Now the patient is ready to go home" and so on. And it just gets worse in that sense that they become more and more specialized, they become more and more fixated on diagnosis, and the treatment times become shorter. (Disch Pl no.5)*

Yet another network participant asserted that discharge planning had a low status at hospital wards, which she meant slowed down the network's progress. She thought that the low status of discharge planning was related to medical and practical issues being more prioritized in practice. She voiced this as follows:

> *Our development is a slow but progressing process. Our difficulties are partly linked to discharge planning not having high status at the hospital wards. There it is more legitimate to prioritize purely medical and practical issues. (Disch Pl no.3)*

In addition to the network participants' viewpoints about internal stagnation and imbalance between the care providers, a few of them pointed out the importance of finding something concrete to work with that could yield results. One argued in the following way:

> *The biggest challenge is to come up with something concrete to work with. If this does not lead anywhere people will run away and leave the network. We have to produce results, otherwise the network will die out, I think. (Disch Pl no.4)*

Most of the network participants referred to above considered the lack of concrete tasks for the network to realize to be frustrating, especially in comparison to what other networks had accomplished. One of them expressed this viewpoint as follows:

> *I thought that we should work with more concrete tasks within the network, for example a manual that we could all use. It is what is written down that is valid. It is a bit frustrating as the other networks, for example Nutrition, Ulcer and Hygiene, have so much to demonstrate. (Disch Pl no.6)*

On the abstract nature of discharge planning, one of the network participants stated that their network was not as self-evident as others, as they on comparison did not

have that many methods or evidence-based research outcomes. She put this standpoint in the following way:

> *Our network is not as self-evident as some of the other networks. Discharge planning does not gain the same interest as other areas, and does not have that many methods, evidence-based research outcomes or companies that back up, which is the case of for example Ulcer, Pain and Nutrition. What I mean is that other networks are more concrete. Instead, we have to find our own ideas that are appropriate for us. (Disch Pl no.4)*

For this reason, several network participants considered it favourable to the network's development to have teachers from the local university connected to the network, as they could provide the network with support and research findings. In one of the network participants' words:

> *It is important that we have the university behind us. You feel that there is someone who supports us and provides input in terms of research results and so on. (Disch pl no.3)*

Most of the network participants attached great value to the network as a forum for reflection, discussions and exchange of experiences as these were aspects that there was not scope for in practice. One of the network participants explained that the network provided her with nurture. In her own words:

> *The value of the network is that you can really immerse yourself. You can reflect, discuss and meet others, which is an opportunity you do not have in everyday practice. When you are working on an overall level as I do, you need nurture in some way, and I think that is what the network provides. One receives nurture and strength. You open your eyes to things that you have not thought of and broaden your knowledge. We come from different realities, so it becomes a way of understanding. You also reflect your own work situation when comparing with others. The network is a kind of mentor that helps you to work in a better way. (Disch Pl no.1)*

Another network participant expressed a similar standpoint in the following way:

> *The network addresses many problems that one experiences in reality. It is a forum in which we can raise problems, or what is good. One can exchange experiences and get to know representatives from the municipalities, which will facilitate future communication. We are working for the same thing, so we should understand each other better. (Disch Pl no.7)*

Moreover, on the value of the network, most of the network participants appreciated the network as a forum for establishment of contacts with other actors involved in the discharge planning process. For some, this advantage included contact with university teachers whom they considered supported their development. As one stated:

> *The greatest value of the network is that you meet the various actors involved in the discharge planning process, and also those from the university who support the network development so that we do not stand still at the same old spot. You establish contacts, you get feedback and you get research results. (Disch Pl no.3)*

A few network participants argued that getting to know each other within the network made it easier for them to contact each other outside the network, which they felt was a way to break down barriers of prestige in practice. One of them expressed such a view as follows:

> *I have noticed that I contact colleagues that I did not contact before, due to our meetings within the network. It means that at the same time we break down barriers of prestige. I think that is necessary for the future. We do not get increased economic resources so we have to help each other, and then we cannot have these territories. (Disch Pl no.1)*

Another network participant presented a similar viewpoint, arguing that getting to know each other within the network probably supported them in erasing boundaries between care providers:

> *Meeting colleagues and exchanging opinions will eventually erase boundaries a bit. Unfortunately, we* [the representatives from the two care providers] *are opponents in some way. I think that the network has a role to play in loosening up these boundaries. (Disch Pl no.8)*

After a period of time, the Discharge Planning network entered into collaboration with the Documentation network. The network participants' expectation was that this liaison would support the network development. During joint network meetings they discussed ethical values, attitudes and behaviours relevant to discharge planning meetings, including the importance of clear documentation. In addition, possibilities to simplify the discharge planning process without lowering its quality were debated. An idea that emerged from these discussions was that far

more discharge planning meetings could be dealt with by telephone instead of at the hospitals. Another idea was that more discharge planning meetings could be held when patients were already discharged from the hospitals and back at home. However, at this early stage in their collaboration process it was not suggested what efforts they should make to implement these ideas in practice. Many of the network participants appreciated the collaboration with the Documentation network as they considered well-documented information about the patients to be of importance for the quality of the discharge planning process. As one of them put it:

> *It may make sense to have meetings with the network Documentation occasionally. These two networks have many connections. It is important how we document so that people understand what it is about. And I think our last meeting was great. It also mixed us so that we did not end up in the same old discussions again. (Disch Pl no.6)*

However, one of the network participants was more critical of the network's collaboration with the Documentation network so far, as she considered the participants of that network to be more fixated on diagnoses. In her own words:

> *There is another category of people within the Documentation network who are very fixated on diagnoses, and I do not like it. Diagnoses are associated with illness, and then you reach a deadlock. It should rather be about: Which language do we use? How do we document? What do we document? When do we document? What is important for us to know within municipal health care services when the patient has been at the hospital? And what is important for the hospital to know about what happened at home? And we have not yet discussed such questions. We are talking completely different languages. (Disch Pl no.9)*

Difficulties with Knowledge Transfer

On the issue of knowledge transfer, only a few of the network participants stated that they shared knowledge and experiences obtained from the network meetings at their own workplaces. One of those who did described that she usually disseminated papers she had been informed of within the network. In her own words:

> *Within the network, we have had access to some papers and things you might not find when you are out there in practice. I disseminate such things at work. (Disch Pl no.3)*

A few more were convinced that their network engagement had an impact in practice, even if they found it difficult to specify how. One drew a parallel that is reminiscent of circles on the water to exemplify. As explained by the network participant:

> *I: Has the network had any impact in practice?*
> *R: It is hard to put a finger on anything specific. The fact that we meet within the network, that we raise questions and discuss always entails that some more people start to think differently and become more broad-minded. (Disch Pl no.5)*

One network participant was of the view that her increased knowledge made her more secure at work, which helped her to raise the status of discharge planning. This was expressed in the following terms:

> *I: Do others benefit from what you take part in within the network at your own workplace?*
> *R: Yes, I think so, but I cannot directly point at in what way. I have increased my knowledge and feel a bit more confident in what I am doing. In my professional role I can help to raise the status of discharge planning, and that is important. (Disch Pl no.1)*

However, one of them asserted that she had not got hold of anything essential from the network to share with her colleagues in practice. She explained:

> *I: Do you inform colleagues about what you take part in within the network?*
> *R: No, not more than general things, that we exist and so. It sounds awful, but I do not think I have received any useful information to share. (Disch Pl no.6)*

One of the network participants highlighted the risk of the network becoming a mutual admiration society rather than engaging in dissemination leading to results outside the network. In her own words:

> *It is a small clan who take a seat in the network, and they do so because they are engaged and interested. But apart from that, it is essential that they can disseminate. It is important that the network is not just a mutual admiration society, it must also pay off results outside the networks. (Disch Pl no.1)*

Yet, a number of the network participants considered that the main obstacle to knowledge transfer could be traced back to practice. It was argued that nurses seldom had time to receive knowledge as they were constantly occupied with everyday work practices. One expressed this viewpoint as follows:

> *Knowledge transfer is complex, but you meet the biggest obstacles in practice. Nurses seldom have the time. They want to, but are in the middle of patient care and are busy with that. (Disch Pl no.1)*

Another obstacle to knowledge transfer, also associated with practice and mentioned by a few network participants, was that not all practitioners were interested in the network's subject area. As one of them stated:

> *One difficulty in the process of knowledge transfer is that everyone in practice is not interested in this and does not want to get acquainted with it. And that is an obstacle if you have expectations that everyone should have the same level of knowledge. The network itself cannot do much to change attitudes, much of the responsibility lies at the individual workplaces. (Disch Pl no.5)*

However, generally, dialogue and reflection were seen as the most important measures for the network to use in the process of knowledge transfer. For example, one network participant asserted that practitioners did not have enough space and energy to adopt information and suggested opportunities for reflection in practice as a solution. She argued in the following way:

> *One obstacle is practitioners' lack of energy to absorb the information. A challenge is to provide space and opportunities for reflection. To pause and reflect and get the opportunity to discuss with colleagues. That is basic. (Disch Pl no.9)*

One of them argued that the network needed different approaches to knowledge transfer and suggested large-scale lectures combined with workshops in practice. This network participant put her idea as follows:

> *Large-scale lectures and workshops, one does not exclude the other. Those who take part in these arrangements in turn disseminate their knowledge. You have to work in different directions to get it out and keep it alive. (Disch Pl no.3)*

Yet another network participant considered that knowledge transfer was difficult and suggested the creation of dialogue groups outside the network, involving representatives from both hospital and municipal care to overcome these problems. She presented her suggestion in the following way:

> *It is the transfer of knowledge that is so difficult. One could create smaller groups outside the network consisting of people from the hospitals and the municipalities who could discuss how we should proceed with discharge planning so that it becomes as good as possible. I think that is important. (Disch Pl no.2)*

Some network participants advocated the use of case descriptions amongst practitioners to overcome barriers associated with knowledge transfer. In the words of one of the network participants:

> *I think it is important that you get possibilities to talk about patient cases. Understanding increases and you think of how this could be done differently. It is important that even what is good should be addressed, but I think we are very involved in addressing what has been bad. (Disch Pl no.3)*

Another suggestion that occurred was that the network could arrange supervision to take place during discharge planning meetings in practice to take the opportunity to support learning amongst those involved. As voiced by the network participant:

> *We would need to arrange supervision during the discharge planning meetings, be there as observers and afterwards discuss with those involved so that the meetings becomes occasions for learning. I think that is the most essential, to take the opportunity when it happens. I think it is the only way to learn. Certainly, you can read a text, but it is not the same as reality. I think it is there we* [within the network] *have to insert our efforts. Initiate and carry it out. The network can be an engine. (Disch Pl no.9)*

One network participant pointed out a specific dilemma associated with knowledge transfer and argued that knowledge is much more than can be captured on a list for example. Her standpoint was that attitudes and reflection are a kind of knowledge that is not possible to list, but are best developed when people meet. She expressed this view as follows:

> *As nurses we are trained to learn from bullet points, and thus we are expected to reproduce and transfer what we have received from the network in bullet points. But it does not work like that. Knowledge is not just what*

> *we can put down in bullets. Knowledge can be so much more. What we are dealing with within this network is more like software knowledge; attitudes, reflection and so on. It is not possible to write down on a list. The more people that get together and meet, the more is won. (Disch Pl no.5)*

However, as noted above, several of the network participants became increasingly frustrated about the abstract nature of the network and the absence of concrete measures to deal with. Their discussions during network meetings about the possibilities for the network to make their work more concrete resulted in my introduction of a colleague to undertake an action research project within the network. Together, my colleague and the network participants decided to transform the concept *holistic approach* into a more concrete form, as this concept was included in the criteria of the network (described above). With use of the Story Dialogue Method (Labonte & Feather, 1996) as a tool (see the section about the Pain network), they entered this process. As a first step, the network participants wrote down discharge planning situations that they felt from their own experiences had been characterised by a *holistic approach*. These stories were then analysed and categorised jointly. Aspects identified were, for example, patient involvement and that the practitioners involved in the discharge planning should not start out from their own needs and beliefs (Peterson, 2010).

The collaborative process described above resulted in evaluation questions intended to be used by practitioners. Another result was that a large-scale competence development day was arranged directed towards practitioners involved in discharge planning (Peterson, 2010). Practitioners from hospital care, primary care and care provided by the municipalities were invited to attend a lecture about communication, followed by inter-disciplinary group discussions. The purpose of the development day was to initiate dialogue and create conditions for the establishment of new contacts. Most of the network participants involved in the collaborative intervention seemed to appreciate this engagement. They hoped that the process had helped them to change their mindset and stop focusing on what does not work:

> *I want to believe that it had a positive effect, that it gave us a slightly transformed mindset. Because we have a tendency to focus on what does*

> *not work. So in that way it was positive. Changing the approach a bit and looking upon what is working. (Disch Pl no.5)*

And:

> *This method* [the story dialogue method] *requires that there is someone who is in charge of it. And that is good, because it leads on. I think it is good to have a case or a story to work with, and then try to dissect it with help of some kind of method as we did. (Disch Pl no.9)*

Summation:

Initiatives undertaken within the Discharge Planning Network:

-The Discharge Planning network entered into collaboration with the Documentation network.

-Involvement in another action research project to transform the concept *holistic approach* into a more concrete form.

-Arrangement of a large-scale competence development day directed towards practitioners involved in discharge planning.

The following emerged:

-During network meetings, the network participants gave particular attention to dilemmas associated with discharge planning.

-The network participants appreciated the network as an arena for discussions, exchange of experiences and establishing of contacts.

-Some of the network participants considered knowledge transfer to be difficult as nurses in practice were constantly occupied with everyday work practices and had not enough energy to adopt information.

-The network participants made inquiries for more concrete tasks for the network to realise as well as for the encouragement of dialogue and reflection in practice.

Table 6 provides an overview of the Pain, Psychiatric Rehabilitation and Discharge Planning networks, including highlighted aims, main activities and their processes and development.

Table 6 The networks Pain, Psychiatric Rehabilitation and Discharge Planning – An Overview

Network	Start	Partici-pants (n)	Meetings	Professions	Care providers represented	Highlighted aims	Activities	Process and development
Pain	2002	50	2 times a year 3h each time	Registered nurses, district nurses, nursing assistants, physiotherapists, occupational therapists and social welfare officers	Hospital care, primary care and municipal care	Transfer of knowledge concerning pain, pain assessment and treatment along the care chain to be of benefit to the patients	-Launching of a web-based learning exercise -Training in the Story-Dialogue method -Internal lectures and dialogue around the subject of pain	-Internal knowledge development -Exchange of experiences -Establishing new contacts across sectors -Perceived difficulties in the process of knowledge transfer
Psychiatric Rehabilita-tion	2004	18	4 times a year 6h each time	Registered nurses, municipal line managers, keepers, trained social workers, officials in charge of functional impairments, coordinators and a repr. from a client association	Hospital care and municipal care	Transfer of knowledge concerning psychiatric rehabilitation along the chain of care to be of benefit to the patients	-Internal lectures and dialogue around recovery from psychiatric illness -Involvement in ongoing projects governed by the coordinator, as the implementation of the case management model	-Internal knowledge development -Exchange of experiences -Establishing new contacts across sectors -Increased understanding of others' perspectives -Perceived difficulties in the process of knowledge transfer
Discharge Planning	2003	12	5 times a year 3h each time	Registered nurses, keepers and municipal administrators of means-tested home help services for the elderly	Hospital care, primary care and municipal care	-Contribution to improvements and the development related to co-ordinated discharge planning meetings in practice	-Internal dialogue around problems associated with discharge planning in practice -Collaboration with the Documentation network -Involvement in another AR-project	-Difficulties from the start in establishing the overall aims of the networks and in making an agreement on what they should focus on -Exchange of experiences -Establishing new contacts across sectors -Increased understanding of hospital versus municipal dilemmas -Perceived difficulties in the process of knowledge transfer

The Feedback and Dialogue Processes within the Three Networks

The results from the data collection undertaken within the networks Pain, Psychiatric Rehabilitation and Discharge Planning were fed back to each of the three networks separately, followed by a number of dialogue sessions. The purpose of these feedback and dialogue sessions was to initiate dialogues on the subject of knowledge transfer that might possibly generate ideas amongst the network participants of benefit to the respective network's development processes.

As described in this chapter, the network participants within the three networks had to some extent different approaches to knowledge development and knowledge transfer. However, a common denominator was that they essentially looked upon their participation in the networks as an opportunity for personal development. All of them appreciated internal discussions, lectures and the sharing of knowledge between them (cf. professional development networks in Docherty et al., 2003). In addition, most of the network participants considered evidence provided by research and the transfer of knowledge from the networks into practice important, even if they did not transfer knowledge into practice to a great extent. Their own explanations for why they did not were in the main time constraints, lack of resources and lack of legitimacy from line managers. Still, some of the network participants argued that they shared what they learnt within the networks with colleagues and applied this knowledge in their own everyday work practices.

The feedback and dialogue sessions undertaken within the three networks essentially followed the same model. First, the results from the data collection were fed back (structured round the patterns described in the paragraph above), along with quotations from the interviews undertaken. Thereafter, dialogue sessions were held, divided into two occasions per network. These dialogue sessions took different directions within the three networks. Within the Pain network a dialogue emerged on how they could expand their ways of working. We discussed possibilities of accomplishing a smaller pilot project together at some of the network participants' workplaces. The idea was to engage practitioners in a project proceeding from practice. The purpose was to increase possibilities for reflection on a subject that emerged from the practitioners' own interest. The assumption was

that development-based and reflective behaviour can occur when routinised behaviour is challenged (Ellström, 1996). An intention of the pilot project was also to identify the kind of support that was needed. My role would be to facilitate the project and take responsibility for the documentation. The concrete measures to be taken would be developed by gradual stages in dialogue with the practitioners. However, this idea was never launched because of a lack of time available amongst the network participants.

During the dialogical process within the Psychiatric Rehabilitation network, various suggestions emerged on measures to be taken. An issue considered urgent amongst the network participants concerned how they could benefit more from the client organisations. Other suggestions that emerged for possible further development were to direct efforts towards team work, visiting activities, the invitation of practitioners to large-scale lectures and the screening of ongoing projects on the subject of psychiatry within the region. In addition, the network participants came up with suggestions for doing something that could provide them with measurable evidence, such as prevalence studies. During the second dialogue session, their different suggestions were discussed in more detail. However, nothing concrete came out of this discussion. In conclusion, it was decided that the network participants should consider their suggestions outside the framework of the research project in the long run.

The feedback and dialogue sessions within the Discharge Planning network were, as with the other networks, accomplished in two stages. On the first occasion, the dialogue concerned the deadlock within the network as to its development process. In spite of lively discussions during network meetings their process did not seem to move forward. Instead, their main focus was on problems associated with discharge planning, especially on the differences between the social and medical perspectives. With the intention of holding up a mirror of the split into two camps that seemed to exist, both outside and within the network, I used a trench as a metaphor. This effort led in itself to a lively discussion. Some of the network participants were provoked, but the majority considered that this discussion was interesting as it made the network's deadlock more visible and might possibly support them in focusing more on solutions instead of problems. Moreover, the

network participants highlighted the importance of implementing activities built upon dialogue. The discussion during the second dialogue session concerned the network's role as to knowledge transfer and the possibilities of involving practitioners in dialogical processes. In conclusion, we agreed that the Discharge Planning network should become involved in another more long-term action research project as well. After a prolonged process within that action research project, the network participants transformed the concept *holistic approach* into a more concrete form and arranged a large-scale competence development day on the subject of discharge planning, directed towards practitioners.

In sum, the following emerged from the feedback and dialogue sessions undertaken within the three networks (stage two):

> -Pain: A desire amongst the network participants to engage practitioners in dialogical and reflective activities.
> -Psychiatric Rehabilitation: Inquiries emerged on measures for the network participants to engage in outside the framework of the present research project.
> -Discharge Planning: Increased awareness amongst the network participants of their split into two camps, and a desire to focus on solutions instead of problems.

The Coordinators' Reflexive Notes

The coordinators of the networks wrote reflexive notes on two occasions parallel to the data collection and collaborative process undertaken within the networks Pain, Psychiatric Rehabilitation and Discharge Planning (stage two). As described in chapter five, these notes concerned what the coordinators regarded as challenges and which aspects they regarded as having encouraged the network development. The intention was to obtain additional data to inform the final feedback and dialogue sessions with the coordinators (stage three). This section presents the results from the coordinators' reflexive notes.

As to the encouraging aspects, it emerged that the steering group were still appreciated as a driving force in the coordinators' development work. One of them

wrote: "When we are all assembled like this, both the coordinators and the steering group, it feels very inspiring. I feel that I get strength, tips and a will to move forward. I hope to convey the same inspiration to my network participants" (Coordinator no.6). It was also evident that several coordinators considered the network participants' engagement as a strength: "A major strength is the network participants' commitment" (Coordinator no.4).

In addition, one of the coordinators had now accomplished the large-scale survey that was planned. In the reflexive notes, this coordinator wrote about how both the network and the results of the survey had met with great demand locally as well as at national and international levels: "The interest in the network is great from other hospitals and municipalities, especially in southern Sweden. The rumour of it has spread throughout the country, and I am asked to come and inform about it at related-associations, in municipalities and so on. The survey required extensive interaction. The results from it have generated interest nationally and internationally. They now want to do equivalent surveys at other hospitals and within other municipalities. It has also generated an intervention in the form of study circles within two municipalities. As a whole, the survey has contributed to that I, in competition, have been awarded prestigious and substantial funding from the Swedish Research Council"[38] (Coordinator no.9).

However, from the reflexive notes on what was regarded as challenges, some of the coordinators considered their network's progress to be sluggish: "My experience of our network is that it works sluggishly" (Coordinator no.3). As an explanation, one coordinator pointed out the lack of continuity within her network: "One difficulty is that not everyone is present at our meetings, and there is a frequent exchange of network participants" (Coordinator no.11). Another coordinator stated without being specific that the problems that existed within the municipalities took much of their time: "Much time is used to tackle the problems within the municipalities" (Coordinator no.4). Yet another coordinator mentioned the difficulties she had to recruit real enthusiasts with the power of taking the initiative: "One challenge is to find enthusiasts out there who want to and can take

[38] In Swedish: Vetenskapsrådet

their own initiatives for development work" (Coordinator no.1). The same coordinator had experienced difficulties in her role as coordinator locally, which without stating in which way she expressed as follows: "It is difficult to be a prophet in your own country" (Coordinator no.1).

Furthermore, the lack of support of network participants from line managers and colleagues in practice was still regarded as an urgent problem, especially within the municipalities: "The network participants have poor support from colleagues and managers, especially within the municipalities, but there is a significant difference between the municipalities too. At some workplaces it means that there is no engagement in the network at all" (Coordinator no.1). As to the managers, another coordinator wrote: "Managers need to understand the benefits of the networks" (Coordinator no.10). The same coordinator highlighted the time aspect as a challenge. She explained that the economic system used within her field of work forced network participants to prioritize a high amount of meetings with patients, which was disadvantageous to the network: "The big challenge is time. Within our sector, we have a peg-system, which means that we must meet as many patients as possible. The result is that we sometimes must choose to produce at the expense of the networks" (Coordinator no.10).

A requirement made by some of the coordinators was more time for planning and reflection. As one wrote: "I would like to have the opportunity to think through and organise the network during working hours. Write an action plan, book meetings, write memos, make plans, book lecturers etc." (Coordinator no.1). Another coordinator asked for better advertising of her network to raise awareness of it and obtain a better representation: "The network is still not well represented within the various sectors. There are many who do not know what we do. We are not good enough at marketing ourselves, we have to be both seen and heard" (Coordinator no.11). In summary, in terms of what the coordinators regarded as challenges and which aspects they regarded as having encouraged the network development, these were fairly consistent with what appeared during the first stage of the research described in chapter seven. What was emphasised more was a slow progression.

This chapter has presented the perspectives of the network participants, including the feedback and dialogue sessions undertaken as a part of the collaborative inquiry process, and what emerged from these. It has also presented the results from the coordinators' reflexive notes. The next chapter contains the third stage of the research, which is the final feedback and dialogue process with the coordinators.

9. The Concluding Process within the Meta-Network –Stage Three

This chapter presents the final feedback and dialogue sessions carried out together with the network coordinators and their facilitator. These feedback and dialogue sessions were a part of the collaborative inquiry process described in chapter five, intended to support the coordinators and their facilitator in the network development and their further understanding of the complex area of knowledge transfer. The sessions held feedback on results from stage one and two taken together, including the following dialogical processes. This stage of the research also embraced the coordinators' final reflexive notes on what they had learnt from the collaborative process undertaken. The current chapter ends with a section on the facilitator of the meta-network's concluding views on how the networks worked.

The Final Feedback and Dialogue Process

As described in chapter seven, during the first stage of the collaborative process with the coordinators of the networks, it appeared that transfer and implementation of knowledge into practice was regarded as an important issue for the networks to manage. The coordinators' idea of how to achieve this vision was mainly built upon a linear top-down approach to knowledge transfer. However, as also described, the coordinators suspected that knowledge transfer and implementation did not work out as hoped. Several of the coordinators expressed a feeling of frustration that knowledge to a great extent remained within the networks.

A feature that emerged from the second stage of the collaborative process, i.e. amongst the network participants of the networks Pain, Psychiatric Rehabilitation and Discharge Planning, was that the network participants appreciated the networks as a forum for internal dialogue and knowledge sharing and that they were given the opportunity to establish contacts across sectors. Most of them also considered evidence provided by research and the transfer of knowledge from the networks into practice as important. However, the network participants as individuals did not transfer knowledge into practice to a great extent. Their own

explanations for this were mostly organisational limitations such as a lack of time, resources and legitimacy from line managers.

These results, along with quotations from the interviews with the network participants, were fed back to the coordinators and their facilitator during a meta-network meeting, in which the steering group also participated. From the following discussion, it appeared that the coordinators recognised the presentation of the three networks. They agreed that the main difficulty was the lack of time and that the network participants needed support from line managers at their own workplaces for their achievements. They also considered these problems to be more explicit within the municipalities by comparison with the hospitals. As to the limited extent of knowledge transfer, the coordinators misgivings from stage one turned out to be justified.

As a next step in the process, the coordinators, the facilitator of the meta-network and the participants from the steering group discussed in teams of two persons and wrote down their ideas on the continuation and direction of the networks, with the focus on knowledge transfer. On the one hand, the ideas from these written notes concerned a so called bottom-up approach. Both coordinators and participants from the steering group made suggestions of increased involvement of practitioners in the networks' future efforts. Tangible proposals were that the networks by use of the story dialogue method or study circles could both support transfer evidence provided by research into practice and learning. It was also suggested that network participants should strive to be involved in already ongoing local development projects and start out from the local conditions in their endeavors.

On the other hand, the statements from the written notes concerned a so-called top-down approach. For example, one of the coordinators suggested that large-scale lectures should be given on a regular basis, directed towards different professional categories. It was also suggested by both coordinators and participants from the steering group that the network participants should regularly give accounts of the networks at workplace meetings. One of the participants of the steering group wrote that it would be easier to sell the networks' message when they could present results of the benefits to the patients. However, the written notes also reflected the

difficulties involved with the process of knowledge transfer. One of the coordinators wrote: "Knowledge transfer is difficult", followed by a rhetorical question: "How do we do it?" Yet another coordinator became inspired by the ongoing feedback and dialogue session and wrote without being specific that the feedback and the following discussion was very interesting and generated ideas on how to work in a similar way within their own network.

The dialogue continued during a second meta-network meeting. The steering group also participated in this meeting. The purpose of this second dialogue session was primarily to find out if there was a foundation for a continuation of the process we had begun. During this dialogue, the ambiguity regarding the different approaches to knowledge transfer that emerged during our previous meeting came to the surface once more. One of the participants of the steering group initiated a discussion in which the importance of dissemination of evidence-based knowledge provided by research and measurable results was emphasised. This account was met with agreements amongst several of those present. In conclusion, the focus in our dialogue moved from an overall concern about the complex area of knowledge transfer and attempts to get routines into perspective, into a focus on more measurable objectives. The intention of this final dialogue session was that the coordinators would take ownership of what came out of our collaborative process as a whole. However, no initiatives or suggestions on a continuation emerged during this meeting.

Finally, the coordinators wrote reflexive notes on what they had learnt from the collaborative process they were involved in. The reflexive notes revealed their mixed experience: From new thoughts on knowledge transfer, new thoughts on the remit of the networks and on the networks' structure, to a desire for quantitative, generalizable results in the future. The account below presents the whole spectrum of statements from these notes:

> *-Learning through reflection on one's own experiences must be encouraged.*
> *-Knowledge is difficult to disseminate through words, instead, knowledge must be perceived and understood.*
> *-All development work is based on learning, dialogue and active practitioners.*

-I have learnt that learning processes take time and require much support.
-You have provided me with an eye-opener, to see the structure of the network and how exchange and communication take place.
-You have helped the network to reflect on the networks' existence and mission.
-I do not know, however, I believe that awareness of the importance of the processes has increased. Time yields results.
-It is difficult to isolate the way in which the research project has contributed to my way of working.
-I hope there is some generalizable knowledge that can facilitate future knowledge dissemination.

In sum, the following emerged from the feedback and dialogue sessions undertaken during stage three, including the coordinators' reflexive notes on what was learnt from the collaborative process:

-An increased interest in the subjects of knowledge transfer, dialogue, reflection and learning.
-The coordinators' initial theory of practice, which was a linear top-down model of implementation of evidence-based practice, seemed partly to be more consolidated.

Shortly after the final dialogue session, the facilitator and coordinators of the networks wrote in their newsletter that knowledge transfer did not work out satisfactorily, and that this was a problem to be solved. Even if this statement was not problematised or developed further, it demonstrated that they paid attention to the subject in question. In addition, and as a concluding measure, I presented results from the research project at a local conference arranged by the research group I was a part of. The purpose of the conference was to hold up a mirror to practitioners in the area on results from collaborative inquiry research projects undertaken within this research group. Translated into English, the title of my presentation was: "Knowledge by means of Networks – Obstacles and Opportunities". The focus of this presentation was on the subject of knowledge transfer. The facilitator of the meta-network and a number of the network coordinators participated in the conference, and were engaged in the dialogue that followed the presentation. However, in spite of their enthusiasm and engagement, nothing new emerged from this dialogue. Later on, after a request from the

facilitator, I wrote a short text about the results from the research project in their newsletter.

The Facilitator's Concluding Views on how the Networks Worked

This section contains the facilitator of the meta-network's concluding views on how the networks worked. The facilitator's perspective intended to provide an additional angle to the analysis to increase the understanding of the networks as a phenomenon and the context in which they operate.

The facilitator of the meta-network was aware that knowledge transfer was a difficult matter for the networks to handle, and argued that the results of their efforts were very much dependent on individual driving forces. She asserted that networks in general could not solve all problems in practice, but she also raised the question of what the alternative to networks would be. In the facilitator's words:

> *I: How does the networks' transfer of knowledge into practice work do you think? As you know, from the interviews with both coordinators and network participants it appeared that most of them considered the internal knowledge development as positive and stimulating, but when it came to knowledge transfer they described problems such as time constraints and so on.*
> *R: I think it is fairly much as you said, and it is a problem we will always face. If you are a driving force or strong enough, maybe you will pursue things right where you stand. It is all about..., what can I say, how the network participants are able to open up at their workplaces: "Should we grasp some of these things? What do we want? Do we need more help?" They can also luxate things in other ways. We will not see everything they do. Maybe they just raise one thing, and perhaps it takes a long time before they do it. I mean, the networks are not a solution or a concept that makes everyone know everything about what they need to know. The managers in the line organisation do also have a responsibility. And there will always be a number of employees who still do not follow the directives or the law. So one must always ask the question: What is the alternative? (The facilitator of the meta-network)*

In addition, it was obvious that the facilitator considered evidence provided by research and national guidelines to be important guiding principles in the networks' achievements. She argued that this was necessary "these days" and called into question why they otherwise should get together in the networks, which is demonstrated in the following extract from the interview:

I: During the meta-network meetings, there has been quite a lot focus on evidence provided by research, national guidelines and so on. How do you look upon it, is it important for the networks?
R: Well, I think we should be in the forefront regarding this, and that is why we have included it in the overall aims as well. It is needed today. And I feel, if we had not, why would we meet? What should we focus on? It has to be there and permeate the whole. I think that is necessary today. (The facilitator of the meta-network)

As to concrete results of benefit to the patients that could be traced back to the networks, the facilitator asserted that there is a great deal of work in everyday practice that we cannot possible measure. Instead, in contrast to her former statement about the importance of focusing on evidence provided by research, she concluded that it was much about having a belief that what they did was advantageous to both network participants and patients. She expressed her viewpoint as follows:

I: Do you have any examples of concrete results of the networks' achievements of benefit to the patients?
R: Well, it depends on what is being measured. I think it is very difficult. One cannot measure if we have fewer ulcers or if fewer patients need pain-relieving pills of a certain kind and so on. I mean, there is quite a lot of work accomplished everyday that we cannot measure. I think it is more about having a belief in what we do and believing in that this can be good. It can be good for the network participants, but it can also result in positive effects for the patients, which is the most important. (The facilitator of the meta-network)

However, the facilitator still argued that the networks had played quite a major role in the improvements she had noticed taking place within care provided by both hospitals and municipalities. She also felt that the networks provided an arena in which practitioners could come together and support one another. This was explained in the following terms:

R: We have not many patients from the municipalities lying in hospital today. Almost never. And I think in some way this is a good sign. That they within the municipalities feel secure and that discharge planning meetings work rather well. There are always problems of course, but we have helped each other to handle the care we are obliged to handle, no matter where.
I: Do you think that the networks have played a role in this development?
R:Yes,quite a big role, bigger than one can imagine actually. And it has been a long process, and this process will never be finished. The networks are of course not the one and only saving faith, but they are at least a part of it. The networks constitute an arena where people from various sectors and responsible authorities can meet. I think that the networks sometimes

also work as a valve actually. The network participants get some tips and advice, and if they have problems, they get a little bit of relief. (The facilitator of the meta-network)

The facilitator also felt that the networks had played an important role in the bridging of borders between hospital and municipal care, as well as in increasing competence within the municipalities. However, she emphasised that the networks were intended to be of benefit to both hospital and municipal care. She put her view on this in this way:

R: I think that the networks are an important element in the kind of world we live in, in the interaction we live in. It is important to open up different kinds of channels and possibilities for practitioners so that they might have nurture and support in more loose forms, which gives at least as beneficial effects as anything else.
I: If I have understood you right, your intention with the networks has been to bridge the borders between municipal and hospital care, as well as improving competence within the municipalities so that they will not be left behind?
R: Mmm, because after all, we [at the hospital] *prosecute medical care and they* [the municipalities] *pursue it. We do not pay attention to social matters, that is their area of competence and responsibility.*
I: When it comes to medical care, it is natural that the greatest skills often are to be found within the hospitals?
R: Yes it is, when it comes to treatment. But we must also become much better in our communication with them. It is really important that it is about both parties. They cannot add two hours of working hours because the hospitals' documentation is so bad that there is nothing to get hold of without making a lot of phone calls to reach people to ask. It has much to do with respect for each other's time and profession. (The facilitator of the meta-network)

She also argued that the networks worked well and that she would not have done things in another way if she had started all over again. She asserted that the loose framework of the networks was advantageous as she felt confidence in the coordinators' competence to decide on the networks' direction. She expressed these thoughts as follows:

I: Do you think that the networks work in an optimal way, based on what you know today?
R: Yes they do, until we get some other signals that show that we should take another direction. I do not change direction without new input, because I know that the coordinators know what kind of advice and support they need. They know what is good or not or if you cannot work in this way anymore. They know their networks.

> *I: So you do not think that there is anything you would have done differently if you had started all over again?*
> *R: Well, I do not know, I find that question hard to answer. We constructed it rather loosely after all. We put a framework around it and never say: "Have you done this and that?" "It must be ready that day!" "What has been done?" I have in no way put a crossbar for what they should accomplish. (The facilitator of the meta-network)*

Moreover, the facilitator claimed that the networks were in a development process, which had gradually led for example to more use of case descriptions within the networks. She explained her thoughts in the following way:

> *It is also about a development process for the networks. Things take new paths, just as the rivers do. For example, we did not have many case descriptions and similar methods during the first years. But when you have established a forum* [refers to the networks] *you take on new stuff, new training, new knowledge and new methods and so on. And case descriptions are such a method that could be useful: "What conclusions can we draw from this case? How does it work at our workplace? What should we look at? What is it that has not been good?" (The facilitator of the meta-network)*

In addition, she thought that constellations like the networks will always be needed to facilitate the interaction between the two responsible authorities. In her own words:

> *I think that this type of constellations* [refers to the networks] *will always have a future. They are needed in conjunction with the two line organisations we have. It is the lines of decision-making I have in mind. As long as we have two responsible authorities, we have to find arenas where we solve problems jointly in the best manner possible, and this is where the networks come into the picture. Such arenas facilitate the processes between us after all. Because I mean, Kristianstad municipality has approximately 2000 employees, and our hospital has 2500. And then we have the other municipalities. There are several thousand people employed, probably around 10.000. And the two main authorities must find ways in which they can interact. This will always be necessary. (The facilitator of the meta-network)*

The facilitator asserted that the network idea had now been spread to the *Skåne University Hospital,* which is the largest hospital in the region. The *Skåne University Hospital* had begun to create networks with nearby municipalities inspired by the networks in the focus of this study. The facilitator explained this as follows:

> *R: The Skåne University Hospital in Malmö has also begun to establish networks in relation to the municipalities.*
> *I: With these networks as an inspiration?*
> *R: Yes, yes. We have been there and advertised the networks, both me and one of the coordinators* [refers to one of the researchers]. *Their chief and I have cooperated a lot over the years, and she felt that this was a great idea. She saw the same problems that I saw in 1995, and when she got this concept she said: "Goodness me, what a great idea!" (The facilitator of the meta-network)*

Furthermore, as to the advertising of the networks, the facilitator asserted that the newsletters she and the network coordinators wrote were in great demand, which she exemplified as follows:

> *The networks have become well established throughout the north-east district of Skåne. Last autumn when we did not have time to get a newsletter ready, the politicians asked: "Oh, where are the networks?" and "Why?" and so on. (The facilitator of the meta-network)*

Next, the facilitator planned to set up a Dementia network. It appeared that this idea was inspired by signals from the National Board of Health and Welfare. However, the facilitator argued that the agenda of the National Board of Health and Welfare also confirmed her own way of thinking, which the following quotation illustrates:

> *What we are discussing right now is a Dementia network. Grant money is available from the government for various areas: diet and nutrition, rehabilitation, drug screening and dementia. These are the actual areas at present. And I have applied for grants for a number of years now with the purpose of lubricating these areas. It is the National Board of Health and Welfare that sets the agenda, but this is nevertheless in line with many of the networks' subject areas, which in a way confirms that I have had the right way of thinking. (The facilitator of the meta-network)*

In sum, the facilitator of the meta-network, who was also the initiator of the R&D networks, regarded evidence provided by research as important guiding principles for the networks. She was also responsive to the directions that the National Board of Health and Welfare pointed out for example. On the other hand, the facilitator asserted that it was not possible to measure a great deal of work accomplished in everyday practice, and concluded that for the network participants it was much about having a belief in what they did. In spite of their difficulties in the process of knowledge transfer, she thought that the networks worked well and had played an

important role in improvements in practice. She also considered that the networks will always be needed to facilitate the interaction between the two responsible authorities.

In this chapter, an account of the final feedback and dialogue sessions with the coordinators of the networks and their facilitator has been given, along with the facilitator of the meta-network's concluding statements on how the networks worked. The next chapter contains a theoretical analysis of the research findings presented in this and the three previous chapters, and seeks an explanation for the inertia shown to be a feature of the network coordinators' and network participants' experiences of knowledge transfer. It also seeks to outline the networks in a field of relative strengths between two poles: the discourse of evidence-based practice (EBP) versus the logic of actual practice. The intention is to develop an understanding of and an explanation of the networks as a phenomenon and the context in which they operate, including structures, strategies and interactions in play.

10. The Greater Picture

In the empirical data presented in the four previous chapters (six to nine), two main patterns emerged. First, it appeared that the facilitator of the meta-network along with most of the network coordinators and network participants were advocates of a linear top-down model of implementation of evidence-based knowledge into practice. Secondly, both coordinators and network participants experienced inertia in the transfer process. Consequently, there was a difference between their idea of how knowledge transfer should work and their experiences of how it actually worked.

This chapter provides an analysis of this data. The initial part of this chapter brings to the foreground how knowledge transfer was understood and handled by the actors. Following that, it seeks to develop an understanding of and an explanation for the inertia that emerged. For this purpose, use has been made of Bourdieu's (1982; 1990a) theory of practice. Potentially, this theory can support the discussion, since it allows us to explore the relationship between scientifically generated knowledge and practice, and how practitioners acquire knowledge in everyday work. This is followed by a section on some general observations made regarding the networks. To further analyse and explain the networks as a phenomenon and the context in which they operate, including structures, strategies and interactions in play, I draw on Bourdieu's theory of social fields (Bourdieu, 1988; Bourdieu & Passeron, 1990). By use of this lens, the networks are placed in a field of relative strengths between two poles: the discourse of evidence-based practice (EBP) versus the logic of actual practice. In this respect, the concepts reproduction and symbolic violence are used as analytical tools (ibid.).

The chapter is organised into seven themes. The first four are mainly empirically generated while the other three to a greater extent are theoretically informed, as in these I look more closely into the material through the lens of Bourdieu. The seven themes concerned are as follows:

-The idea of knowledge transfer
-Dissonance between idea and experiences

-The vertically informed networks
-Reproduction of structures
-Tensions in the field
-Legitimacy and strategies to improve positions
-The symbolic value of the networks

The Idea of Knowledge Transfer

As stated, the nine R&D networks were created in nine prioritised areas that brought together professionals from different organisations and professions within a local health and social care setting. The overall aims of the networks were to cross organisational and professional boundaries, and to transfer and implement methods and strategies into practice, based on research and good practice. It turned out to be the case that the transfer of knowledge into practice was regarded by most of the coordinators and their facilitator to be the most urgent matter for the networks to handle. For example, the subject of knowledge transfer was frequently brought up for discussion during meta-network meetings, and was also stressed in most of the interviews undertaken. This issue was also drawn attention to in the newsletters the networks produced and in the document they developed specifying the assignments of the network participants (see chapter seven).

Pervasive too, was confidence in a linear top-down model of implementation of the facilitator of the meta-network and most of the coordinators and the network participants. Despite some ambiguities in their reasoning (see later discussion), most of them considered it ideal to start out from evidence provided by research, concretise it and, following that, transfer it into practice (cf. for example Nutley et al. (2000) on macro approaches and Mullen (2004) on top down strategies). For instance, one of the coordinators explained that she considered it important that measures they implemented in practice were based on scientific evidence and national guidelines. It was also commonly believed that practitioners needed help to apply research findings, and that a role of the networks was to filter this type of knowledge and make it more practicable. An example of this is that one of the coordinators argued that practitioners are not able to absorb all research findings, thus others have to select and filter the knowledge that is needed (cf. Bahtsevani 2008 who argues that some sort of receiving system seems to be needed that can

receive and transform information into accessible recommendations to be used in everyday care).

Their top-down thinking also permeated a great deal of their activities. For example, the coordinators and network participants developed files with instructions built on research findings meant to assist practitioners in their everyday work practices. They also accomplished large-scale prevalence studies, started study circles and arranged lecturers and training, all intended to support knowledge development in practice. Even if several of these activities came to involve practitioners in varying degrees, they emerged from the networks and were driven by the coordinators and network participants. However, as will be further discussed in this chapter, both the coordinators and network participants experienced that the process of knowledge transfer did not work out satisfactorily.

Dissonance between Idea and Experiences

As stated above, most of the coordinators of the networks and network participants had confidence in a linear top-down model of knowledge transfer into practice. However, the empirical data reveals that the majority of both network coordinators and network participants also experienced a certain degree of inertia in the process of knowledge transfer. For example, one of the participants in the Psychiatric Rehabilitation network argued that the clients they met probably could benefit from the knowledge they had obtained, but probably no one in wider circles. Participants from the Pain network stated that in addition to the patients they met, it was principally just their nearest colleagues who could benefit from what they learnt within the network (cf. Odin [2006] who argues that it is the key participants in the networks who obtain increased knowledge, while engagement, experience exchange and learning decrease concurrently with the distance from the centre of the networks). Also the coordinators considered the process of knowledge transfer to be problematic, and for that reason, some of them had brought this matter up for discussion during network meetings within their own networks. This implies that the coordinators' and network participants' idea of knowledge transfer did not correspond with their experiences of how it worked in practice.

As discussed in chapter three, research demonstrates that implementing EBP in health care settings is difficult for various reasons. For instance, it is argued that it is relatively easy to make information available and to transfer data and facts, for example by use of information technology (Parent et al., 2008), but making changes in behaviour is more complicated. As also discussed, critics assert that rational, unidirectional models of knowledge transfer do not take the complex and interacting non-linear systems in practice into consideration (Petros, 2003). Moreover, it is argued that linear models of knowledge transfer, realised by means of training efforts, conferences or reports produced by the authorities, do not provide lasting effects (Lindqvist et al., 2008).

The reasons for the inertia in the process of knowledge transfer were explained in different ways. For example, several of the coordinators of the networks expressed in the interviews that they wanted the network participants to take more initiative in the process of knowledge transfer. Indirectly, these statements indicated that the network participants did not fully come up to the coordinators' expectations as regards the transfer of knowledge into the various workplaces involved in health care provision in the area. In fact, most of the coordinators had concerns about whether knowledge was actually transferred into practice or not. Another barrier in the process of knowledge transfer that the coordinators highlighted was the lack of support and resources from municipal line managers. Lack of support was argued to make it difficult for the network participants to fulfil their mission.

The network participants, in turn, primarily pointed out organisational limitations in the process of knowledge transfer, such as lack of time, lack of support from line managers and being without appropriate forums for knowledge transfer as explanations. In addition, some of the network participants argued that the greatest obstacle was that practitioners seldom had time to receive the knowledge or were not always interested since they were constantly occupied with everyday work practices (cf. for example Larsen, 1999). It was obvious that the prevailing view of knowledge transfer amongst the network coordinators and network participants, discussed in the previous section, did not correspond with their experiences of how it worked in practice. Is there any explanatory value in their explanations for the inertia in the transfer process?

First, as regards organisational limitations such as lack of time, lack of support from line managers and being without appropriate forums, it cannot be denied that these are aspects that would interfere with the process of knowledge transfer and reduce the possibilities for taking action. For example, time constraints make it difficult to think beyond everyday work practices and already existing routines and generate a lack of reflexivity within the system[39]. In the current case, the line managers allowed the network participants to participate in the different networks' meetings during working hours, but to judge from the continuous criticism during network meetings, line managers did not seem to have a deeper engagement. A reason why the resources and support required were not available could be that the line managers were not involved in the build-up phase and continuing development process of the networks, and were therefore not entirely aware of the networks' purpose. For them, the networks' activities might have been seen as something separate, going on beyond the everyday work practices at the workplaces they were responsible for.

Secondly, as mentioned above, some of the network participants pointed out the practitioners when they described obstacles in the process of knowledge transfer. It was argued that practitioners rarely had occasion or interest in receiving what was counted as knowledge, as they were always busy with everyday work practices. The network participants' experiences correspond to what the literature indicates. As described in chapter three, research has demonstrated that practitioners do not adopt evidence-based knowledge to a great extent and neither do they find it supportive (Bahtsevani, 2008; Greenhalgh et al., 2005; McCaughan et al., 2002). A reason for this could be found in Bourdieu's (1982; 1990a) theory of practice, in which it is argued that practitioners do not learn a scientific theory first and then apply it. Real changes emerge from practice and the alterations taking place there. As described in chapter four, research has both empirically and theoretically demonstrated that practice is invented in practice, i.e. in the practical situation, and

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[39] As will be discussed in chapter eleven, time constraints had implications also for the coordinators' and network participants' participation in the collaborative process that was a part of the current research project.

adjusted to, for example, scientific theories, existing norms and economic limitations (cf. Boge, 2008; Engström, 2001; Larsen, 1999). According to Bourdieu (1990a), practitioners primarily learn through their own incorporated experiences of life. Scientific theories function just as references that exist parallel with practice. This implies that scientific theories are recognised according to a practical logic (Callewaert, 1999a). Giving Bourdieu (1990a) a hearing, it could be argued that the networks' top-down model of implementation of EBP did not primarily take the practitioner's process of incorporation of knowledge into consideration.

A further possible explanation of the inertia in the process of knowledge transfer could be found in the ambiguity that emerged from the interviews with the network participants. On the one hand, most of the network participants had confidence in a linear top-down model of implementation, on the other, some of them more or less called this approach into question. For example, one of the network participants questioned that they as network participants were expected to transfer what they had learnt from network meetings into practice in a simplified form, such as in terms of lists or in bullet points. Her own standpoint was that knowledge is more complex than that and it is not possible just to capture on a list.

As regards this kind of ambiguity, it should be noticed that the network participants were also practitioners. With use of Bourdieu's (1982; 1990a) theory of practice, it could be assumed that they as practitioners might have experienced that theories or methods provided by research were not always supportive in their own complex everyday work practice. They might for example have been aware of the fact that the patients' life situations are complex, and for that reason could not easily be subjected to standardisation. Therefore, an assumption could be that some of the network participants unconsciously associated such experiences with the networks' top-down approach, and consequently did not transfer knowledge actively. In other words, some might have questioned the conditions of knowledge transfer, based on a feeling that adoption of innovations does not work or is a slow process that requires acquiring what Bourdieu (1990a) calls habitus (explained in chapter four).

Consequently, one could possibly argue that the network participants who were advocates of implementation of evidence-based practices might unconsciously have been torn between these two orientations: a belief in top-down processes versus doubts about whether practice could be evidence-based or not. If such a division in their beliefs existed, it might have restrained their activity of transferring knowledge. In addition, since the idea to create the networks proceeded from the facilitator of the meta-network, it could be assumed that the network participants had not yet fully incorporated its intentions. Instead, they may have had other incentives to participate in the networks' activities, and for that reason not exerted themselves to transfer knowledge as expected. Such an incentive to participate might have been opportunities for learning. From the empirical data, it turned out to be the case that most of the network participants put high value on the networks' internal knowledge sharing and the individual knowledge development that took place. For example, one of them emphasised that their network meetings were like a vitamin injection to her[40].

The Vertically Informed Networks

Assuredly, notwithstanding the widespread confidence in a linear top-down model of implementation within the networks, it was evident that its participants had also created horizontal structures across organisational and professional boundaries, built on voluntary collaboration and boundary-crossing communication. For example, through the networks, the network coordinators and network participants obtained an enlarged net of contacts that they argued was useful in their own everyday work practices. One of the network participants within the Pain network explained that as she now was familiar with the other network participants, it was easier for her to give them a call to obtain advice and so on. Moreover, without

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[40] There is other literature as well exploring inertia in processes of knowledge transfer. Researchers are discussing both the transfer process (see for example Shani and Docherty (2003) who argue that failed change interventions in organisations often depend on inability to create learning mechanisms, i.e. arrangements that initiate, facilitate and support learning), the absorptive capacity in practice (see for example Szulanski, 1996) and are suggesting appropriate measures to be taken to solve this problem (see for example Bahtsevani, 2008; McColl et al., 1998). However, for reasons that have been discussed, the analysis in this thesis is principally undertaken in the light of Bourdieu's theories.

being specific, the facilitator of the meta-network argued that the networks played an important role in the bridging of borders between hospital and municipal care.

Nevertheless, taking these horizontal dimensions into consideration, the networks could yet be characterised as knowledge networks or staff development networks albeit having a relatively hierarchical structure. As described in chapter three, knowledge networks can be defined as hierarchically structured, composed of groups of experts working together on a common theme or issue to strengthen their collective knowledge base (Canadian Health Services Research Foundation, 2005b). Characteristic of knowledge networks is also the creating and sharing of knowledge based on evidence, experience and expertise (ibid.).

The strong knowledge base of the coordinators has meant that the networks have become groups of experts working together, partly to strengthen their collective knowledge base, partly to transfer knowledge into practice (cf. ibid.). As presented in chapter seven, most of the coordinators themselves regarded their role to be not only that of a facilitator, but also a knowledge resource within their networks. The coordinators had also great confidence in other experts. For example, the vast majority of them considered it an advantage to invite lecturers who were experts on a specific topic to their network meetings on a regular basis. Experts supported internal network knowledge development, and the network participants were in turn expected to transfer the knowledge obtained into practice. The networks were certainly partly informed by practice since most of the network participants were practitioners and identified problems in practice that generated ideas for further discussions within the networks. However, it could be argued that the networks were largely vertically informed since they put great confidence in for example experts, national guidelines and evidence provided by research in their various achievements.

Moreover, the process through which the networks were initiated could also be described as a top-down process of implementation. As described in chapter six, it was the facilitator of the meta-network who was the initiator of the networks and the driving force in the build-up phase and in the continuing development work. In her duty at the central hospital in the area, the facilitator had a responsibility to

implement the *Community Care Reform*[41] locally, and had identified in this work a need to bridge borders between hospital and municipal care. She also identified a need to increase competence within the municipalities. The facilitator assembled a preliminary steering group, and together they formulated the overall aims of the networks and identified what they considered to be appropriate network areas. As shown in chapter six, the network areas chosen proceeded largely from what were considered to be municipal challenges, such as treatment of pain and identification of malnutrition amongst the elderly. A number of coordinators were selected who were experts in the different subject areas concerned, who in turn started to assemble appropriate and interested network participants. This process implies that already from the start, a hierarchy was set up. It could be argued that both the decision to start up the networks centrally and the recruitment process itself involved a top-down approach.

Notably, the networks' approach to knowledge transfer and their relatively hierarchical structure are not consistent with the sharing ideal discussed in the network and communities of practice literature (Bate & Robert, 2002; Goodwin et al., 2004; Wenger, 1998). According to Powell (1991), the common centre of attention in the varying literature on network-like organisational practices is the horizontal patterns of exchange, the interdependent flows of resources and mutual lines of communication. Regarding communities of practice, strength is gained by practitioners as it is themselves who link across traditional organisational boundaries and develop their own practice (Bate & Robert, 2002; Goodwin et al., 2004; Wenger, 1998). In the current research project it was evident that there was a certain degree of involvement of practitioners in the networks' achievements. For instance, for natural reasons, the network participants within the Pain network who practised the story dialogue method (described in chapter eight) engaged practitioners in the dialogue sessions that took place. Practitioners were also involved in discussions that followed the lectures and workshops that were

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[41] As described in chapter two, through the *Community Care Reform*, established in 1992, the responsibility for long-term inpatient, health care and social services regarding the elderly and disabled, including payment of costs, became transferred from the county councils to the municipalities (Edebalk, 2008; Hjortsberg et al., 2001; The National Board of Health and Welfare, 2007a).

arranged in practice by the networks' participants. However, the point here is that practitioners outside the networks were not particularly involved in the decision-making and planning of these activities. A consequence might be a limited extent to the networks' impact.

Furthermore, as presented in previous chapters, the collaborative process undertaken in the present research project strived to challenge the coordinators' linear top-down-model of knowledge transfer. As also presented, initially the common dialogue sessions led to the coordinators' assumptions of knowledge and learning becoming less vertical and closer to the sharing ideal outlined in the network and communities of practice literature (Bate & Robert, 2002; Goodwin et al., 2004). However, during the final stage of the collaborative process it turned out to be the case that the coordinators and their facilitator to a great extent still regarded knowledge as an object that one possesses and is able to hand over from x to y (cf. Cook & Brown, 1999; Ford & ogilvie, 1996). In spite of their increased interest in the subjects of knowledge transfer and learning, their original linear top-down model of knowledge transfer seemed to be firmly rooted. The reason for this will be elaborated on in more detail below. Critical reflections on the collaborative inquiry process as a whole will be presented in chapter eleven.

Reproduction of Structures

As discussed in this chapter, in spite of the coordinators' and their facilitator's exploration of the subjects of knowledge transfer and learning, their linear top-down model of knowledge transfer seemed to be firmly rooted. Why did they prioritise a top-down approach at the expense of involving practitioners outside the networks in horizontal patterns of exchange, planning and accomplishment of activities? As discussed in chapter three, Redfern and Christian (2003) assert that the management of change in health care systems has traditionally been realised by such linear models of implementation, characterised by dissemination of information within a command and control structure. Gustafsson (1987) in turn has observed that the direction of developments within health services is bound by already existing structures.

As presented in chapter two, Swedish health care and social welfare services are in general organised in a vertical structure, characterised by strong departmentalisation of different responsibilities (Anell, 2004; Åhgren, 2003). This way of organising has long traditions. According to Gustafsson (1987), the first delimitations of health care activities into sub-divisions emerged in Europe in the late Middle Ages, and has since then been reinforced. A milestone in this development, which included a development towards increased control and a scientific rationality, was at the end of the 19th century when the number of hospitals grew rapidly. Now it became possible for the physicians to diagnose and treat patients in a more rational way, which also implied that the physicians were given the role as experts and obtained higher status (Foucault, 1975). Since then, specialisation and demarcated forms of health care organisation have been encouraged (Gustafsson, 1987). Taking both the historical development process of health care services and contemporary ways of organising into consideration, it is not unexpected that the networks have preferably chosen a vertical way of organising. It is difficult to take steps outside traditional patterns and structures.

Moreover, as stated previously, it was the implementation of the national *Community Care Reform* locally that inspired the facilitator to create the networks. In addition, the local political decision to implement the health care restructuring called *Integrated Care* (described in chapter two), which took place as a parallel process to the network formation, led to the networks approximately two years after the start being formally linked to this implementation process. Even if this particular health care restructuring did not appear to have any clear impact on the coordinators' agendas or on the networks' development processes, it was judged by the facilitator as a useful label of development. For example, after a period of time the facilitator affirmed in a newsletter that the networks were now well established in their important roles as development agents of *Integrated Care*. It was not surprising that the facilitator had greater commitment to national reforms and ongoing health care restructuring processes in comparison with the coordinators. She was in her profession obliged to be updated on national requirements and directives. Since she was part of the managerial group at one of the hospitals, she was also well informed about the areas in focus at national level and upcoming changes within the Regional Government. It could be assumed that new directions

from these levels influenced the facilitator in her priorities. For example, as described in chapter nine, next she planned to set up a Dementia network, which appeared to be an idea inspired by signals from the National Board of Health and Welfare about a new area of concern.

Furthermore, the local health care restructuring named *Integrated Care* was a cornerstone in a regional policy document called *Vitality in Skåne – A concept for health care delivery* (presented in chapter two). This policy document was in turn a response to the *National Action Plan for the development of health care* approved in the year 2000, in which it was established that primary care instead of hospitals should form the basis of health care (Anell, 2004; The Ministry of Health and Social Affairs, 2000). In Sweden, a process of transfer of responsibility from the county councils to the municipalities started with the *Community Care Reform*, established in 1992. As discussed in chapter two, the *Community Care Reform* coincided with the economic recession in the early 1990s and is regarded as a starting point for a new direction within Swedish health care leading to financial cut-backs (Anell, 2004; Hjortsberg & Ghatnekar, 2001; The National Board of Health and Welfare, 2007).

The enactment of major structural health care reforms entailing such transitions from expensive to more cost-effective alternatives has become an emerging trend, not only in Sweden, but also in a number of countries (Atun, 2004; Edgren & Stenberg, 2006). As discussed in chapter two, it is argued that this new way of organising has links to an ideology which gained impetus in the 1980's, referred to as new public management (NPM) (Hasselbladh et al., 2008). The NPM ideology implies increased emphasis on market solutions, cost efficiency and control (Pollitt & Bouckaert, 2004). As a consequence, public sector organisations have been actively searching for ways to improve the efficiency, effectiveness and responsiveness of their systems. The ongoing developments within the public sector towards increased privatisation and open competition have created the need for measurement and the search for evidence about what works.

It is probably drawing a too far-reaching conclusion to state that the networks in addition to being a matter of quality were also an economy measure. However, it is

undeniable that the networks emerged within a context where cost efficiency was evident and health care services subjected to great pressure to maintain or improve quality of care (Anell, 2005; Hjortsberg & Ghatnekar, 2001). Characteristic of the time was also that public sector organisations were increasingly exposed to competition, and that decision-makers within these sectors focused largely upon results through measurement and assessment of the impact of their activities (Pollitt & Bouckaert, 2004). Even if it was not stated explicitly, it could be argued that such contextual matters influenced the coordinators of the networks, their facilitator and the network participants in their reasoning. As discussed, most of them considered mapping and measuring to be particularly desirable in the networks' achievements. For example, one of the coordinators argued that it was important to accomplish large-scale research studies so that they could bring forth facts that could be used to put economic pressure on politicians. Moreover, one of the network participants within the Discharge Planning network stated that they had to come up with concrete results within the network in the future, otherwise the network would die out.

The requirements for quality, efficiency and productivity that have been strongly emphasised within health and social care services during the last few decades have also entailed explicit requirements for a more scientifically supported knowledge base in practice (Bergmark & Lundström, 2006). In other words, as described in chapter three, there has been a growing concern that practice should be more evidence-based and that research-based knowledge should be more widely used by practitioners, resulting in more efficient care (Bergmark & Lundström, 2006; Roberts & Yeager, 2004; SOU, 2008).

As has been discussed previously in this chapter, even if the coordinators were interested in starting from the perspective of the practitioners, most of them considered evidence provided by research to be the point of departure in their endeavours. Supporting the EBP implementation required from central levels seemed to be attributed higher value in comparison with acting in line with what the network and communities of practice literature suggest, which is acting from the perspective of the practitioners. One could assert that the coordinators and network participants had adjusted to the prevailing norms about knowledge within

health and social care services. With reference to the historical aspects and contemporary health care restructuring influenced by NPM ideology and the evidence-based discourse discussed above, it could even be argued the networks were a means by which the medical and scientific discourse was reproduced. This reasoning will be further elaborated on through the lens of Bourdieu in the next section.

Tensions in the Field

As discussed in the previous section, it could be claimed that in their achievements the coordinators and their facilitator and the network participants adjusted to and reproduced existing structures and norms within health care sectors. According to Bourdieu (Bourdieu, 1999b; Bourdieu & Passeron, 1990), processes of reproduction in a field also involve power relations, which imply that there are always tensions and struggles involved. Bourdieu associates such competitive and often subconscious processes with what he terms symbolic violence. As described in chapter four, symbolic violence is exerted by those who are in control of doxa, that is, in control of the tacit belief or unspoken rules that are taken for granted and characterise a certain field. This competition concerns the acquiring and preserving of capital, and the process takes place subtly and unseen, for example through recognition (ibid.). The culture of what is legitimate in the field is reflected in what is discussed and how it is discussed. Those exposed to symbolic violence learn the prevalent definition of the situation and the culture of what is right and wrong from those who define the situation within a field. In this way doxa becomes incorporated in the opponents, i.e. the heterodox, and this slowly turns into new habitus (Bourdieu, 1984). The heterodox accept doxa as natural and true since it is dominant, and act in accordance with it. However, as described in chapter four, the heterodox are always challenging doxa as well.

If we at first take a look at Swedish health care organisation in general, the vertical structure and the three levels of government (described in chapter two) indicate that boundaries and power relations must be involved. Alaszewski et al. (2004) argue that medical services due to more specialists and better recourses have a stronger position in the field in comparison with social services. This statement implies that hospitals have the strongest position, followed by primary care and

municipal care. In this respect, the data analysis indicated that hospitals seemed to be associated with higher status as they were attributed with higher competence in comparison with the municipalities. For example, as mentioned previously, the facilitator of the meta-network asserted that a reason why the networks were formed was that she had identified a need to transfer medical competence from the hospitals to the municipalities. Even if she explained that the transfer was intended to take place in both directions, it could be inferred from her reasoning that she considered it essential to increase competence within the municipalities so that they could approach the hospitals' standard. Several of the coordinators also considered that the level of knowledge amongst front-line health care workers was lower within the municipalities. This difference in competence was argued to be observable also within the networks. For example, one of the coordinators asserted that the level of knowledge was surprisingly low amongst the municipal nurses within her network.

The imbalance in status between the care providers involved was also described by some of the network participants. The subject of imbalance was highlighted primarily by network participants from the municipalities, and in particular from those within the Discharge Planning network. For example, as presented in chapter eight, one of the network participants within the Discharge Planning network maintained that it was the hospitals that dictated the conditions for the collaboration between the hospitals and the municipalities in the discharge planning process. This was regarded as a problem since it was the municipalities that had the main responsibility for the discharged patients. The network participant also felt that the hospitals' dominance had become worse due to an increased degree of specialisation and shorter treatment times at the hospitals. The tensions between the two care providers were visible not only outside the Discharge Planning network, but within the network as well. For example, some of the network participants considered that there had been too much focus during network meetings on the perspective of representatives of the hospitals. It was argued that the network needed more representatives from the municipalities to get the balance right.

Based on the empirical results, it could be assumed that tensions were involved in the networks' attempts to transfer evidence-based knowledge into practice as well. As has been discussed previously in this chapter, EBP based on scientifically generated knowledge seemed to have occupied a place apart from other types of knowledge and became taken for granted, pointing out what kind of knowledge practitioners should draw upon in their everyday work practice. The medical evidence-based discourse permeated the health and social care sectors in different ways, for example through legislation and ideologies. On this basis, it could be argued that the medical evidence-based discourse has been established as a doxa within this field. It could also be argued that the network participants in general and the coordinators and the facilitator in particular were in control of the doxa. Through their background and position within the networks (discussed further down), they had the authority to communicate the doxa to practice in various ways. The coordinators, the facilitator and the network participants could therefore be regarded as the orthodox since they legitimised doxa and transferred not just knowledge, but also the prevailing theory of practice in society through their activities.

However, as already stated, based on Bourdieu's (1882; 1990a) theory of practice, doxa are always challenged. In the present research project, it could be argued that the doxa was challenged by practice. On the one hand, the coordinators and their facilitator were proponents of a linear top-down model of evidence-based knowledge implementation. On the other, as described in chapter four, researchers have demonstrated both empirically and theoretically that this type of implementation does not work so well (Boge, Bourdieu, 1990a; 2008; Engström, 2001; Larsen, 1999). Instead, these researchers claim that it is habitus that generates practice, and in that sense practice has a logic in its own right. This implies that practice is primarily generated from practice (which is in agreement with the logic of communities of practice, discussed previously). On this basis, it could be asserted that the practitioners outside the networks were the heterodox, i.e. those who in a subconscious way were challenging doxa and the existing dominance in the field.

Furthermore, from my interpretation of data obtained in the present research project, the doxa was challenged not only by practitioners outside the network, but to some extent also by network participants. As stated, the network participants did not come up to the coordinators' expectations as to their transfer of knowledge into practice. From the interviews with the network participants themselves, it emerged that they did not take much of their own initiative as knowledge transferrers. As indicated previously, it could be argued that the network participants, who also were practitioners, were ambivalent in their roles. One the one hand, as practitioners they might have felt that it does not work well to disseminate knowledge generated from research into practice since such knowledge never can foresee the infinite number of moves that can be made in practice. For example, as presented in chapter eight, one of the network participants from the Discharge Planning network asserted that the process of knowledge transfer was complex, but argued that the biggest obstacle was situated in practice. On the other hand, as network participants they might have taken the dominant linear top-down model of knowledge transfer for granted. Assuredly, during the interviews various suggestions came up on how to overcome problems associated with this model, but not many questioned the top-down approach explicitly.

However, regardless of whether the assumed ambiguity amongst the network participants discussed above existed or not, the doxa was strong. This can be illustrated by use of one of the interviews undertaken within the Discharge Planning network (see chapter eight). On the one hand, the network participant concerned argued that the main purpose of the network was to come together and discuss common problems. On the other hand, the same network participant was frustrated as well, since her network had not made manuals or accomplished large-scale research studies as the Nutrition and Eating network had done. From the analysis it emerged that the focus on knowledge transfer was not self-evident amongst network participants, but since the evidence-based discourse was strong, they supported doxa, at least on a rhetorical level. In other words, the network participants' reasoning seemed to follow a doxic logic. The medical evidence-based discourse was accepted as true, implying that structures of domination were reproduced.

Legitimacy and Strategies to Improve Positions

As discussed, the coordinators, their facilitator and the network participants had the authority to decide what kind of knowledge, guidelines, attitudes and behaviours that should be implemented in practice. How could it be, then, that the networks enjoyed such a relatively powerful position? Based on Bourdieu's theory about fields, and as will be discussed below, a reason for this could be that those involved in the networks were in possession of symbolic capital, i.e. capital that was recognised and had gained recognition within their field (Bourdieu, 1993; Broady, 1998b).

If we first take a look at the position of the facilitator of the meta-network, it could be argued that she had a powerful position locally. Being part of the managerial group at one of the hospitals, she had real power, and she was also well known in the field. Her idea to create the networks was well established within the managerial group at the central hospital in the area, and the idea was politically anchored as well. These circumstances meant that the networks gained recognition and legitimacy from both politicians and the managerial body at the hospital, i.e. from those who were in positions of power in the field. The facilitator had also an extensive network of contacts herself in her everyday work practice, along with knowledge of formal and informal decision paths within the organisations. In addition, as already described in this chapter, she was well informed about the areas in focus at national level and upcoming changes within the Regional Government, which provided her with a `feeling for the game´. It could be argued that the facilitator contributed strongly to the networks' accumulated symbolic capital.

Moreover, if we take into consideration the steering group that was connected to the networks, it could be assumed that the participants within this group had an impact on the networks' legitimacy as well. Most of them were registered nurses having a specific overall medical responsibility in relationship to nursing within municipal care, which carried a certain cachet within municipal care. This professional category for natural reasons also had an extensive network of contacts in their everyday work, which the networks benefited from. For example, as described in chapter six, they at times took the opportunity to anchor different

ideas arisen from coordinator meetings and suggest measures to be taken during meetings with their own colleagues within the municipalities. It could therefore be argued that the steering group participants' positions as professionals provided the networks with symbolic capital, which were advantageous to the networks' positioning in the hierarchy within the field.

Furthermore, the coordinators of the networks were in possession of symbolic capital themselves because of their backgrounds. For example, they were all well-educated and familiar with research and clinical methods in relationship to evidence-based nursing practices, which were competences that were assigned value in their field. The coordinators had also through their experiences incorporated knowledge of how the hierarchy and social order worked within this field. It was obvious that their acquired capital manifested itself in the networks' approach and directions. Several efforts made within the networks and measures taken outside the networks had started from and were strongly influenced by the coordinators' competence and ideas on needs for improvements in practice. This was evident for example within the Nutrition and Eating network and the Ulcer network, in which the coordinators took advantage of their competence as researchers to accomplish large-scale prevalence studies. Moreover, the coordinators that had research or medical qualifications were paid more attention to and referred to more frequently in comparison with the other coordinators, as they were considered to be guarantors for a high standard. This came out for example in discussions during meta-network meetings and in the newsletters they produced.

According to Bourdieu (1988), and as presented in chapter five, the orthodox develop strategies to maintain or improve their positions within a field and to defend the existing doxa. They also make investments to accumulate capital and have it recognised in the field (ibid.). Within the health and social care sector, such investments could be manifested in documents, methods and instruments of various kinds as well as through reputation. In this chapter it has been discussed that the coordinators, their facilitator and the network participants legitimised the doxa and transferred not just knowledge, but also the prevailing theory of practice in society through their activities. In addition, as described in chapter seven, the

meta-network participants made various efforts to disseminate information about the networks and their value. Examples of such efforts were their writing of newsletters, development of posters and participation in regional and national conferences. Several coordinators also strove to create stronger links to the local university since they considered this would contribute more weight to their achievements. A reason for this could be what is touched upon in chapter four, namely that in society in general, higher value is attached to an evidence-based and analytic rationale (episteme) at the expense of knowledge developed through action (phronesis). It seemed that the participants within the meta-network strived to obtain symbolic capital from the academic field to draw upon and use inside their own field of health care and strengthen their position.

A similar investment made by the coordinators was to invite external lecturers to network meetings who were experts on a specific topic. As presented in chapter seven, it was generally considered to be an advantage to invite lecturers who had a PhD, since their ability was regarded to be of a high standard. In addition, a number of the coordinators made attempts to recruit physicians to their networks as they thought that the physicians' position in the field would back up their achievements. Physicians are usually seen as the profession with the highest status within the field of health care (Foucault, 1975; Johannisson, 1997), which indicates that the coordinators wanted the networks to have a more prominent position. One could argue that the various efforts described above were measures taken to support network development and fulfil their mission, but also strategies developed to gain recognition and enhanced reputation, and through this to strengthen the networks' position within the field.

The Symbolic Value of the Networks

Seen from the perspective of those who were in control of doxa locally, it could be assumed that the networks were beneficial and a relatively good investment. For example, an advantage for the politicians in the north-east district under the county council *Region Skåne* and the managerial body at the central hospital in the area might have provided new opportunities to demonstrate an innovative initiative that hopefully would lead to more effective routines in practice. This assumption suggests that the networks at least had a symbolic value for those in authority.

Did the networks have a value in practice then? At the period of the data collection, it emerged that both coordinators and network participants had difficulties in coming up with concrete examples of the networks' impact in practice. This was approximately two years after the network formation, so maybe it was too early for them to tell. However, according to Bourdieu (1990a), it could be argued that their dominant assumption about knowledge transfer, i.e. that knowledge is something that can be transferred from the networks and adopted in practice, was founded on an incorrect basis. As discussed previously, his argument is that such models do not take the practitioner's process of incorporation of knowledge into consideration (ibid.). This argument implies that scientific theories or methods do not guide practitioners in their everyday work to a great extent. Instead, solutions in practice are usually created ad hoc and determined as rules retrospectively. Given this theory of practice and the coordinators' and network participants' current approach to knowledge, their prerequisite of bringing about real change in practice does not appear to exist.

Yet, one point is to be underscored. A strength of the networks, underlined both by coordinators and network participants, was that the network meetings functioned as arenas for discussions, exchange of experiences and establishing of contacts. Such aspects are valuable and can be assumed to have influenced routines, attitudes and behaviours in practice in ways that are not easy to make visible. In addition, as the intention with the networks was to facilitate knowledge transfer and close the gap between knowledge producers and users, one might say that they acted as knowledge brokers or boundary spanners (Hargadon, 1998; Huzzard et al., 2010; Ward et al., 2009). As described in chapter three, knowledge brokers are engaged in recognising knowledge of value, internalising experience from different actors, linking disconnected knowledge resources and the implementing of knowledge (ibid.). It could be argued that the strengths of the networks lie in such linkage activities (ibid.). However, the critical point here is that real change in attitudes and behaviours should reasonably go in the same direction as when they were formed, i.e. through acquiring new habitus. As explained in chapter four, habitus is accumulated experience from a lifetime, and usually takes a very long time to transform (Bourdieu & Passeron, 1990). Therefore, if knowledge is constructed and meaning is attributed to it in context (Cook & Brown, 1999) and the purpose of

the networks was to bring about more substantial change, it could be argued that more focus should be on how new habitus is incorporated.

In general, a long tradition of relying on experience-based and tacit knowledge is now being challenged by explicit and evidence-based knowledge, considered to be essential for being a skilled practitioner (Nutley et al., 2003). In the current research project, the coordinators and their facilitator confirmed the evidence-based discourse rather than challenging existing routines and structures, and they did not start out from practice to a greater extent. Why? Their interpretation of evidence-based practice was strongly related to implementation of knowledge provided by research into practice. If they had started out from practice to a greater extent, practice would from their understanding of evidence not have become evidence-based. In reality, this implied that the coordinators and their facilitator used almost the same traditional strategies as before, guided by facts, natural science and the medical hierarchy, but now in a network organisation. Consequently, even if the network and communities of practice literature suggests the sharing of knowledge horizontally (Bate & Robert, 2002; Goodwin et al., 2004; Wenger, 1998), they could presumably not easily have been socialised into thinking otherwise.

In this chapter, the results that are presented in chapters six to nine were analysed. This analysis sought to understand the inertia that the network coordinators and network participants experienced in the process of knowledge transfer. It also sought to outline the networks in a field of relative strengths between two poles: the discourse of evidence-based practice (EBP) versus the logic of actual practice. The intention was to develop an understanding of and an explanation of the networks as a phenomenon and the context in which they operate, including structures, strategies and interactions in play. The next chapter presents the contribution of the research and gives some critical reflections on the research as a whole, including the collaborative inquiry process undertaken. The next chapter also embraces suggestions for future research.

11. Concluding Reflections

This final chapter contains the contribution of the current research project. It also embraces critical reflections on the research undertaken, which include reflections on the collaborative inquiry process that was part of the study. The last section in this chapter presents some suggestions for future research.

Contribution of the Research

The overall aim of the thesis was to explore the network coordinators', their facilitator's and the network participants' perspectives on the role of the networks and their ways of working. The thesis also sought to explain these perspectives in relation to networks as a phenomenon and the context in which they operate, which included structures, strategies and interactions in play. The specific research question was: What are the actors' perceptions of knowledge networks and how might we account for the networks' evolution, role and ways of working? As described in chapter one, the theoretical tools used in this thesis were chosen as a way of answering and explaining the empirical story line. The initial data analysis suggested the explanatory value of Bourdieu's theory of practice and theory of fields, including the concepts symbolic violence and reproduction functioning as analytical tools (Bourdieu, 1982; Bourdieu, 1988; Bourdieu, 1990a; Bourdieu & Passeron, 1990).

As stated in chapter three, networks have become an important area of research within different disciplines such as health policy (e.g. Meijboom et al., 2004; van Wijngaarden et al., 2006), medicine (e.g. Baker & Lorimer, 2000), organisation studies (e.g. Docherty et al., 2003) and public administration (e.g. Bate, 2000). As discussed, networks and network-like organisational practices such as communities of practice generally occur as a response to hierarchical organisation, authority and rule-bound thinking, and are usually a mark of a perceived need for collaboration and learning in practice (Bate & Robert, 2002; Goodwin et al., 2004; Wenger, 1998). Literature usually presents the advantages of networks, and discusses, for example, their potential for learning, boundary crossing or successful implementation processes (e.g. Bate & Robert, 2002; Lugon, 2003; Meijboom et

al., 2004; van Wijngaarden et al., 2006). Networks have become an ideal painted to deal with complex problems, and not much work is to be found that places health and social care networks under critical scrutiny. Based on the empirical results and the theories used, the current research project contributes to a critical discussion on networks as a measure for facilitating knowledge transfer within health and social care sectors.

Empirically, this thesis has focused on nine research and development (R&D) networks set up to promote a professional approach to care and strengthen the collaboration between health care sectors in the north-east district under the county council *Region Skåne* in Sweden. The network activities have been accomplished in many different ways, principally built on the coordinators' and network participants' own ideas and suggestions. The data shows that the facilitator of the meta-network along with most of the network coordinators and network participants were advocates of a linear top-down model of implementation of evidence-based knowledge. In addition, practitioners outside the networks were not particularly involved in the decision-making and planning of network activities. A key finding, discussed in chapter ten, was that the networks' approach to knowledge transfer and their relatively hierarchical structure was contradictory to that which the network and communities of practice literature in general argue as being the strengths of networks (see example of such strengths in the paragraph above). This implies that there was an inconsistency between the ideal outlined in the literature and the transfer model adopted by the participants in the current research project. Certainly, as indicated in chapter three, there is a vast body of research that advocates linear top-down implementation models of knowledge transfer, but the point here is that network literature in general emphasises a more horizontal sharing ideal.

Furthermore, the data also revealed that both network coordinators and network participants experienced inertia in the process of knowledge transfer into practice. Consequently, there was a difference not only between their transfer model and the ideal outlined in the network literature; there was also a difference between their idea of knowledge transfer and their experiences of how it actually worked. In addition, a consequence of not taking network literature into more consideration

might be the limited extent of the networks' impact. Therefore, our common dialogue sessions undertaken as part of the collaborative inquiry process focused on the subject of knowledge transfer. Initially, this process led to the coordinators' assumptions of knowledge and learning becoming less vertical and closer to the sharing ideal outlined in the network literature (Bate & Robert, 2002; Goodwin et al., 2004; Wenger, 1998). However, in spite of their interest in the subjects of knowledge transfer and learning it emerged from the collaborative process that their original linear top-down model of knowledge transfer seemed to be firmly rooted (see chapter ten).

Theoretically, the thesis contributes to an understanding of why the process of knowledge transfer was considered by the coordinators and network participants to be a sluggish process. The thesis also contributes to an explanation of why they adhered to the macro-discourse of evidence-based medicine at the expense of involving practitioners outside the networks in horizontal patterns of exchange. Through the lens of Bourdieu´s theory of practice, and as discussed in chapter ten, it could be argued that the inertia the coordinators and network participants experienced in the process of knowledge transfer was because top-down models of implementation do not primarily take the practitioner's process of incorporation of knowledge into consideration. In addition, as also discussed, underpinned by Bourdieu's theory of fields the networks could be outlined in a field of tensions between two poles: the discourse of evidence-based practice (EBP) versus the logic of actual practice. This thesis has discussed historical aspects, contemporary health care restructuring influenced by the NPM ideology, the prevailing evidence-based discourse within the field of health care, and the ongoing struggles for the acquisition of better positions in this field. On the basis of these aspects, it is argued that the coordinators and network participants preferably chose a vertical way of organising, but in a network organization form. As elaborated, the doxa was strong and made it difficult to take steps outside traditional patterns and structures, which the collaborative inquiry process confirmed.

Moreover, the research undertaken asserts that the networks were also a product of and reproduced the evidence-based discourse and the prevailing structures within their field. Those involved in the networks legitimised the doxa and transferred not

just knowledge, but also the prevailing theory of practice in society through their activities. As discussed in chapter ten, especially the network coordinators and their facilitator were in possession of symbolic capital, i.e. capital that was recognised and had gained recognition within their field. They also gained legitimacy and recognition from those who were in positions of power within this field. The thesis discusses the symbolic value of the networks for those in authority as its participants reproduced the culture of what is right and wrong, a process that Bourdieu terms symbolic violence (Bourdieu & Passeron, 1990). Undoubtedly, the networks concerned have several advantages, such as being a forum for internal dialogue and exchange of experiences. However, it is indicated that networks might not be a necessary panacea in processes of knowledge development and change in practice.

A methodological contribution of this research project is the combination of a practice based approach with a theoretical lens. As presented in chapter five, an essential feature of action research (AR) is the involvement of both researcher and participants in processes of participation, dialogue, reflexivity and democracy (Greenwood & Levin, 2007; Gustavsen, 1992). However, one of the criticisms levelled at AR is that practice based methodology's contribution to theory is limited. Critics argue that action research projects are deeply embedded in practice at the sacrifice of a distanced gaze (Baskerville & Wood-Harper, 1996). The practice based approach adopted in this research project aimed to support network development, which implied a primary focus on participation, dialogue and reflexivity. The theoretical lens used helped to break with common-sense and the prevailing perceptions that always exist and explaining the empirical story line (Bourdieu et al., 1991). (See next section for critical reflections on the combination of AR and the particular theoretical lens used.)

The research undertaken does not come up with a solution to the problem of knowledge transfer into practice. Firstly, as presented in chapter three, a vast body of research is discussing this issue (see for example Bahtsevani, 2008; McColl et al., 1998), and there is no simple answer to be found. Secondly, if I had recommended a particular model to the participants of the study, I would have done what I am criticizing, namely imposing a solution from outside. Instead,

based on the empirical results of the study and the theories used, the thesis has discussed the complexity involved in linear transfer processes. The present study was conducted at a local level, but the theoretical contribution that is summarized above could be relevant also at a macro level. The structures, positions and symbolic violence discussed constitute a framework that might also be valid in discussions on the subject of knowledge transfer into practice in other health care contexts.

Critical Reflections on the Research Undertaken

As described in chapter four, habitus and capital are core notions in Bourdieu's theory of fields. Since the analytical tools used in this thesis were derived from this theory, I can be criticised for not having collected data that captured the network participants' habitus and possession of capital. Exploring agents' habitus and capital allows for an in-depth explanation of the relationship between the agents' action and the structures they function within. By capturing, for example cultural, economic and social capital, one can better describe the orientation that is manifested in practical action. However, as described, the theoretical lens was not adopted until the data collection was accomplished. It was the initial analysis undertaken that formed the basis for the theoretical lens to come. As also described, the analytical tools were used to interpret and explain the inertia the network coordinators' experienced in the process of knowledge transfer, and to identify structures and tensions involved in the field. Instead of carrying out a regular field analysis in which the participants' habitus and capital are captured, I aspired to conduct a line of reasoning built upon the theory of fields, including the notions of reproduction and symbolic violence (Bourdieu, 1988; Bourdieu & Passeron, 1990). Using these concepts as a lens assisted me in reconstructing a social field consisting of relative strengths and in reflecting upon positions and strategies involved.

I am aware that the analytical tools chosen have an impact on the conclusions to be drawn. Using a specific lens implies that some aspects become highlighted while others remain unseen. In this study, the main focus of the analysis was at a structural level. The individual views were considered during the collaborative inquiry process undertaken, but not analysed in depth. Rather, the statements of the

participants were analysed from a collective level in relationship to the theoretical lens. In addition, the theories of Bourdieu have in themselves certain limitations. Critics argue that these theories are deterministic because of their focus on competition and the unconscious transfer of power from the dominated to the dominant (Jenkins, 1999; King, 2000). However, Bourdieu's defenders argue that these theories rather involve a belief in peoples' capacity and opportunities to liberation through knowledge (Müller, 2002). In this thesis, despite the weaknesses mentioned above and for reasons that have been discussed in this chapter, I argue that Bourdieu's theories constituted a fruitful framework for the analytical work.

Moreover, as described, methodologically, the research project was embedded in an action research (AR) approach. As also described, characteristic of AR is the involvement of both researcher and participants in processes of participation, dialogue, reflexivity and democracy (Greenwood & Levin, 2007; Gustavsen, 1992). Bourdieu et al. (1991), for their part, emphasise the importance of breaking with the participants' spontaneous thinking through reconstruction of the scientific object. This standpoint implies that the role of the researcher is to uncover unreflected everyday comprehensions, i.e. that of an outsider accomplishing traditional research. From these different approaches to proximity and distance, it could be discussed whether an action research approach is commensurable with the theories of Bourdieu. This thesis has attempted to reconcile both perspectives. I handled this by conducting the research in two partly overlapping phases; first the collaborative phase and then the epistemological break and reconstruction phase.

Furthermore, as stated in chapter one, the purpose of the collaborative process undertaken was by means of a dialogical process, to encourage the coordinators of the networks to engage in reflection on a subject that emerged from their own interest. The whole process was intended to support network development and possibly initiate a process of change. However, the action research process was less collaborative than the ideal outlined in the literature (see for example Greenwood & Levin, 2007; Heron & Reason, 2001). As described in chapter five, from a continuum of non-intervention to a great degree of intervention, this research project leans towards the non-interventionist side of the continuum. Data collection, the interpretation of data and writing were not accomplished

collaboratively with the network participants. Yet, the network participants were involved in decisions on data-collection methods, the dialogue sessions and the direction of the collaborative process. For example, it was the coordinators who asked for a combined lecture and workshop in learning and suggested the continuation of the process within the three selected networks.

An explanation for the process being less collaborative than the ideal was the temporal dimension. For the coordinators and network participants in this study, the collaborative process was only part of their busy everyday work practices, which inevitably impacted on this process. Their opportunities to become involved were rare and the participants themselves met rarely. The participants within the meta-network had meetings about four half days a year, which implied that the time I had at my disposal to give feedback and facilitate dialogue and reflection sessions was limited, and also competed with other things on their agenda. The coordinators and network participants were involved in the networks, but only temporarily engaged in them, and from their perspective, the collaborative inquiry process was even more marginalised. Hence, the temporal dimension impinged on the nature of the collaborative process (cf. Platteel et al., 2010). I aspired to conduct collaborative inquiry, but the process ended up more closely resembling traditional research than expected.

My own experience from the current research project is that there is an inherent dilemma in handling the sometimes different frames of references of the participants and the researcher. More precisely, the network coordinators and I started out from different perspectives and disciplines. As a social researcher I had a lens which made overall structures, power relationships and conflicting interests particularly interesting. As described in chapter one, my view of knowledge was that knowledge is constructed and that meaning is attributed to it in context (see for example Cook & Brown, 1999). The coordinators of the network had a clinical view, which implied a greater focus on standard operating procedures and measurable outcomes (Ford & ogilvie, 1996). These differences were not clearly articulated maybe as we did not understand the value of them. It certainly revealed a dilemma that the participants in the collaborative inquiry process had their specific theory of change and I as a researcher and facilitator of the collaborative

process did not fully share their mindset. However, if I had started out from their paradigm, I had possibly not been able to challenge their basic approach to knowledge transfer, which they actually asked for. Instead, I would probably have facilitated dialogue and reflections within existing frames. Looking back, we could have clarified our different roles better and been more explicit as to our expectations.

Moreover, I have had concerns about how to combine the collaborative and critical aspects of the research practically (cf. Svensson, 2008b). A collaborative process is built on trust. Adding a critical perspective involves a balancing act that could undermine this trust. In this case, as described in chapter five, I asked questions and challenged routine-like ideas and ways of working with the intention that reflection and developmental learning should be supported (Ellström, 1996). From Berglund and Danilda's (2008) perspective, the role of interactive research is not only to listen to the practitioners' voices, but also to be critical and provide contrasting images, reveal new perspectives and problematise established conventions. In this research project I strived to allow practitioners to examine their own knowledge and to situate this knowledge within a broader framework by challenging perspectives taken for granted (cf. Ledwith & Springett, 2010).

One question I have asked myself during the collaborative inquiry process is whether I should have taken a more leading role in the networks' development process? As described in chapter five, my approach was to leave to the coordinators and the facilitator to take responsibility for possible actions to be taken (Stringer, 1999). In this respect, Svensson (2008b) claims that interactive research approaches imply that researchers tone down their responsibility for the development work and emphasise instead the common learning process. Still, as described in chapter eight, I made an attempt to engage the participants within the Pain network in a smaller pilot project that was based on their interest. One experience from this attempt was that as an outsider it is difficult to contribute to the creation of a better practice. What I also learned was that it is important to be flexible and responsive to the participants' ability to become involved (Herbert, 2000). A conclusion drawn, based both on my empirical experiences and the theories of Bourdieu, is that it is primarily the participants themselves who have to

find better solutions and start on the long journey for these new solutions to be incorporated as habitus. What is achievable as an outsider is to question routine practice. However, it is important to stress that through the collaborative process I have gained a deeper understanding of the complexity involved in development processes than I would have gained by exclusively using traditional data-collecting methods such as observations and interviews (Svensson, 2008b).

Another challenge I have faced was the newness of the action research methodology and my role as facilitator. In parallel with the collaborative process undertaken, I had to learn both theoretical and practical understanding of action research. Despite invaluable discussions with my director of studies and the participants within the research group I was part of on how to facilitate dialogue and reflection amongst the participants, this did not give me a clear role or position in relation to the process of development and change of their practice. As described in chapter five, a co-researcher participated in the feedback and dialogue sessions undertaken during stage one, holding a role as observer and sounding board for my reflections and interpretations. Looking back, the collaborative process might have been more innovative and could possibly have had a beneficial impact on the change process if I had received such a concrete support for a longer period of time.

Furthermore, as described, the intention of the final dialogue session during stage three was that the coordinators of the networks would take ownership of what came out of our collaborative process as a whole. However, as also described, no initiatives or suggestions on a continuation emerged during this meeting (see chapter nine). It is perhaps debateable whether the coordinators of the networks and their facilitator really wanted to change their practice but rather viewed me more as symbolic capital. As described in chapter seven, several coordinators strove to create stronger links to the local university since they considered this would contribute more weight to their achievements. Maybe the coordinators of the networks and their facilitator contacted the research group I was part of to become involved in a research project for the same reason. According to Bourdieu (1988), and as discussed, the orthodox make investments to accumulate capital and have it recognised in the field. Obtaining symbolic capital from me as a part of the

academic field might have been considered to strengthening the networks' position inside their own field of health care. However, this is a speculative reasoning based on theoretical arguments rather than on empirical data.

In what way have the collaborative process served the networks' development process? As described in chapter seven, during the dialogical process undertaken during stage one, the coordinators' original linear top-down model of knowledge transfer became more multifaceted, implying that the one-way direction of knowledge they emphasized earlier on now became multi-directional. Now they highlighted the perspective of the practitioners more explicitly compared to what was the case during the observations and interviews that were undertaken earlier. For example, suggestions emerged to support network participants in the use of case descriptions amongst practitioners. However, the feedback and dialogue sessions undertaken during stage three (see chapter nine) showed more contradictory results. On the one hand, the coordinators seemed to have an increased interest in the subjects of knowledge transfer, dialogue, reflection and learning. On the other, their initial theory of practice, which was a linear top-down model of implementation of evidence-based practice, seemed partly to be more consolidated. However, it should be noted that outcomes of processes are difficult to measure. Gunnarsson et al. (2007) argue that small but important changes are often not explicitly articulated and therefore difficult to make visible. In addition, the collaborative process undertaken in the current research project could be seen as a start of a cumulative process, when taken in a long-term view leading to increased consciousness and new ways of thinking and acting.

Future Research

A major challenge facing health care sectors is that of how to support practitioners in the incorporation of new practices resulting in actual changes. Networks may possibly have a role in such processes. However, more research has to be undertaken in this area. Further research is needed not only on what is required from the practitioners' perspective, but also on what is required of networks, to correspond to the complex and interacting non-linear systems in practice and create a sharing culture and to overcome limited extent in impact. This suggestion might include research on how to minimise organisational barriers in the support of

knowledge development in practice and on what resources both practitioners and networks need in this process.

Furthermore, as discussed in this thesis, characteristic of action research projects is the involvement of both researcher and participants in processes of participation, dialogue, reflexivity and democracy (Greenwood & Levin, 2007; Gustavsen, 1992). However, as also discussed, critics argue that action research projects are deeply embedded in practice at the sacrifice of a distanced gaze (Baskerville & Wood-Harper, 1996). Further work is needed on the subjects of proximity and distance in action research projects to overcome both the epistemological, methodological and practical dilemmas involved in collaborative inquiry projects.

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Appendix 2

Abbreviations and English-Swedish Glossary

Abbreviations

AR	Action Research
EBM	Evidence-Based Medicine
EBP	Evidence-Based Practice
NHS	National Health Service
NPM	New Public Management
PAR	Participatory Action Research
R&D	Research and Development

English-Swedish Glossary

Administrator of means-tested home- help services	Biståndshandläggare
Integrated Care	Närsjukvård
Government bill	Proposition
Nurses with a specific overall medical responsibility in relation to nursing within municipal care	Medicinskt ansvarig sjuksköterska (MAS)
Officials in charge of functional impairments	LSS-handläggare
Qualified homecare services	Kvalificerad vård i hemmet (KVH)
Special forms of housing	Särskilt boende
Swedish Association of Local Authorities and Regions	Sveriges Kommuner och Landsting
Swedish Government of Official Reports	Statens offentliga utredningar (SOU)
The Community Care Reform	Ädelreformen
The Ministry of Health and Social Affairs	Socialdepartementet

The National Action Plan	**Nationell handlingsplan för utveckling av hälso- och sjukvården**
The National Board of Health and Welfare	**Socialstyrelsen**
The Regional Council	**Regionfullmäktige**
The Swedish Medical Association	**Sveriges Läkarförbund**
The Swedish Research Council	**Vetenskapsrådet**
Vitality in Skåne – A concept for health care delivery	**Skånsk Livskraft – vård och hälsa**
Scania's Association of Local Authorities	**Kommunförbundet Skåne**

Appendix 3

Interview Guides

The coordinators of the networks

-How would you describe the role of the networks?

-How would you describe your role as a coordinator?

-What are your ways of working within your network?

-How do think your achievements work in practice?

-What do you consider to be strengths/limitations?

-What is the networks' relationship to *Integrated Care?*

-How would you describe the future of the networks?

The network participants

-How would you describe the role of the networks?

-What do you consider to be the value of the network?

-What are your experiences of knowledge transfer and implementation in practice?

The facilitator of the meta-network

-How would you describe the role of the networks?

-What were your thoughts behind the network formation?

-How would you describe the build-up phase?

-What were your thoughts behind the recruitment of the network coordinators?

-Which were the resources devoted to the networks?

-How would you describe your role as facilitator?

-How do you think the transfer of knowledge into practice is working?

-What is the role of evidence provided by research?

-Which are the benefits for patients/clients?

-Is there something you would have done differently?

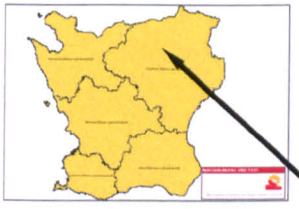
-How would you describe the future of the networks?

Appendix 4

The Geographical Area in which the current Research Project is Undertaken

1. Sweden*

2. *Skåne,* which is the southernmost province in Sweden. The county council concerned is named *Region Skåne,* which in this particular case covers the same geographical area. This area embraces 1,1 million inhabitants and 33 municipalities in total (Swedish Association of Local Authorities and Regions, 2006). **



3. *Region Skåne* is in turn divided into five politically run health care districts (Swedish Association of Local Authorities and Regions, 2006.). The R&D networks in the focus of this study functioned within the north-eastern district.***

* The map is available at: http://sv.wikipedia.org/wiki/Europa (Accessed: Jan 30, 2009).
** The map is available at: http://sv.wikipedia.org/wiki/Sk%C3%A5ne (Accessed: Jan 30, 2009).
*** The map is available at: http://www.skane.se/templates/Page.aspx?id=132850 (Accessed: Jan 30, 2009).