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ABSTRACT

Dominant research streams in healthcare management conclude that knowledge transfer between patient groups is accomplished through instructions and/or socially constructed practices. Underlying these views is the belief that texts and practices carry with them the codes necessary for their own decoding and, therefore, enable an unproblematic knowledge transfer. The analysis focused specifically on the interrelated effects between constituents of a group receiving ongoing healthcare and the relationships to knowledge transfer management, through which, group membership and knowledge exchange was mediated. The research asked if this relationship could be improved from both a personal and organisational perspective, by better understanding of the knowledge transfer mechanisms at work. We argue that because private and cultural models mediate decoding of information into meaningful knowledge, knowledge is created from the unique combination of cognitive dispositions of acumen, memory, creativity, volition, emotion, and socio-cultural interaction. Thus, mechanisms for decision-making affect socio group dynamics and interactions via the healthcare environment, manager or practitioner.

Design/methodology/approach – **CASE STUDY.**
This case study adopted a qualitative constructivist methodology and thematic analysis of the output data. A total of 20 (n1=20) main interviews and 10 (n2=10) follow up interviews took place over a two month period.

Findings – Findings indicate that for this group of participants, knowledge transfer depended on the assumption of real world values as opposed to determinates of healthcare practitioners.

Conclusion – These findings show that in a healthcare or organisational context, different perspectives to knowledge must be comprehensively understood before any technique to reduce transfer abnormalities is introduced within an environment.

Originality/value – The objective of the article is intended as a theoretical reflection on the implications of knowledge transfer in an organisational context.

Keywords: Knowledge, Knowledge transfer, Healthcare, Business, organisation, competitive advantage, culture

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INTRODUCTION AND BACKGROUND

The creation of knowledge before it is transferred is theorised by *Nonaka and Takeuchi (1995)* as a fundamental and important factor for any business or organisation as it is a fundamental constituent of success. Efficient knowledge transfer is therefore essential for any organisation wishing to become or remain efficient in today's healthcare environment. To support organisational development, *Kane, Argote, & Levine (2005)* explain that within the organisation, group membership changes are advantageous for group learning and performance development in that, as new members join, the group's knowledge increases exponentially and this in turn supports new knowledge development. Whatever the healthcare speciality, degradation of knowledge transfer will directly affect the usefulness of any new knowledge development *(Berman et al., 2002; Majumder, 2014).* It is clear that associated research surrounding knowledge transfer has seen the emergence of competing epistemological approaches that provide diverse theoretical and methodological views.

This research project collaborated with the Edinburgh Multi Cultural Society (EMRI). EMRI are involved in supporting a large number of independent business and retail start-ups within Edinburgh, Scotland. As such, information regarding its members along with their associated social and healthcare interactions underpinned the study. This grounded the research in a specific 4 field topology regarding knowledge transfer interactions; psychological, organisational, philosophical and cultural also known as *POPC (Fascia, 2015).* A central tenet of this research is the exchange of knowledge between participating actors from both a business and healthcare perspective. The emphasis of this study is to highlight the complexity of the interaction in the occupational, organizational and social contexts for knowledge transfer, but in relation to a healthcare management environment. This perspective represents a shift away from event, or sequenced accounts of knowledge transfer, and goes beyond simple process accounts of transfer mechanism interpretation and measurement. Informed by current literature and practices involving knowledge transfer, this research seeks to provide a meaningful understanding of ways in which knowledge transfer is recognised, understood, and utilised in both primary and secondary care milieus. It

provides a useful perspective of the role knowledge transfer plays in supporting business development from a healthcare management incentive.

For this study, we examined group healthcare changes, and how this affected business performance in the context of a knowledge transfer amongst the members of EMRI. The study looked at necessary interaction levels required to achieve specific business functions, such as: Information collation, information understanding, interaction with satellite groups and information exchange. Interactions were across differing businesses and differing management levels, thus providing a broader underpinning for data collection and analysis. These interactions are acknowledged within current literature as problematic areas for businesses and are identified as likely key areas for improvements. Most businesses, will after all, have actors of one sort or another who are likely to share, capture and exchange information and of course healthcare experiences.

KEY LITERATURE

A critical analysis of the literature was undertaken regarding the concepts and theory behind knowledge transfer in relation to an effective business situation. The literature review process involved a rigorous systematic search strategy followed by content analysis of material that met the specified inclusion criteria. Subsequently, due to the complex philosophical nature of knowledge, this literature review polarizes theoretical conceptualizations for knowledge, rather than assuming specific mechanics of a transfer contrivance. As such, many key authors focus on ways to understand and ultimately enhance this knowledge understanding, exploring various propositions using occidental foci, derived from historical secular concepts of: positivism *(Gates, 2001),* empiricism, *(Gupta, 2006)* and rationalism *(Katz, 2000).* The principal focus of the literal scope is in a business context and the understanding of the Knowledge mechanism within a group setting; this facet is principal to the verification of personal belief before the transfer of knowledge takes place.

A study by *Levine and Choi (2004)* looked at differences between group memberships, and results indicated that membership change encouraged participant members to revise their shared approach to performing knowledge related tasks. These changes infer that communication structures re-aligned to the specific desired outcome, after membership changes occurred. However, the process indicated that knowledge

transfer, in this context, is rarely an isolated event but rather a continuing relationship between the transfer source and recipient within the concept of the group. Within the literature reviewed, two fundamental approaches which overarched group interaction related to knowledge management emerged, that is, the process approach and the practice approach. The following text offers a brief interpretation of perspectives.

- ***Process Approach***

According to *Hass & Hanson (2007),* within a business context the process approach towards knowledge reacts to codify organisational knowledge through formalised controls, processes and technologies. Similarly, *Quinn (1992)* advises that this process approach commonly adopts the use of information technologies, such as intranets, knowledge repositories, decision support tools, and groupware to enhance the quality and speed of knowledge, creation and distribution in the organisations. In relation to this, but in a slightly differing context, *Quinn (1999)* acknowledges that a core competence does not consist of a product or something a company does well, but rather, it is the collective learning in the organisation, and especially, how to coordinate production skills and technology. *Currie, & Kerrin (2004)* further explain that this coordination requires communication, involvement and commitment in order to work across boundaries and levels, and this is one of the reasons why any core competence (associated with tacit knowledge) is difficult to imitate.

- ***Practice Approach***

However, *Brown and Duguid (2001)* offer criticisms regarding the concept of this process approach, in that, it fails to capture much of the tacit knowledge embedded in firms and that it forces individuals into fixed patterns of thinking. In this regard, *Brown and Duguid (2001)* explain that the practice approach to knowledge management assumes that a great deal of organisational knowledge is tacit in nature. From this position, *Harman & Brelade (2003),* and *Edmonstone (2013)* ascertain that the focus of this approach should be to build the social environments or communities of practice to facilitate the sharing of tacit understanding, as opposed to building formal systems to manage knowledge.

- ***Summary***

The literature review indicates that a number of competing strategic viewpoints have emerged regarding the importance of managing organisational knowledge both in a business and/or healthcare management context. Although the literature acknowledged measured management processes as the basis for creating competencies and innovative trajectories regardless of speciality discourse, group membership research provides diminutive comprehension into the effects of how new group participants evolve this dynamic. For the purposes of this study, it remains unclear in specifically what way a newcomer's arrival affects the relative stability of the figurational group structure. Currently, the majority of business and healthcare management literature suggests preference in the use of positivistic methods to investigate and analyse knowledge as a strategic tool in relation to a pre supposed efficiency trajectory, utilising case studies to establish knowledge enablers and barriers.

- ***Problem Statement***

Current studies reveal that the critical perspective is polarised against the resource based view of the firm, (RBV) stream and offers little in the way of alternative theoretical prisms to engage healthcare practitioners. A large majority of current research underpinning makes the assumption of the observed settings as an empirical study, focusing on power struggles between competing groups and shaping the analytical context on underpinning organisation pretexts. These assumptions are clear, in that it is assumed the variables under investigation can only be objectively measured, and that objective causal relationships between these variables can be revealed easily. From this perspective, we argue that any real world view, seen through {a}; an organisationally induced lens and {b}; as an individual participating in process scenarios, form two separate realities, incapable of a reunification structure. To elaborate this failure, knowledge, within a transfer mechanism, requires to be understood, shared and received to facilitate measurable successful transfer in any contextual architype. Thus, at the onset of analysis, knowledge is conjoined by barriers of interpersonal communication, irrespective of origin, meaning and context, implying

that knowledge emanates from a problematic origin before it is received by a receptive group.

H0 : The quality of knowledge transfer within a group will be comparable to that of non-intact groups in effecting transfer efficacy.

DATA COLLECTION AND ANALYSIS

The study adopts a unique position associated with complex relationship phenomena. At the same time, it acknowledges problems associated with current knowledge transfer analysis theory. That is to say, existing methods fail to assimilate individual or person centred differences, which relate to experience and/or understanding, and also affects organisation efficiency.

- ***Design***

The ontology of the study is based on a constructivist paradigm suggested by *Berger & Luckmann (1966),* wherein the social construction of reality remained paramount to aligning assessment of an interpretation. Thus, the design consists of an overarching interpretivist method of qualitative data analysis. To underpin this design, *Creswell's (2009)* example of a qualitative research script for questioning was adopted. Importantly for this study, this allowed for any interrelated complexity to be easily definable within the open-ended interviews. For example: "How or what" is the "meaning of" the phenomenon and the phenomenology of the "knowledge-sharing patterns", for individual "participants". In relation to this, figure 1.0 shows how the study adopted the following 'How' and 'What' aspects of the script and these were augmented to include 'Why' aspects to allow deeper exposure to interactive knowledge transfer experiences from the knowledge transfer practitioner's perspective.

The participants in this study were business practitioners in a community business partnership who were receiving healthcare for a number of proprietary complaints. The sample group (N=20) experienced interaction with a healthcare practitioner and

were identified from all levels of management hierarchy; thus, operators, consultants, managers and senior managers all participated in the study and from four locations within the business arena. There were no observable differences across conditions, or dependent variables related to age or organisation [position]. Similarly, attrition did not differ across conditions, nor were there any demographic differences lost to attrition. The average age was 38.

- ***Collection***

Due to the complex nature of the phenomena under investigation, the data collection consisted of a two-stage process informed by *Holloway & Todres (2003)* as an expressive paradigm for data collection. In this regard, stage 1 allowed the flow of knowledge or knowledge transfer to be observed first hand, from a primary source to a secondary source via any intermediary knowledge transfer points; thus, at the point of delivery and the point of dissemination to the group. Stage 2 involved expert knowledge input from senior members of the organisation and healthcare practitioners, who validated the interpretation of the knowledge transfer scenarios. There were a total of 20 interviews and 10 follow up interviews.

Each interview lasting approximately 30 minutes and each follow up interview lasted approximately 15 minutes. Transcribing of the interview was conducted immediately.

- ***Analysis***

Adopting a view from *Frith & Gleeson (2004)* regarding thematic logic, themes were carefully unpacked in an iterative process. A multi-method analytic procedure was then used as a form of triangulation. Additionally, the use of ATLAS/ti assisted greatly with data coding and cross-referencing. Analysis was a somewhat complex endeavour. This is due to the multifaceted iterations attached to knowledge.

For example, *Thompson and Walsham (2004),* stress that because knowledge is a subjective perspective of an individual's experience, associated problems are inextricably related to the context of the knowledge itself. The data highlighted underlying inference individual perspectives had on the qualitative answers relative to a POPC paradigm described earlier. The phenomenological properties of the interview data were also interpreted using classical thematic theory. In this regard, item-

response theory was appropriate for the qualitative aspect of this research as it supports knowledge transfer specific questions along with a priori objectives, and it was used as a means to summarise data into thematic charts. Thus, the complex relationship between knowledge transfer processes emerged to form a sociological perspective. This view can neither be adequately presented nor adequately explained by simple calculation and analysis. The use of a POPC definition matrix (Fascia, 2015) of interpretation allowed us to identify the dynamic interactions, which link all working practices/processes and at the same time identify knowledge transfer networks and supporting efficiency.

In addition to this comprehensive structure, this planned approach is also informed by previous investigations by this researcher into knowledge transfer process and practices in a business context. Utilised in this way, a POPC lens of interpretation allowed situational awareness and interpretation of complex knowledge transfer relationships to emerge from the interview data. Importantly, this included junctures of interpretation, which would normally sit under the radar if efficiency analysis were purely metric driven. This allows for identification of multiple qualia, or meanings attached to particular knowledge transfer perspectives and, in turn, underpinned efficiency evaluation of a specific point of the transfer process. This permitted interpretation of data to relate to a specific business context and any supportive expectation of the knowledge transfer outcome, and subsequently utilise an augmented dimension of analysis in a complex organisational structure by reunification of positional entity to which knowledge transfer underpins.

KEY FINDINGS

H0: The quality of knowledge transfer within a group will be comparable to that of non-intact groups in effecting transfer efficacy.

Key Findings 1: The study suggests that for this group, the quality of knowledge transfer within a group is comparable to that of non-intact groups and effects business

efficacy. This is because, before any knowledge transfer takes place, a strategic and fundamental analysis surrounding the perception of knowledge must be revealed in order to identify knowledge transfer practitioner involvement. Results reveal that the association of healthcare and knowledge from this participant group is derived not from a relationship to standard empirical data and models but from the conjoint levels of relational causality surrounding the unity of knowledge, to conclude a unification of joint perspective. This suggests a more philosophical stance on the concept of knowledge value, particularly from a healthcare management orientation, wherein interpretation offsets any arguments to incorporate a much more significant transfer paradigm. In this regard, it can be seen that for these practitioners, knowledge, within the context of knowledge transfer validation, can only have two states in the reflection of its value; either YES or NO. In this sense, findings contradict current literature streams that suggest knowledge in a healthcare surrounding is interpreted from multiple positions and streams of verification, wherein it is often perceived as multi-faceted and multi-sourced, difficult to interpret, without origin and in need of decryption. This essential prescript for validation of positional interpretation of knowledge as a definitive entity but not defined by value, empowers the practitioner to asses the position of knowledge through a phenomenological filter. As such, the relationship for transfer will be modified by past experience, including characteristics such as previous healthcare interaction, communication, process support, success recognition, and failure within the relationship. This encompassment ultimately identifies the facilitators and barriers to the use of knowledge for these practitioners, and it is this perspective that is used to develop guidelines for improving transfer amongst a receptive group.

Key Findings 2: Current literature dictates the need for measurement of a prescriptive and static process, which starts, stops and is measured from a procedural interpretation in relation to specific knowledge management practices. However, for this participant group, the understanding and utilisation of knowledge from a personal experience is already assumed as being unproblematic. Furthermore, encompassing both business and personal decision-making processes does not distinguish a precedence of creation from an experiential concept. These states or positions of

entity are, historically, individually viewed through the lens of either Rationalism or Empiricism. Therefore, contrary to current management theory, findings from this study indicate that for these practitioners, each transfer is surrounded by an irrefutable evaluation of knowledge value, importantly, before it is even transferred. This positioning then determines the capability to functionally evaluate its transfer ability as a unified structure and hence, its value. More specifically, for this group of participants, it is the holistic permeability of practices, encompassed within an ideological framework, which support knowledge transfer practices. Daily healthcare practices related to business decisions are not aligned to any specific empirical model, nor driven by imposed economic pressures. Ultimately, for this group of participants, a personalised stance on knowledge awareness eliminates the necessity for protracted philosophical argument over a corrective thesis for any knowledge to be transferred whatever the context or origination manifestation. In adopting this stance, practitioners from this group are not aligned to or indicative of current theoretical healthcare management models, in fact, quite the reverse.

CONCLUSION/REMARKS

The angst of most perpetuators of knowledge and its transfer capabilities within the healthcare arena is the complex nature of its constituent parts. This study shows there are conflicting academic views on the actual construction parameters in determining the priority and appropriateness of key values and sub section deliverable variables. There is a literary view on knowledge both as a category and as a commodity, which conceptualises how the dichotomies of tacit and explicit knowledge facilitate each other to the benefit of the recipient and resource stakeholders. Clearly, the work of *Polanyi (1958; 1962; 1966; 1969),* and *Nonaka and Takeuchi (1995)* identifies a starting point for a fundamental argument whereby logical positivism or scientific empirical objectivism should not be considered the complete solution to knowledge management, with further acknowledgement that a consideration of subjectivism must be included in any hypothesis. Simply put, knowledge, as a focal point of scrutiny underpinning any argument against pure objectivity is myopic, and as this study has shown, unnecessarily reductionist, particularly given the relevance associated to healthcare interventions.

FUTURE RESEARCH DIRECTION

Determining a conclusive scenario of reproducing knowledge in a concise and understandable way, personalised for each recipient, is perhaps asking too much of modern complex organisational healthcare infrastructures. Detailed Research, specific to social alignment, could produce a variable analysis model within a mode of dynamic flux, thereby allowing the model to adapt symbiotically to any given healthcare situation with multiple contexts. This would include a provision of constructive variables to efficiently integrate personalisation and codification strategies, thus easing the understanding of complex knowledge transfer mechanisms. A further enhancement of this model could be the inclusion of reflective learning paradigms, organised to completely encompass social and scientific theoretical development in both healthcare and business contexts. Ethical and social responsibilities are also missing from a more comprehensive solution, as are ethnic, religious, and socio-cultural microclimates. These individual facets could all be a dimensioning factor for consideration in the development of a singular model for knowledge construction and dissemination within a complex organisational healthcare management structure or environment.

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