

# On the Institutional Moorings of Talk in Health Care Organizations

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By examining the conversations that make up day-to-day organizational life, we can understand and improve organizational processes and outcomes. The value of this communication-constitutive view of organizing is especially apparent in health care. Conversations among managers and providers influence the administration of health care organizations (Iedema, Degeling, Braithwaite, & White, 2003). Conversations among providers within multidisciplinary teams are related to the productivity, cohesiveness, and effectiveness of the teams (Poole & Real, 2003). Conversations among managed care organizations and providers shape how they see the practice of medicine (Barbour & Lammers, 2007). Moreover, conversations among providers and patients can affect even healing itself (Street, Makoul, Arora, & Epstein, 2009).

Given the recent struggles of policy makers in the United States to reform the U.S. health care system to balance issues of quality, access, and cost (see a discussion of this trilemma in Conrad & McIntush, 2003), understanding and managing these conversations well has ever-increasing practical relevance. This relevance is especially clear given that any restructuring of health care will certainly have unanticipated consequences for the day-to-day provision and management of care. Understanding and accounting for the institutional moorings of such conversations will help address important and persistent challenges in health care, and communication and management scholars should attend to how individuals use institutional logics to communicate and to adjudicate the effectiveness of communication strategies.

It is not surprising how often researchers investigate professional, technical, and knowledge work processes in health care contexts. The prevalence of

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professionals and other “agents of formal knowledge” (Freidson, 1986, p. 9) makes a principal contribution to the character of conversations in health care, and research has demonstrated that institutions act through these professionals in their day-to-day work in health care organizations. For example, Apker, Propp, and Zabava Ford’s (2005) research into nurses’ negotiation of identity tensions in health care teams demonstrated that institutional logics proffered interprofessional status differences that worked against local management’s efforts to build more collaborative teams. Barbour and Lammers (2007) found that institutional beliefs influenced physicians’ perceptions of their communication with managed care organizations. Abramson and Mizrahi (1996) found that, in collaborations between social workers and physicians, social workers generally sought the approval of physicians whereas physicians did not seek the approval of social workers, and both physicians and social workers reported the influence of professional differences on interaction. These examples illustrate the importance of professional roles in health care organizations, the importance of the role of institutions in professional work, and the importance of communication between these professionals.

Health care professionals (and all knowledge workers to some degree) shepherd, appropriate, and suffer knowledge-intensive discourses in their conversations, and these individuals draw their legitimacy in organizing—their power to create and judge these discourses—from their attachments to institutions. By the “institutional moorings of talk” (a phrase borrowed from Taylor, 1995, p. 29), I mean to suggest that institutions have the capacity to control and constrain talk but also that actors appropriate institutions to their own ends. Institutions—“constellations of established practices guided by formalized, rational beliefs that transcend particular organizations and situations” (Lammers & Barbour, 2006, p. 364)—anchor and tether communication, but talk can float around on these moorings. Although institutions may change very slowly, actors can appropriate institutional logics in novel ways and to their own ends.

An institutional perspective sensitizes us to the importance of the negotiation of legitimacy in conversations about health care and particularly those between professionals (Lammers & Barbour, 2006; Scott, 2001). Professionals work to establish their legitimacy (Scott, 2008) to know, to question, to answer, to judge. To do so, they draw on their institutional memberships, professional identifications, power as legitimate actors, and established schema (Thornton & Ocasio, 2008). Scott (2001) explicated the concept of legitimacy by identifying three elements of institutions (three pillars): regulative, normative, and cultural-cognitive. Each of these elements represents ways that institutions can moor conversations in health care. Institutions are regulative in the sense that rules, laws, and sanctions can govern organizing. Institutions have

regulative power in perhaps the most literal sense that certain behaviors in health care organizations can lead to imprisonment or civil censure. For example, United States federal law stipulates the makeup of interdisciplinary hospice teams (Demiris, Washington, Oliver, & Wittenberg-Lyles, 2008). Contractual obligations incumbent with managed care may regulate these conversations as well. Institutions are normative in that certification, accreditation, and professional standards create expectations about how work should be done, who should be doing it, and what value work has. The physician-manager, for example, must negotiate the social obligations of the medical and managerial professions (Iedema et al., 2003). Institutions are also cultural-cognitive in that “common beliefs” and “shared logics of action” deem legitimate that which is “comprehensible, recognizable, and culturally supported” (Scott, 2001, pp. 57-58). Institutional logics offer established ways of communicating, perceiving work, and adjudicating disagreements. Routine and ritualized conversations in health care should involve institutions because the schemas for them come in part from institutions. The prescribing powers of nurse practitioners represent changes in these institutional elements (e.g., law related to who may prescribe medicine, the norms of medical work, and established ways of thinking about who does what sort of work).

Other examples of conversations that involve issues of legitimacy include challenging the judgment of another professional (Lambert, 1995), interprofessional information management (e.g., knowledge providing, seeking, and sharing; Lammers & Garcia, 2009), and negotiating organizational change among professionals. Giving feedback to a professional may require that the person offering feedback has the legitimacy to do so. Managers of professionals without bona fides can struggle to supervise them (Iedema et al., 2003; Kluger & DeNisi, 1996). For example, a hospital administrator with an MBA may have more trouble managing physicians than an administrator with an MBA and an MD. These interactions are rife with challenges and opportunities.

Understanding the legitimacy issues implicated in these interactions may enable researchers' and managers' efforts to support them. For example, the institutional moorings of these conversations are important for implementing change in health care. Health care change can involve multiple interdependent organizations and institutions. Transitioning to an electronic medical record at a hospital may require communication with stakeholders not only at the particular hospital but also with physicians at their own clinics who have admitting privileges and with managed care organizations, regulatory agencies, staffing companies, unions, and patients. Judging the effectiveness of the record will include notions of not only how it influences the quality of care but also access to care and the cost of the care—constellations of established

beliefs about what is good, true, and right in medicine that transcend any particular health care organization (Scott, Ruef, Mendel, & Caronna, 2000).

The communicative negotiation of such change as it occurs among health care professionals is guided by institutional logics. Gross et al.'s (2001) research on implementing evidence-based practices, for example, suggested the importance of dialogue among professionals about organizational changes versus messages from managers or other change agents. The day-to-day conversations between health care professionals that undergird—supporting, shifting, or undermining—change efforts in health care organizations implicate institutions.

Efforts to reduce medical errors offer further examples of conversations constrained and enabled by institutions. Interest in understanding how communication contributes to and can prevent medical errors includes change initiatives for improving communication among providers and creating cultures of safety (Eisenberg et al., 2005). Patient handoffs (e.g., between providers during a shift change) are a perennial villain in studies of medical error and a target for communication-focused interventions (Greenberg et al., 2007). SBAR—a standardized tool for prompting certain topics during handoffs—represents one such intervention. Practitioners have built on this tool to create forms to regulate and reinforce communication among providers (Veljii et al., 2008). As the handoff occurs, health care professionals, according to SBAR, should ask and answer questions about the patient's situation, background, and assessment and offer recommendations.

Such efforts, although laudable, may be limited because they do not take into account the realities of day-to-day life in institutionally moored health care organizations. First, these tools would seem to work well in situations where communication is already marked as critical. They may work when providers have recognized a situation as special and realized that they need such a technique. Yet intervention is needed that addresses routinized, ritualized care—care guided by assumption and heuristic methods. Handoffs may be dangerous precisely when communicators act on assumptions about who should do what, who should know what, or who has a legitimate right to ask questions. Different professionals have different assumptions about conceptualizations of medical work, information needs, and approaches to working together (Poole & Real, 2003). In other words, cultural-cognitive institutional schema may be more likely to influence routine, day-to-day interprofessional exchanges than communication training interventions like SBAR.

Second, interventions like SBAR also offer limited assistance in situations where professional status differences (Lambert, 1995) or fear of reprisals (Rosenstein & O'Daniel, 2005) constrain conversations. Power differences stemming from who has legitimate authority during a handoff might prevent the

raising of questions or doubts (Greenberg et al., 2007; Murphy, Eisenberg, Wears, & Perry, 2008). Interventions that ignore the institutions that influence health care organizing may be less effective than efforts that recognize the regulative, normative, and cultural-cognitive exigencies of institutions.<sup>1</sup>

Research efforts and interventions aimed at supporting conversations in health care should account for the institutional logics that constrain and enable them. Future research might examine (a) how interdisciplinarity complicates the development of knowledge management systems including the electronic medical record, (b) how implementers might reconcile standardizing medicine through evidence with the archetype of the autonomous professional (Timmermans & Berg, 2003), (c) how professionals' communication with each other influences the success of the change efforts, (d) how communicators can effectively give feedback to and challenge each other despite professional status differences, or (e) how actors reproduce and resist existing institutional logics as they work in novel organizational forms (e.g., ambulatory care clinics, urgent care centers, mobile clinics).

Work already ongoing by communication scholars offers rich ground for interventions to address these interprofessional dynamics. Changing enduring institutional logics may be difficult. However, communication research can contribute strategies for working well with institutional constraints and strategies for challenging those constraints. A constructive goal of research at the intersection of institutions and conversations would include investigating effective and ineffective communication strategies given institutional constraints and how communicators use institutions to produce and evaluate communication (see, e.g., Goldsmith, 2004, for a model of investigating the adaptiveness of communicative constructions). Such work could also be valuable for those working to critique and change existing institutional constraints. Understanding can foster creative appropriation and resistance. Apker et al. (2005) identified strategies used by nurses to manage interprofessional tensions (e.g., softening hierarchy, humor, and segmenting communication among different audiences). Thompson (2009) recommended that managers of interdisciplinary teams invest time to build trust between collaborators, discuss language differences explicitly, schedule social time, and confront communication challenges at the outset. These recommendations may work because they take for granted the institutional facts of life, honoring the professions and professionals involved while illustrating strategies that have worked for manipulating and resisting institutional logics in service of the goals of the communicators. From an institutional perspective, such efforts would allow time and space to consider default institutional logics and integrate them into local appropriations.

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## Note

1. For examples of the importance of institutions of organizational interventions see Petersen, Woodard, Urech, Daw, and Sookanan's (2006) research on pay-for-performance for providers, Timmermans and Berg's work on evidence-based medicine (2003), and Zbaracki's (1998) analysis of the application of total quality management in health care.

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