Abstract

This paper aims to explore critically the role of an action research team in the social construction of interorganisational collaboration aimed at transgressing organisational and professional boundaries. We will argue that the new relationships, actor conceptions and in some cases forms of work organisation arising from the change process have been socially constructed through the discursive interventions of the researchers. This largely occurred through informal interaction with and between the actors engaged in the development process. The action researcher, rather than being a neutral discursive gatekeeper in collaborative development projects, is an active constructor of the discourse shaping the collaboration. A case is presented showing how the researcher role is thus better seen as being an active boundary subject mediating across various professional and organisational perspectives rather than a passive boundary object. Accordingly, by focusing on the discursive role of active researchers as boundary subjects, we can reflect more critically on the roles we adopt in our intervention endeavours and their inevitably political nature.
Introduction: Towards Integrated Care

A recurrent feature of many recent reforms in health care systems appears to be the move towards process working and boundary crossing (Denis et al, 1999; Keruoso, 2003; Ekman Philips et al, 2004; Fältholm, 2005). The basic idea here is that the interests of the client or patient are privileged above all else and various care practices, from diagnosis to cure, should be integrated along patient pathways rather than seen as discrete functions separated in time and space. This has prompted a research interest both in how the transition to this is organised (Buchanan et al 2006; Ekman and Huzzard, 2007) and in the role of boundaries and the attendant practices thereat in facilitating or hindering change efforts (Rodriguéz et al, 2003).

The notion of process working and boundary-crossing in health care organisations (Denis et al, 1999; Ekman Philips et al, 2004) has attracted various labels including patient-centred care (Stewart, 2001), shared care (Hughes and Pritchard, 1995) and integrated care (Ekman and Huzzard, 2007), the term we will use here. Integrated care implies creating productive collaborative relationships. This in essence means boundary-crossing activities such as networking between different occupations, organisations and care givers. It also implies transforming local domain knowledge into collective knowledge among the various participants involved. Furthermore, actors from different local contexts are involved in a process of sharing work experience, interpreting and comparing different understandings of aspects of care and constructing shared meanings on the performance of their work tasks. This suggests a shift of research focus away from the organisational structures and processes of specific care functions towards studies of the boundaries and boundary objects between them, both during the transition phase and in the institutionalisation of integrated care thereafter.

In furthering such a research agenda, this paper aims to explore critically the role of an action research team in the social construction of inter-organisational collaboration in a regional health care context. In the setting of a project aimed at introducing integrated care in the West Skaraborg district in south western Sweden, a team of inter-disciplinary action researchers was engaged by practitioners to assist with a broad (inter)organisational development effort encompassing a wide variety of regional actors (Ekman Philips, 2004; Ekman Philips et al, 2004). The paper specifically analyses the role of researchers at the complex series of boundaries that were to be transgressed during the development effort through mediating across organisations and actors. The question is how these productive collaborative relationships across boundaries in West Skaraborg became and remain connected. We will argue that new relationships, actor conceptions and in some cases forms of work organisation arising from the project have been socially constructed through the discursive interventions of the action research team (ourselves). Specifically, we will explore our role in the talk and construction of discourse in the development process (Hardy, et al, 2005).

In short, the paper shows how we constructed a development discourse at boundaries between different levels of health care and between various developmental networks. This largely occurred through informal interactions with the project participants. Accordingly, the research team constructed a development discourse at boundaries between different levels of health care and between various developmental networks. The action researcher, rather than being a neutral discursive gatekeeper, is thus better understood in collaborative development projects as an active constructor of the discourse shaping the collaboration (Hardy et al, 1998; Lawrence et al 1999; Hardy et al, 2005). The practitioner expectations were such that the researcher role transformed from that of being a passive boundary object (Star and Griesemer,
1989; Paulsen and Hernes, 2003) to being an active boundary subject mediating across various professional and organisational perspectives (Boland and Tenkasi, 1995).

The paper proceeds with a discussion of the boundaries and boundary objects in organisational and management studies and how we position ourselves by adopting a processual-discursive perspective. We then discuss our action research methodology and present the case of integrated care in the West Skaraborg Health Development Coalition. Thereafter we discuss the discursive effects of our intervention as well as the action researcher role more generally in the case of broad-based, low intensity interventions. In concluding the paper, we sum up our argument that action researchers have a pivotal role in shaping the discourses underlying the development efforts that are targeted by their interventions thus highlighting their non-neutral role and how such efforts are inevitably embedded in power relations.

**Boundaries in Organisation and Management Studies**

As Paulsen and Hernes point out (2003: 3):

‘the increased temporality and transience of organizational arrangements challenge researchers to stretch their imagination beyond current notions of organizations and to consider alternative ways of representing more or less stable patterns of interaction’.

In orthodox, systems views of organisations, the notion of a boundary is fairly straightforward. It is represented well by the organogram of organisational structure – those within a formal span of control or line management structure are on one side of the boundary whilst those outside that structure are on the other side. At the heart of this approach is the assumption that there is a clear divide between organisation and environment, a central tenet of systems theory (Scott, 1992). In such a view, an increasing interest in the role of boundaries has been prompted by a belief that bureaucracy is on the decline (Ashkenas et al, 2002).

An alternative view, which is that adopted in this paper, sees organisations as comprising social processes and relationships (Watson, 2002). The notion of a ‘boundary’ here is that between different communities of practice. Boundaries are ‘demarcation lines between different world views, identities, enterprises and fields of practice’ (Zdunczyk, 2006: 2). Carlile (2002; 2004) has argued that in a processual-relational view, communication processes for managing knowledge across communities have three levels of complexity and thereby three distinct boundaries: a syntactic or information processing boundary for transferring knowledge; a semantic or interpretive boundary for translating knowledge; and a pragmatic or political boundary for transforming knowledge. From such a perspective, it seems that despite a waning of bureaucracy, boundaries still matter (Marshall, 2003).

Different communities of practice face difficulties in communicating with each other. Shared understandings, identities and meanings do not exist upfront. Rather, if they exist at all, they evolve incrementally through collaborative conversations. Such conversations, however, require a common point of reference. This may not necessarily imply shared meanings or understanding, but at least it does entail some means of co-ordination and alignment. In the language of semiotics, boundary crossing conversations need shared signifiers although their significations may well be contested. Researchers have called these shared signifiers boundary objects (Star and Griesemer, 1989) – and noted that they serve as a means of
A boundary object is ‘an object which lives in multiple social worlds and which has different identities in each’ (Star and Griesemer, 1989: 409). Boundary objects can be repositories, standardised forms and methods, artefacts, models or maps (Carlile, 2002).

In the literature on organisational boundaries and boundary crossing, the mediating link or boundary object thus plays a crucial role. A mediating link could be texts as policy documents, or a mediating discourse in the organisations about development issues, or people with a specific mandate for development as managers, trade unionists, and other key actors. In our project, the concept ‘integrated care’ played the role of a boundary object. As a concept and as a policy text it was translated into different local contexts. As a boundary object it had a function of linking the past with the future, in this case it meant the organisations underwent a transition from being apart to becoming collaborative and connected. A boundary object can thus be understood as being adaptable to different local contexts and at the same time robust enough to hold an identity or convey meanings in different settings (Star and Griesemer 1989). It can be abstract but also concrete and function both within and between groups (Czarniawska, 2001; Karlsen, 2006).

One issue of contention in the literature on boundaries to date is whether individuals can act as boundary objects. Star and Griesemer (1989) argue that individuals acting at boundaries cannot fulfil this role on the grounds that their reflexive actions inhibit boundary object functionality. The ability of politically motivated actors to manipulate social processes across communities fatally undermines any notion of objectivity. This view, however, is challenged by Zdunczyk (2006) who found in empirical studies of inter-regional development projects that people have the inclination and capability to act as boundary objects or decline to act reflexively and remain relatively passive in their endeavours to assist others in translation activities. Either way, it is accepted that individuals cannot claim to be politically neutral. In this paper we endorse the latter approach, by highlighting the political role of the action researcher. However, we argue that it might be fruitful in such situations to understand individuals as boundary subjects given their inevitable role as constructors of discourse.

In an action research project the relationship between the researcher and the field is necessarily the subject of critical reflection. Action researchers are connected to practice as one actor among many involved in joint knowledge production, being part of a whole. But can action researchers be boundary objects? In our view, it is more useful to adopt the concept boundary subject here to capture the role of the action researcher in a development project. This could serve us better in our attempts to show how this role can be understood in relation to the wider development process of which the intervention is just a small part. Before proceeding to discuss our role as boundary subjects, however, we will describe our methodology and provide a brief summary of the West Skaraborg case.

**Methods**

The initiative for inter-organisational collaboration in West Skaraborg came from regional health care administrators who sought co-operation with the region’s R&D institute, the Skaraborg Institute for Research and Development (SKI). Senior health care managers recognised that the institute could not only contribute with competence, but also with practical co-operation as a development partner. The position of the research institute being a partner in collaboration with the surrounding health care communities has developed over a long period of time whereby the institute’s role has changed from being an external adviser to becoming a
development partner. In turn, the SKI also sought additional assistance from the National Institute for Working Life in Stockholm (NIWL).

Following the drafting of a needs analysis, a lengthy period of process training and information exchange about the forthcoming development project with line managers and other key actors at the focal hospital, in primary care and in local authorities, the senior administrators in each of the three tiers engaged in dialogue with the action research team. This was to develop and agree the outlines of a dialogically-based change process centred around eight project groups or learning networks. These would each focus on boundary crossing solutions in various frontline care and support activities that would put the visions on integrated care into practice. These networks would be formed from frontline employees from different professional categories and different organisations and each would be given discretion to generate their own solutions ‘from within’ (Shotter and Gustavsen, 1999). Once network remits and personnel were established, the administrators agreed with the action research team on a series of dialogue conferences as well as ongoing developmental activities within the networks.

The initial challenge, then, was to define how research could contribute in the creation of future health care in accordance with the visions set out in the findings of the needs analysis, namely working together across boundaries with ‘the patient at the centre’. The contacts between the researchers and administrators culminated in the creation of a ‘regional development coalition’ (Ekman Philips, 2004; Ekman Philips et al 2004, Ekman et al 2007). The concept ‘regional development coalition’ is increasingly in use in other sectors in working life for supporting value creation (Ennals and Gustavsen, 1999). The notion of the regional development coalition is used in business as a means to straddle boundaries that separate the actors and their activities thus creating an enabling environment for building new relationships and structures to achieve higher productivity and value creation. In the health sector, we have subsequently used the concept to help realise the idea of integrated care.

A dialogical approach enabled the research team to capture data from a number of sources as the process unfolded. First, the various members of the research team were present at many of the network meetings and took contemporaneous notes. Secondly, data was captured directly from the dialogue conferences attended by representatives from the entire development coalition. This data consisted of contemporaneous notes taken by the research team from informal group conversations as well the presentations of groupwork summaries documented by the participants themselves. Thirdly, informal reflection meetings were held with the learning networks. These were tape recorded and transcribed. Fourthly, supplementary telephone interviews were made with some of the learning network co-ordinators to fill in gaps in the data. Finally, documents produced from various sources within the coalition were drawn upon. The data was analysed and reflected upon at a series of intense review sessions attended by all members of the research team. It can be seen therefore that the credibility of our findings have been enhanced by both data triangulation and researcher triangulation.

In sum, the approach to change and development processes drew its theoretical inspiration from action research based on inter-organisational learning and development through social constructionism, dialogue and pragmatism (Gustavsen, 1992; Gergen and Thatchenkerry, 1996). This entails a process of knowledge production through researcher-practitioner interaction, such knowledge being transdisciplinary, non-hierarchical and heterogeneously organised. This type of socially distributed knowledge (Gibbons, 2000) enables a broad range of different actors to take a more active role in knowledge creation, in this specific case, on
future health care. Knowledge ‘from within’ is seen as socially and contextually bounded and has a greater impact on the social relations between the participants than knowledge brought in by outside ‘experts’ (Shotter and Gustavsen, 1999).

**Integrated Care through the West Skaraborg Health Development Coalition**

As stated, the process of change started after the West Götaland Region conducted an analysis of patient needs in what was called then the Lidköping area (Västra Götalandsregionen, 2001). The analysis showed that patients wanted more influence over and participation in the treatment process. Moreover, patients were living longer, had higher expectations of the health care service at the same time as technology continued to develop. There was clearly a need to move from a focus where injuries and diseases were the point of departure for the health services.

These developments were putting pressures on resources suggesting the need for rethinking around organisation in the provision of health care. In practical terms this implied better co-ordination and co-operation between the various care providers and a more integrated view of care provision that eliminated unnecessary duplication and called for more simultaneous provision of care in time and space. Thus, to provide care closer to the patients, the concept of integrated care, and its Swedish equivalent ‘närsjukvård’ featured prominently as the idea around which collaboration could be organised. This would give better contact between users of care and care providers where primary care would play a greater role in the non-acute treatment that had hitherto been the preserve of the hospital (Västra Götalandsregionen, 2001). This initiative resulted in the setting up of a project ‘Future Health Care’ in the Lidköping area organised around a steering group comprising of managers and administrators from both the region and the local authorities.

**Establishing a Health Development Coalition**

The initial focus of the project was the setting up of a health development coalition. This covered an area with a population of about 100,000 people and included the local hospital at Lidköping, primary health care providers and care providers in six local authorities: Lidköping, Skara, Vara, Götene, Grästorp and Essunga, all served by the Lidköping Hospital. Some 5,000 employees work in the health care sector in this area. The coalition comprised actors including policy makers, operational level actors, different occupational categories, interest/pressure groups and researchers. The project was thus organised around:

- A steering forum or leadership network with representatives from Lidköping Hospital, primary care providers from the six local authorities;
- A leadership team or administrative committee linked to the steering forum comprising the regional director of primary care, the director of Lidköping Hospital and one of the chief executives of local authority care;
- Working (or ‘learning’) networks formed from various professional and occupational categories from the care sections of the councils’ social services departments, primary care and the hospital;
- A special group comprising unions and patient organisation representatives;
- A political co-operation group comprising representatives from the West Götaland Regional Health Board, the executive board from the regional hospital, Lidköping Council and neighbouring local authorities;
- The research team.

The figure below shows graphically the actors in the development coalition:
The aim was to facilitate innovative processes of development and create platforms to integrate research, development and education thus enabling various professional and
occupational categories to obtain knowledge from outside their own field of activities. Through this, the partners constructed meaning in the development of care thereby creating what McNamee and Gergen (1999) term *relational responsibility*. In such a process, the hospital staff, for example, would create a platform to engage in discussions on various societal issues outside the hospital on consumer interests or the dynamics involved in access to care for different consumer groups, thus shaping health care in new directions. Clearly, then, a complex array of boundaries existed which required collaborative processes to transgress: boundaries between the three layers of care (the hospital, primary care and social services departments); boundaries between the learning networks; boundaries between the professions; and boundaries between the networks and the leadership.

*The learning networks*

At the core of the coalition and its attempts at promoting boundary crossing were eight learning networks. The network idea was chosen to address the problems of bureaucratic structures (Castells, 1996) that separate and split the core health care process around the patient. The understanding that innovation does not come by isolating different functions and actors from each other but instead through relations put the emphasis on networks. Through forging new relationships, benefits were derived from the diversity of experiences and competencies that helped develop new practices. Interaction with new partners offers opportunities to reflect on ones own views of reality from the perspectives of others. In this sense, the networks offered both structures that crossed established boundaries between caregivers as well as possibilities for reflective learning (Schön 1983).

The eight networks consisted of members from the organisations involved, drawn from various occupational categories. Each group was assigned with responsibility for developmental activities in a specific area of health care provision as follows: a Near-Dischargeable Patients Network, a Palliative Care Network, the Örjan Project (change project on patient pathways already underway), an Intermediate Care Network, a Rehabilitation Network, a Personnel Network, a Health Care Information Network and a Psychiatry Network. Each of these networks consisted of members from the three organisational tiers – the hospital, primary care and local authority care. The networks each had a mix of professions such as doctors, nurses, assistant nurses, physiotherapists, psychotherapists, psychiatrists, community health care workers etc. These learning networks started by undertaking mapping activities of current care practices. The mapping activities provided opportunities for network members to explore and construct a picture of work that was already shared, to listen to each other, to take on each other’s perspectives and to explore new ways of organising work. Later, as new ideas emerged, the activities assumed developmental forms. Concrete collaborative development work was thus put into practice.

An example of mapping was the new law introduced by the government outlining how to discharge patients from hospitals. The Near-Dischargeable Patients Network was thus charged with the responsibility of finding/mapping out the routines for the discharging processes between the different caregivers. The task was to find out how the new law affected these routines. Doing this in a more developmental way, the network invited relevant actors to a conference to investigate the existing routines and explore how to develop them to fit within the new law. Constituting these types of networks entails the creation of arenas and spaces that cut across boundaries in ways that were not previously available in the formal line structures of the various organisations.
One network, Örjan, pre-existed the project and its developmental activities were well underway at the time of the first dialogue conference. The network focused on quality improvements in the care of the elderly (named after a model patient) by assessing and developing the quality in the patient pathway by using Total Quality Management (TQM) techniques. The network started as a large network in one local authority but took up intensive discussions on how to expand and successively extended its reach to incorporate actors from other local authorities within the coalition. The network has also been looked upon as a type of model for the other networks in that it pre-existed them and was generally ahead of the others in its developmental and boundary-crossing activities. But how did the developmental dynamics materialise? To examine this we will now focus on our role as action researchers by drawing on Tuckman’s model of group development processes (Tuckman, 1965). We thereby show how we constructed a developmental discourse at the various boundaries across the coalition as the developmental effort unfolded.

The Development Discourse and its Effects

In general, the chronology of the research process was as follows:

• Data collection from dialogue conferences and meetings of learning networks (by researchers)
• Data analysis
• Conceptualisation of the development process in textual form (typically in the form of overhead slides)
• Inscription of texts as artefacts
• Dissemination elsewhere (through talk).

Specifically, the actors saw a key role for the researchers in seeking to describe and capture the process. In practice this task initially involved conceptualising, from theory and from in vivo data from the field, the development process in what appeared to be the leading network at the various stages of its development work. In such a way we were able to analyse the lead network, Örjan, from Tuckman’s model of group development processes (Tuckman, 1965) and coined terms for successful execution of each stage of the process viz:

• Forming – dialogue, learning
• Storming – attempting cross-perspectivisation
• Norming – reaching shared understandings
• Performing – development activities, participative extension,
• Adjourning – permanentisation.

This conceptualisation then set an ongoing discursive frame for analysing and understanding the dynamics of the remaining networks in our ongoing conversations with them.

At the start of the process, there was a feeling among members of the various networks that there was a lack of clarity about the strategic goals on the part of the top leadership. This lack of clarity led to frustration and uncertainty about future developments on integrated care. The network members had been unsure of what was expected of them as the following quote from a member of the Rehabilitation Network indicates:

*If there is to be any continuation, the ball is not in our court now. We have hit the ball to the leadership and now it is their turn to tell us, I would think.*

Another network participant had this to say:

*If there is no vision in the leadership the learning networks lose their spirit.*

Similarly, a female member of the network at the first focus group held with the Örjan Network said:

*We didn’t know what it [the network] was. They [the top management team] thought: one from the local authority, one from primary care, one from the hospital. [We thought] We can’t manage that – think again! We didn’t know what the hell it was. No, we didn’t know at all. But now it’s fun…*

These quotes suggest the lack of any shared meanings or understandings around the aims and goals of the project at the ‘forming’ stage of group development. Each network had a remit which acted as a boundary object, but a general sense of ambiguity prevailed. Early meetings between the researchers and the networks stressed in particular the role of dialogue in development processes (Isaacs, 1993) and that successful development work presupposed learning. This was underscored through reference to the progress already registered in the work of the Örjan network.

Shortly after ‘forming’ and the initial exchanges at the first dialogue conference, some networks, in particular the Palliative Care Network, experienced serious internal conflict on their role and way forward. This was well illustrated by a member of the network in an exchange with the research team at an early focus group:

*When we came together we had different expectations about what our work was to entail. And the difficulty has been that we’ve sometimes conducted the conversation at the organisational level and sometimes at the practical level and sometimes it’s been a little hard to know where we’ve been.*

Differences in perspective also surfaced elsewhere. For example, the following quote is a reflection made on their workplace by a member of the Rehabilitation Network during a focus group discussion:

*… the rest of the world does not look the same as the local authority’s rehabilitation unit at Lidköping. There are other variations and no place looks like Essunga either. The daily work has developed differently depending on the co-workers and the interaction with the world around.…*

These quotes suggest varying degrees of conflict in how the networks saw their task and illustrate the differences in perspectives that prevailed. Tackling these differences can be likened to Tuckman’s stage of ‘storming’. In the conversations between the researchers and the networks, however, the former stressed that some elements of conflict were inevitable and not necessarily dysfunctional. In particular, for learning processes to be effective, participants had to appreciate the perspectives of others and see the world through such perspectives (Boland and Tenkasi, 1995).

Later, however, the network members became more secure as they used the mapping activities to explore new ideas and identified the activities they could continue in a development process of their own. Some reflected a great deal on and recognised the value of their conflict-laden discussions during the initial stages as part of their learning and development as the following quote, again from the Palliative Care Network, suggests:
that was really difficult... the mapping assignment was really broad. So we started by discussing very broadly. And it took a long time before we could get a clear focus of what we could work with... we ended or found ourselves finally in a situation where... we agreed that, that is what we should work with... we now feel we have landed.

Here we see the group reaching the ‘norming’ stage characterised by agreement on procedures and routines governing the work of the group. This was also discernible within the top management team who underwent transformation from being concerned with the everyday issues such as assigning duties to the networks to becoming a more development-oriented entity as this reflection made by one of the members of that group suggests:

I see the most important task for this leadership group is to start networks instead of directing content.

This gradual move towards agreement, again, was noted as something that had been previously detectable in the Örjan Network’s activities and the researchers drew on Örjan’s experience to stress the role of reaching shared understandings and how this had previously helped that network function effectively as a group.

Over time, the fatigue and scepticism towards ‘expert change’, expressed when the process started, faded away. A feeling of appreciation, understanding and pride about the ‘from within’ approach became evident. By this stage, change had resulted from the increased intensity of contacts and interaction through different learning networks having regular meetings; regular learning network co-ordinators’ meetings; regular meetings of the administrative committee both alone and with the learning networks; and, notably, with the research group being conversation partners at these meetings offering reflections and descriptions of the development process, notably through reference to what the Örjan Network had already experienced. At this stage the groups were beginning to engage in ‘performing’ activities including diagnoses and proposing suggestions for collaborative forms of organising work, again, largely inspired by the already noted experiences of the Örjan Network. At the later of the focus groups the co-ordinator of that network stated:

We have co-operation [now]...like the creation of a lasting network. We all saw the patient as being central. All three of us should be there for him and perform as a single organisation. I think we’ve reached [that goal].

At the ‘performing’ stage the research team stressed the need for practical development work as opposed to mere talk about development (Pålshagen, 2001) as well as stressing the need to broaden the participative reach of the networks’ conversations, particularly to workplaces, as had also been the experience with the Örjan Network.

The final stage in Tuckman’s model, adjourning, suggests the arrival at some sort of closure of the development effort. In this sense the analogy is with some sort of project that reaches its predetermined conclusion. However, in the case the aim was to establish integrated care in such a way that ongoing development would be institutionalised as a permanent feature. That this became accepted throughout the coalition was evident in a gradually emergent stance of being ‘anti-project’. Although project management technologies and language were very prominent in the early stages, these gradually receded during the course of events and the term ‘project’ was notable by its absence at the third dialogue conference. Discursively this was well expressed by the co-ordinator of the Örjan Network at the second focus group thus:
We are sort of convinced now that this is going live on. We were well convinced earlier too but had no grounds for such conviction. But now we have a strong sanction from above.

The leaders of the other networks expressed similar views several months later at the third of the dialogue conferences. Summing up his role in the network, the Orjan Network co-ordinator reflected at the second focus group that the network was about:

Leading, leading, leading...long-termness, patience...and that it’s not a project one is starting. It’s a way of working. And then there are more diffuse bits too – it’s about motivation, commitment: we can give each other that in the network but it’s also about diffusing outside the network, too.

The idea to make permanent this way of working grew from being just a part of the discussion to becoming the major issue in the future of the coalition. There is now notable hesitation and resistance towards the idea of ‘projects’ as development tools. Rather, development should be seen as an ongoing activity. There was recognition, too, that this type of development process would take a long time and meant taking small steps conducted through informal conversations. However, the process enabled the practitioners to move from their insecurity when they started the mapping assignments, as they increasingly explored new ideas and realised that the process did not necessarily need to have a start and an end. It seemed that the characteristics of a learning organisation had emerged. However, as described here, this was the result of the development process being constructed discursively by the action researchers from their boundary positions in such a way that had normalising effects.

Although the formation and initial development of the networks was observed and described by us to the participants in linear terms (Tuckman, 1965), we also assessed that the wider notion of development once they had become established and started ‘performing’, was not as easily discernible in such terms. One of the main discursive effects of the development process was, rather, a shift from a perspective of looking at development as a linear activity starting with mapping, analysing, implementing and evaluating, to seeing it as parallel activities having a development perspective on work.

Much of the interaction within the networks, between them, with other parts of the coalition and with workplaces was of an informal nature in the form of everyday conversation. All these contacts led to a feeling of openness. The networks had intensive discussions on how to create stronger linkages with each other to improve the patient pathways. They also learnt to take on each others’ perspectives, to learn from each other, not to expect ready-made solutions, but rather to reflect on how they themselves should move on with the development process, using each other in that process. The discussions on how to create linkages were for example, ever-present for the Örjan, Rehabilitation and Near-Dischargeable Patient networks. The networks, however, used different methods such as focus group discussions, reflective meetings, study visits, visiting each others’ workplaces and dialogue conferences, in order to increase involvement and participation at the workplace and establish linkages beyond their workplace and organisation.

Clearly a development effort supported by action research is a process of knowledge generation or learning. But such knowledge requires translation across boundaries for innovative solutions to take root in terms of new work practices in line with integrated care.
On the other hand, such knowledge can not only be a source of innovation, it can also be a barrier to it (Carlile, 2004). More to the point, such knowledge is mediated by the action researcher and is inevitably intertwined with power. In other words, the boundary spanning activities of the action researcher, as a boundary subject, are inevitably political in nature.

From a functional view we can certainly state that effective discourse is an essential component in collaborative development work. From a critical perspective, however, taking on the role of being a boundary subject as a researcher of development processes suggests the need for critical reflexivity as a key practice in our scientific endeavours (Mezirow 2003).

The Role of Action Research in the Development Process

The role of the researcher in this particular development of integrated care in West Skaraborg was that of contributing with strategies for organising the processes of change, systematising the experiential reflections of the participants and contributing to joint knowledge creation from practice through these reflections. From a practical point of view, the issue of how to mobilise and connect people around development task for joint action was the major challenge. Here, action research played a crucial role. At least a year before the development activities started, discussions took place with different actors, concerning methods and strategies of change. This established the process of a series of regional dialogue conferences (Ekman and Huzzard, 2007), starting with a start conference focusing on vision, followed by one midway concerned with support structures and processes for development activities and the third focusing on results achieved. Over time, it became apparent that the researchers required to be even more integrated into the development structures and processes. The researchers met the network groups on a regular basis in informal reflective meetings and also in more systematic focus group discussions. In special meetings for network leaders, issues related to how to manage networks were explored.

Our role as researchers, in particular the practices of documenting and systematising of the process, had initially been questioned or viewed with suspicion. However, through ongoing conversation, the researcher role was increasingly accepted. One network described how they now were exploring how to use the documentation guidelines prepared earlier with the help of the researchers but initially rejected by the networks. In this way, this development process indicates that it takes time and informality to build less threatening relationships in an act of collaboration. But it also shows how the action research team had a mediating role at the boundaries between professions and organisations.

The aim of the research then was not to strive for radical change in the system of work or workplace. Rather, it was to link the ongoing parallel development processes and to strengthen the knowledge already embedded in practice. Through building on knowledge existing in practice or workplaces, this successively led to renewal or changes in forms of work organisation. By enabling the actors to participate in new configurations of dialogue, where the conversations could open up new understandings arising from dialogic methods, our intervention can be seen as that of shaping alternative interpretations of reality. Instead of talking of knowledge transfer, the participants identified and constructed knowledge in what Gibbons and colleagues (2000) call ‘the new type of production of knowledge’. The process can thus be understood as collaboration around construction of knowledge and not the conventional knowledge transfer from one place to the other. That is the reason why we chose methods which could bring together different actors in dialogue about work across the entire development environment. In Carlile’s terms, what was significant was not so much the
syntactic boundary that transferred knowledge, but, rather, the semantic and pragmatic boundaries that translated and transformed it (Carlile, 2004).

The research focused on the whole development coalition as a research field rather than focusing on the individual organisation. With such a research focus it became necessary to carry out an overview of the research process. A major dilemma encountered was the expectation that researchers could provide solutions to the special needs of a specific workplace. This is understandable and hardly surprising, since the health care organisations are used to experimental research common in the natural sciences, rather than to research as a collaborative practice with a focus on communicative processes.

Action research strives to link reflection and theory with practice by the researcher working together with practitioners. The aim of action research is to find solutions to specific practical problems of importance to people (Brydon-Miller et al. 2003; Greenwood and Levin, 1998). This is based on the belief is that the knowledge people gain through their daily work and life situations can no longer be ignored. Instead, it needs to be explicitly articulated in dialogical arenas to become the basis for knowledge creation (Bradbury and Reason, 2003). Moreover, action research is generally underpinned by values that seek to humanise change processes in a way that is consistent with increasing participation or what Habermas has called emancipatory knowledge interests (Habermas, 1972). In this sense it can be seen as an attempt to change social relations to the advantage of those who do not enjoy positional power (Docherty et al, 2006).

In West Skaraborg, the top management team explicitly endorsed the participatory approach to change proposed by the action research team, and the concomitant empowerment to the frontline employees in the learning networks that this entailed. However, we should acknowledge that this also involved a shift in power relations to the action researchers in our mediating roles at the boundaries between professions and organisations. In our attempts at providing discursive tools for the network participants to make sense of the developmental process through informal encounters, we were not only providing descriptive accounts of the process, but at the same time these also had a normative perhaps even disciplinary effects in terms of articulating how the process should be implemented (Foucault, 1977).

**Conclusion: The Action Researcher as Boundary Subject**

The health care development process in West Skaraborg could be described as the formation of a development coalition (Ennals and Gustavsen, 1999), a variant of a community of practice (Wenger, 1998), or a productive infrastructure for development (Gustavsen, 1992). But regardless of the different concept used to describe the phenomenon, the key dynamic entailed new sets of relationships between the actors and how they could create connectedness and stay connected. In this paper we have explored how this happened in the case of introducing integrated care and the role of an action research team acting at the boundaries within the coalition and making the connections happen, in particular through informal conversations.

Action researchers can work within local, regional or national contexts for example workplace, regional development coalitions or national, global networks and work with different types development situations. The researchers in this particular development process came into a situation where links between different levels of health care were poorly constructed as a result of functionally-based management, different health care organisations,
line management based on budgetary discipline, professional dominance and antagonism between professionals. As researchers, we were in a situation with its own history and established routines, norms and values. Not surprisingly, the practitioners initially looked at the researchers with some suspicion wondering what their contribution could be. Yet over time we acquired what we might term discursive legitimacy, a phenomenon that has been recognised as a key component of power in inter-organisational domains (Hardy and Phillips, 1998).

Our role as researchers entailed partly identifying the types of development situations, partly contributing with strategies and methods for organising the development processes, to systematise the participants’ and the researchers’ reflections over practice and in that way contribute to knowledge creation. But the main question was how to mobilise and link different groups and actors around the health care development activities in West Skaraborg. This was a complex development task that reflected the challenges and complexities constituting a world full of ambiguity, multiple identities and conflicting interests. Ultimately, the key intervention practice was that of informal talk and conversations. Although this did not involve entering the field with pre-conceived models of best practice, the conversations nevertheless constructed the development effort discursively in particular ways.

As theories of discourse suggest (Potter and Wetherall, 1987; Grant et al, 2004), however, these constructions were not neutral and highlight the role of the power relations between the researcher and those researched. The discourse of development (Ekman Philips and Huzzard, 2007) has normative (perhaps even disciplinary) effects (Foucault, 1977) and limits the number of subject positions available to the actors engaged in the development effort. Accordingly, by focusing on the discursive role of action researchers as boundary subjects we can potentially reflect more critically on the roles we adopt in our intervention endeavours (Alvesson and Sköldberg, 2000).

The paper has suggested that in action research in interorganisational settings, we might more usefully see researchers as boundary subjects rather than boundary objects. One way in particular of seeing this role is that of providing ‘connections for sensemaking’ in situations of ambiguity, multiple identities and conflicting interests (Weick, 1995). Our role was guided by a political and ethical commitment to emancipation in development processes even if only understood in terms of small wins (Weick, 1984). A critical perspective on action research must inevitably reject the call for critical management studies to be non-performative in nature (Fournier and Grey, 2000). Rather, it must adopt a ‘critical performativity’ guided by ethical commitments to values of transparency, participation and genuine shifts in power relations as well as being sensitive to the political and non-neutral role of the action researcher.

References


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