WHOSE KNOWLEDGE? WHAT TRANSFER?

By Michael Agar

Introduction

The article is a written version of an invited plenary on knowledge transfer for medical practitioners and researchers in Alberta, Canada. The heart of it, as presented and as written here, is that "knowledge transfer" needs to be thought of as *knowledge* from front line organizational staff and clients *transferred* to leadership that controls resources and regulations. The argument is based on three cases from health-related settings. The conclusion is that a mix of ethnography and complexity theory can serve as a kind of short-term "clinical" intervention into an organization, but that long-term structural change is required and that is usually more problematic in social services than in the private sector.

In late 2009, the Alberta Heritage Foundation for Medical Research asked me to give a keynote lecture at their conference on "knowledge transfer," or, as some Canadian colleagues preferred to call it, "knowledge translation." I was honored but suspicious. Many years ago, when I worked in the substance use/abuse field, government staff and their funded researchers had talked of "technology transfer," by which they meant, "How do we get practitioners to do what we tell them to do?" The concept, at that time, was *anti*-innovation with reference to local program realities and *pro*-standardization and control with reference to external, academically driven models.

Since those early days my suspicions had grown. I wish I had a nickel for every time I've heard a practitioner say, "That expert wouldn't last fifteen minutes in a clinic" (or classroom, or business, or wherever the practitioner's daily workplace happened to be). More recent complaints that I've heard are cast in the contemporary rhetoric of "evidence based practices." Here the telling line that comes up now and again is, "Yes, but what about practice-based evidence?"

No one would disagree that participants in a task—both staff and client—have a sense of problems and solutions based on personal experience with task dynamics and boundaries. Not that people inside the task always see clearly, analyze well, and come up with good suggestions. And it's not that expertise can't offer new and useful perspectives. But the fact is, people on the front line are seldom taken seriously as a source of new ideas, part of official efforts to generate innovation except in terms predefined by chiefs and consultants, or given space to experiment on their own terms when task change is sought.

I decided to build a presentation around examples of innovation from the ground up instead of from the top down. I used one well-known example of a success and two examples from my own experience where I was the outside expert, once before the fact and once after. At the end of this article I'll describe that outside expert role, a mix of complexity and ethnography. It's different from the usual expert. At least I think it is, but then, I would. Rather than bringing in a model of what people *should* do, I show an organization ways of paying attention to those who know tasks first-hand and then says to the consultant, "Now go home." In fact, the latter is the feature that I think explains success in the first example.

MRSA Infection

Example one is a success story, well documented on the web pages of The Plexus Institute, the nonprofit that organized the project with support from the Robert Woods Johnson foundation. [1] The problem: Hospital borne infections, specifically MRSA (Methicillin-resistant *Staphylococcus aureus*) infections in hospitals. In spite of their best efforts, using expert advice, hospitals couldn't seem to get infection rates to come down. Several hospitals participated in the Plexus project, with most of them focused on their intensive care units. The new strategy for this project was guided by a concept called "positive deviance." The term was made popular by the late Jerry Sternin, who together with his wife Monique Sternin created an Institute at Tufts University.[2] The simple and powerful idea behind the concept is this: Within an organization, there will be variations in how people do tasks. Some of the people will be "deviants," in the sense that they will do things differently from standard operating procedure. When a problem comes up, or even when it doesn't, some of them will have figured out how to improve the task. They are the "positive" deviants.

The Plexus project encouraged every person involved in intensive care tasks to be positive deviants, to come up with new ways to prevent MRSA infection. They encouraged staff to create scenarios and experiment and try things out. In one memorable event, a chief of surgery played patient while chocolate pudding was used to mark any contact where MRSA infection might occur, from arrival through surgery into intensive care. The trail was a chocolate covered mess by the end of the exercise. Everyone then pitched in to figure out how to do it again without leaving a trail of pudding.

One result of this project was a 73 percent drop in MRSA infection rates across four sites over a three year period (Lindberg et al. (2009). What the previous expert models hadn't been able to accomplish, the hospital front-line staff did. Their innovations, taken one at a time, were usually simple tweaks in details of practice, but the tweaks were organized around a goal shared by all, whatever their job title, namely, reduce infection. The quantitative evaluation was easy—Infection rates went down. But the material on the Plexus web speaks of other non-numeric positive outcomes—What "valuable assets" the frontline staff felt themselves to be, the "culture change" that occurred, how "everyone wanted to be part of a team."

Positive results were more profound and pervasive than just an infection rate moving in the right direction.

Drug Treatment from the Bottom-Up

A second example: Baltimore in the late 1990s and early 2000s, and probably still, has one of the highest proportions of drug and alcohol dependent residents in the nation. And as most readers know, the forty-year U.S. "war on drugs" hasn't helped much. In fact, it has made things worse. This frustration led the Abell Foundation, located in that city, to experiment by funding a community based program that was already underway. It was called RIC, for Recovery in Community. The foundation told the program, in effect, "Nothing is working, you all are trying something different, here's a little money for a few years, do whatever you want." No consultants were mandated; no project management charts required; no evaluation instruments provided.

After foundation funding ended, RIC asked me to come and visit and write an op-ed piece for the local daily newspaper. Things were falling apart. When I visited, they talked about how the program had grown out of the neighborhood in a sort of organic way. Staff people, most from the neighborhood, did a variety of things, depending on what needed to be done that day. A person who worked for a while as an outreach worker, for example, did many different things besides look for new clients. He or she stayed in touch with the neighborhood in general, letting people know the program was ready when anyone in trouble was. And later in the day, the outreach worker might well come back to run a group or work the front desk.

When a drug dependent person came in the door, he or she was offered coffee and a conversation rather than paperwork and immediate questions about insurance. Program graduates were doing better on average than the usual drug program results, though this was more apparent in events and biographies than in any formal records. RIC did have numbers to show they handled about as many "patients" per dollar as any other program in the city, though no one I talked with ever said "patient." Even allowing for exaggeration, results were pretty impressive compared to the many programs I'd visited over decades of drug work.

So why had they called me? As the foundation money came to an end in the third year, the state and city recognized a winner when they saw one and picked up support for the program: They meant well. There are no villains here. But with state/city funding came forms to fill out, job descriptions to write, reports to file, a hierarchical structure to establish, credentials to require. Without meaning to, the bureaucracy shredded the coherence that had grown out of community history and participation. A new director had been hired. Members of the original neighborhood staff were leaving for other jobs in the city. I went and found a couple of them.

It was a Greek tragedy. I wrote the op-ed piece, as RIC had asked me to do, but the newspaper didn't want it. They printed an earlier piece about prevention, but not this one. I have no idea why not. Maybe by now RIC is back on track. Maybe it was a change of funding life crisis that passed after they reinvented themselves. I hope so.

Unlike the previous story of MRSA, this is a good story gone bad. It starts out with positive deviance generated by an on the ground community group, and a funding source willing to provide support without wrapping the money in a thicket of rules and regulations. The innovation grew out of the neighborhood and the people in it rather than from an expert model imposed from outside. RIC had all the makings of the MRSA story. Then city and state stepped in, with the good intentions of supporting and continuing RIC's innovations. But when it came down to the details, the old hierarchical system kicked in: more concern with process control than result, with form rather than function, with accountability up the chain of command rather than responsiveness to those below.

When I first started working on my own, I talked to a colleague familiar with organizational innovation in the private sector. I told him my Robin Hood fantasy, namely that I was going to steal from the corporate models and give it to social services. He laughed. "They can't adapt," he said.

Cancer, Time and Uncertainty

A final example is different from the one I used in the original presentation in Canada, because it is more hopeful. This one I've described elsewhere, most recently in a journal called *Organizational Research Methods* (Agar 2010). An outpatient chemo treatment center wanted to reduce the waiting time of their patients when they came in for treatment. They'd tried all sorts of organizational research, usually with computer models and time and motion quantitative data. They'd been able to shave a little time off the average patient's treatment day, but not much. They asked me to come in and see if I could spot anything else they might try.

I listened to some patients and front line staff members talk about waiting. It was a powerful experience, hearing patients put "waiting" and "cancer" into the same story. And it was complicated untangling the threads of what waiting was really all about when patients did talk about it. When a disease and a doctor suddenly take over your life, alter its trajectory dramatically, and make its end visible, it's not hard to understand that "waiting time" sometimes becomes an occasion to express anger about more profound things.

The most immediately relevant result was this: I learned that it was in the nature of the disease and its treatment that unpredictable fluctuations in waiting time would occur. The disease changes all the time, signaled by the blood test on arrival that might require a longer and more complicated visit than anticipated. It doesn't take but a few of those surprises to cause a cascade of delays throughout the clinic. And it's not just the blood test and what might follow that can alter the flow of events. An emergency can occur during chemo, at which point everything stops until the emergency is taken care of. Many are the unexpected changes that come up,

on a regular basis. They are normal. The schedule never goes as planned.

For any patient, waiting time fluctuates unpredictably from one visit to another, whether or not that patient needs more time personally or not. You can't do much to standardize the average number of minutes, I learned. But what the patients and staff taught me was, you could do a lot to improve the *quality* of those minutes.

Unexpected waiting tended to be interpreted as meaning personal bad news. If you then tried to find out what was going on, the front line staff would most likely know nothing beyond the fact that there was a delay. At the end of the project we suggested using ombudspersons. The clinic had actually experimented with them, and during the experiment their quarterly patient survey showed a marked improvement in the various "waiting" attitude questions. We also suggested a web page for each patient with real-time case information and links to background information needed to interpret it. We also proposed an organizational information page so that a patient could find out if a delay was caused by a snafu that had nothing to do with their particular case.

There were many other strategies we came up with, but the point was simple and obvious. Chronic disease—and particularly cancer—means a contingent life filled with threatening uncertainty. Uncertainty reduction made a lot of sense as an innovation to focus on. Stories about patients sharing information in the waiting room or family/friends with some medical expertise were the data that pointed the way. We suggested they take the lead in designing, evaluating and modifying the new system.

Once again, the positive deviance theme played a key role. We learned from front line staff and patients how they saw the waiting time problem and how they saw possible solutions. As mentioned earlier, the clinic had had its own positive deviant history during the brief time it experimented with ombudspersons. It was interesting that staff I spoke with remembered the effort fondly and wondered why it had stopped. The original evaluation—measures of the absolute number of minutes—had missed the point. Frustration with waiting was usually about not knowing, not about watching the clock.

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Unlike the example of the drug treatment program in Baltimore, this time there was an almost happy ending. The proposal was well received. But then institutional leadership announced that MRSA infection would have to be their top priority, a decision that brings us back to the first example in this article. The waiting time proposal was shelved, not rejected, but postponed. With any luck it will eventually be implemented. When it came to a choice between making patients more comfortable versus avoiding unnecessary illness, not to mention avoiding lawsuits, it was not hard to predict where the resources would go. It's easy to understand the decision, but a little disappointing all the same.

Ethnography, Complexity, and Those Who Own the Store

The lesson of the examples is pretty simple. People proximate to tasks, whether clients or staff, are likely to see problems in context and, if given the opportunity, produce innovative responses that attend to local circumstances than people who are distant from those tasks. This is not news.

A second moral of the stories: What the task-proximate people have to say is seldom attended to in its own terms, or even heard at all, by those who control the lifeblood of organizational tasks, the resources that nourish them and the rules and regulations that limit their outcomes. The tendency on the part of resource and regulation controllers is actually the opposite. They tend to *block* innovation at the task level under the banner of control and standardization. Given the first lesson, this makes no sense.

The historian of business Alfred Chandler is famous for his saying that structure follows strategy (Chandler 1998). By that he means that a change in organizational strategy can't happen unless there is a change in organizational structure to allow and support it. The three examples in this article show the wisdom of Chandler's words.

- Front line staff and client voices have to be consulted and taken seriously as part of problem definition and innovative response. But if they speak and it makes no difference to resource providers and rule-makers, things won't change.
- Resource providers and rule-makers in the organization, not to mention outside experts, have to take participatory rather than controlling roles. If they are not taking risks, collaborating, and altering their initial sense of rules and resource flow based on what they learn from front line people, things won't change.

In the end there is much more to say about the three examples. For the moment I'll just write that over forty years of working in and with social service programs it has been difficult to argue with resource providers and rule makers that front line people need to be included in organizational change in consequent ways. There are traditional

answers to the problem that have to do with deeply embedded organizational metaphors like command and control and recurrent personal issues like the authoritarian personality. These are all topics worth discussing, but they are beyond the scope of this brief article. Let me close by suggesting ways to increase the chances that change might result.

Why open the door to "challenges to one's authority?" Recent organizational concepts out of complexity theory—"positive deviance" is one of many examples—answer this first question, as do growing numbers of complexity applications, mostly in the private sector, where a stronger bottom line is the immediate result. It becomes more clear every year, across a variety of organizations, that organizational improvement is, in fact, in the self-interest of everyone, including the resource providing/rule writing leadership.

Argument by example is a good strategy here. The problem is that social services don't have a clear "bottom line" like businesses do, and they are often tied into conflicting networks of resources and regulations that make it more difficult to change. Earlier I told a story about a business colleague who said "social services can't adapt." That is what he meant. But as time goes by, more examples accumulated, the Plexus MRSA project being a well known case in point.

The second problem is that organizational leadership doesn't know how to learn the wealth of experience, in its own terms, available from task involved staff and clients. Learning involves more than listening to opinions, nodding patiently, interpreting what is said according to mental models already in place, and then continuing on with pretty much the same structure that existed before any listening was done. Roberta Flack would call it killing us softly with their song.

This is where the ethnography part of the mix helps. Organizations invite me because I'm an ethnographer, not because I'm a complexity theorist or organizational consultant. For now, it's enough to say that ethnography has more than a hundred years of experience learning, documenting and translating language and practices from one perspective for the benefit of another, and vice-versa. A recent article in the journal *Organizational Research Methods*, cited above, summarizes the ethno-complexity mix that I use.

But really, who needs an outside expert? RIC didn't. They grew their own program. But some organizations do need some help, at least at the beginning. Much of any organization, much of daily life for that matter, consists of practices that have become routine. They are deep habits, far out of awareness, difficult to recognize, never mind to change. And many of those habits carry a heavy emotional load, making it difficult to stand back and look at them dispassionately even if one is made aware of them.

Given habits, emotions, power relations, and personal antagonisms, an outsider has a better chance of seeing how things work and how they might be changed. An outsider will notice and articulate things that have become invisible on the inside. A guru of organizational consulting, Edgar Schein, calls this "clinical fieldwork," which I translate as "clinical ethnography" (Schein 1987). Like *family* therapy, its purpose is to make some social group self aware in a useful way that leads to change, in this case, change that establishes the value of task-proximate knowledge and experience.

This is a kind of organizational expert role that isn't about telling the leaders what to do under a long-term outrageously priced contract. This other kind is about helping an organization learn about itself, about its "theory in use" as Michael Argyris called it (Argyris 1993), and about the intelligence of the humans that make it up. Once that job is done the outside expert can go home. And the organization doesn't have to say they are doing theory X, Y, or Z. They continue to innovate and change in a way that they've learned to do, but only if the rules and resources—the structure—has changed.

Key words: organizational consulting, ethnography, complexity theory

Notes

[1]For more information, see http://www.plexusinstitute.org.

[2]Additional information about this project is available at http://www.positivedeviance.org

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