THESIS

The struggle to stay in relation: How the dominance of an ideology of certainty marginalises practical judgement and political action, from the perspective of a senior manager in the NHS

Submitted to the University of Hertfordshire in partial fulfilment of the requirement of the degree of Doctor of Management.

Tobit Emmens
Student Number: 20014548

October, 2023

Supervisor: Dr Karina Solsø
Ethics Protocol Number: cBUS/PGR/UH/05278
Word count: 77,216

Acknowledgements

Writing this thesis was made possible through the involvement of many others, who have contributed in different but equally important ways.

My deep gratitude to my first supervisor, Dr Karina Solsø, for being so supportive of my work and for challenging me in ways that have developed and shifted my thinking. I am also grateful for her depth and breadth of knowledge, which has helped to shape my research. I am grateful to my second supervisor, Professor Karen Norman, for her detailed and careful attention to my work; this has been invaluable in clarifying my writing.

My sincere thanks to the entire DMan community for all their inspiring and challenging conversations. My particular thanks to my learning set — past, present, and honorary — and to my philosophy breakfast club colleagues for their friendship, support, and company. Philip Ayuk, Yinka Oduwole, Stephen Mitchell, Keven Bartle, Lynne Wardle, Jannie Rasmussen, Chris Morten, Mikkel Ruge, and Kiran Chauhan, I could not have achieved this without your support and encouragement.

I also thank my work colleagues. Your patience with and interest in my research, along with your feedback throughout my time studying, have reminded me that this work is worthwhile.

Finally, I am forever grateful to my wife, Mary, for supporting my endeavours and encouraging me to keep going, and to my children for bearing with my absences and the many peculiar meal-time conversations we have had over the past three years.

Abstract

In this thesis I explore my everyday work as a director of research in an NHS mental health trust. I use collaborative narrative autoethnography to explore episodes where research activity and evidence is contested, questioned, and sometimes causes conflict. In a health and care environment such as the NHS, it is often assumed that producing evidence of a high quality puts an end to politics and dispute. Drawing on the complexity sciences, pragmatism, and process sociology, I claim that, in addition to the scientific and bureaucratic rationality of evidence-based medicine (EBM), undertaking and using research is a complex and relational process that involves contestation and working with conflicting notions of the 'good'. Evidence may be (more or less) clear about an area of practice, but producing research and deciding what should be done with it involves human, social, and political activities characterised by strongly held values, contested meanings, and conflicts.

Through the research I have done for this thesis, I found that the production and use of clinical research in healthcare is dominated by an ideology of certainty, which manifests as EBM, and bureaucratic rationality in health service management. This ideology of certainty closes down discussion in favour of bureaucratic or scientific ends. In turn, this may lead to conflict and the breakdown of working relationships. In the course of my research for this thesis, I found that it is impossible to run clinical research without exercising practical judgement, taking political action, and being immersed in the social melee of human relating.

I have argued that navigating this ongoing and dynamic process in a way that might be less harmful requires practical judgment. My research contributes to the ongoing conversation that selves are social, and therefore, even the most scientifically rational research is also social, constrained and enabled through differing ideologies, thought styles, beliefs, and values.

Even research that is described as objective (for example, Randomised Controlled Trials [RCTs]) involve processes that are relational, political, and processual, by nature of the everyday activities undertaken to ensure that the research takes place. By improving our understanding of the challenges that arise from the relational nature of research and by exercising practical judgement, it may be possible to help to sustain research activity, reduce the potential for conflict and harm, and, ultimately, make the research more useful.

My thesis concludes that although EBM and RCTs are essential in how the health service operates, practical judgement (phronesis) and political action are important when managing research activity. Working with conflict, ambiguity, and uncertainty is not easy. However, engaging reflexively — in particular, with prior assumptions, differences of views and beliefs, and within a community of inquiry — can increase confidence of managers and clinicians in dealing with the complex everyday work that they are involved in when it comes to research activity.

Key Authors: H Arendt, L Fleck, T Greenhalgh, A Honneth, N Elias, C Mowles, J Sandberg, J Shotter, R Stacey, C Taylor, B Townley, H Tsoukas, T Vine.

Key words: research, evidence based medicine (EMB), mental health, thought collectives, ideology, reification, recognition, practical judgement, political action, conflict, violence, wriggle room, truth, relational dynamics.

Contents

Introduction

For the last 15 years, I have been working as a senior manager in a medium-sized, geographically dispersed mental health and learning disabilities NHS trust. My organisation employs approximately 4000 people and provides care to over 60,000 people a year. Some experience episodic mild to moderate depression or anxiety, others have a severe and enduring mental illness, and others are cared for in secure facilities. I am responsible for the delivery of a wide portfolio of mental health and dementia research. My team has made a significant contribution to research that underpins the evidence base for NHS care. I am immersed in the world of evidence-based research methods, including randomised controlled trials (RCTs), systematic reviews, high-quality studies, evidence assessments, and clinical effectiveness work.

Over the past 20 years, the governance burden for clinical research in the NHS has steadily increased. In part, this is a response to some horrific incidents, which include the falsification of research, for example, Andrew Wakefield's MMR vaccine research (Horton, 2004), use of zombie trial data (Carlisle, 2021), organ retention scandals (e.g. Bauchner and Vinci, 2001), clinical negligence and malpractice (e.g. Goodyear, 2006), and data breaches (e.g. Powles and Hodson, 2017). It is increasingly normal to talk about administration and management in public sector organisations, including the NHS, in financial, technical, and performance terms (Elkington, 2022:52, 56-58) that emphasise control and predictability (Townley, 2008:8).

More generally, public perception of the NHS seems to be idealised and at the same time fractious. During the COVID-19 pandemic, nurses and doctors were heroised, yet now there are record-breaking waiting times for GP and hospital appointments (BMA, 2022). NHS trusts recorded more than 35,000 cases of rape, sexual assault, harassment, stalking, and abusive remarks against staff between 2017 and 2022 (Torjesen and Waters, 2023). Over one-quarter of healthcare staff report having experienced violence and aggression from patients (NHS England, 2022:30). Healthcare professionals have taken part in an unprecedented number of strike days due to wage restraints (Baldwin, 2023). The burden of mental illness has never been higher, and demand on services far outstrips capacity (CQC, 2022).

In the NHS, the use of research evidence is a core principle of how care is provided. However, I have noticed that my colleagues and I sometimes use evidence in unpredictable ways. This has manifested as breakdowns or disruptions (Alvesson and Kärreman, 2011) in my practice. Conflicts have emerged over the best way to recruit patients into a clinical trial, how to run a research project, how to implement a particular type of evidence-based treatment, how to provide care not underpinned by an accepted evidence base, or where 'following the science' has resulted in harm.

Over the years I have met with a colleague, Nick (a consultant psychotherapist and an organisational psychologist), to try to make sense of some of my experiences at work. It was after one such meeting that Nick reminded me of the DMan programme, where he is a faculty member. I had considered joining the programme previously, but it had never seemed to be the right time. This time it was different, and I enrolled on the programme in late 2020, just as the initial disruptions to the NHS caused by the COVID pandemic appeared to be receding. I finally felt that I had the space to start thinking more about how I, and those in my organisation, went about doing and using research. Much of what I previously had taken for granted, had done without questioning, and had assumed about research in the NHS — specifically in a mental health setting — had been disrupted by the pandemic, and I felt that I needed to find some safer ground to stand on.

Research Question

When I joined the DMan programme, it was with the experience that doing mental health research is difficult, despite the idealised public discourse that positions it as relatively straightforward. Clinical research requires a clear research question, followed by the design and implementation of an appropriate research method.

Experiencing a gap between the simplicity of this idealised view and the complexity and messiness of clinical research in practice motivated me to explore what it is that makes research difficult. More specifically, I wanted to try to identify the complexities of managing research delivery in a mental health setting in the NHS and the kinds of dynamics involved that make research so difficult.

Documented in my thesis is the record of the evolution of my sense of self and practice. This is reflected in my research question, which I have formulated broadly as *What makes doing mental health research difficult?*

Drawing on the work of Stacey and Mowles (2016), Nicolini (2021), Butler (2020), Bourgois (2001), Arendt (1967), Tsoukas (1997), Elias (1978), Fleck (1935), Taylor (1994), Honneth (2005b), Vine (2020), and others, I describe how research, despite its veneer of order, calm, and certainty, is complex: full of power struggles and imbalance, recognition and misrecognition, marginalisation, and conflict. I show how, despite those involved in research appearing to have the best intentions, it is sometimes violent and harmful to those involved.

In my three key arguments I describe how healthcare research is dominated by an ideology of certainty, which manifests as evidence-based medicine (EBM), and bureaucratic rationality in my management practice. My research shows that whilst this ideology of certainty can sometimes close down discussion in favour of bureaucratic ends, this may lead to conflict and the breakdown of working relationships. However, there is often ‘wriggle room’ within the processes of doing and managing research; I found it is impossible to undertake research (RCTs) without exercising practical judgement (phronesis), being engaged in political action, and being immersed in the social melee of human relating.

This thesis has been written in this context and through my participation in the Doctorate of Management (DMan) programme at the University of Hertfordshire, where the practice of thinking about organisational experiences as complex responsive processes of relating (as summarised by Mowles, 2021) has been developed over the past 20 years.

Structure of my thesis

My participation on the DMan programme comprised paying attention to my practice, discussing my work within my research community and with colleagues, and an ongoing process of reading, writing, reflecting, and paying attention again. By 'paying attention to my practice', I mean trying to be more aware of the way I might inadvertently be selective about what I see going on in my practice (Simons and Chabris, 1999). The structure of my thesis comprises four projects and a synopsis, organised in three parts:

1. This introduction to the thesis
2. Four projects
3. A synopsis of the projects, including my methodology, arguments, and contributions to theory and practice

This qualitative inquiry into my everyday life as a senior manager in the NHS aims to make sense of my experiences of interacting with others, including my DMan research community. Through this process, I have paid attention to my experiences of participating with others (Stacey and Griffin, 2005:2). This thesis presents a summary of the themes and reflections that emerged from my inquiry and informed my arguments and contributions.

Projects

Following my first project, each of my three subsequent projects starts with a breakdown in my professional practice, which is narratively constructed. These narratives become my 'empirical material' and allows me to explore patterns within my practice. Through a process of sense-making, I arrive at an 'animating question'. This question guides a theoretical and reflexive exploration. I bring in literature in an attempt to theorise about my experiences, identify themes, and develop plausible responses to my research questions which allows me to make some provisional conclusions. The projects and synopsis were all written iteratively, with comments provided by fellow students and my supervisory team. Using a process of abductive reasoning (Misak, 2013:47-50), I sought the most plausible and resonant conclusion to my breakdown in practice. A more detailed account of this is in the methodological section (p117-127).

Project 1 (P1) is a narrative autoethnographic account of the experiences and assumptions that have influenced the way I think. In the broader context of my thesis, its purpose was to identify patterns, themes, and questions for further research, and to situate me as a reflexive writer and researcher. Usually, healthcare research begins with a literature review and a process of 'gap-spotting'. However, as Alvesson and Sandberg (2011:247) describe, gap-spotting tends to *"under-problematise existing literature and, thus, reinforces rather than challenges already influential theories"*. During my research for this thesis, thinking about and challenging my assumptions became an alternative way for me to generate research questions. Therefore, P1 is a reflexive account of how I have become the person I am today, and it is central to how my research unfolded. It shows how the questions that were beginning to shape my inquiry emerged in my life, education, work, and reading. In it, I pay attention to habitual patterns that emerge: my ‘quest for truth’ and my tendency to work ‘in the shadows’ or ‘behind the scenes’. Working on P1 gave me the opportunity to describe and reflect on the assumptions I held and introduced me to a more reflexive way of thinking about them. In this research, ‘reflexivity’ means taking into view both the subject and the object of study, and understanding them in paradoxical relation (Mowles et al., 2010).

Projects 2 to 4 are based on recent episodes of breakdowns in my practice.

Project 2 (P2) is an account of an audit-research project I jointly led in one of our clinical services, which was subjected to intense internal and external scrutiny.

Project 3 (P3) is an account of a meeting I attended to support a colleague in another organisation who was experiencing significant barriers to carrying out a research project due to the position adopted by their information governance (IG) team.

Project 4 (P4) describes a series of meetings with clinical and managerial colleagues in which we tried to decide how to proceed with a clinical intervention that was also the focus of a major RCT we were running.

Synopsis

Following the four projects outlined above, my synopsis is presented. This consists of the following sections.

Complex responsive processes of relating

The DMan programme involves writing narratives about experiences at work, and ‘taking experience seriously’ (Stacey and Griffin, 2005). This approach is informed by ‘complex responsive processes of relating’ a perspective which considers organisations not as systems, but as ongoing patterns of interaction between people. I have sought to understand events from my practice, described in my projects, that illustrate the “*ongoing, iterated processes of cooperative and competitive relating between people”* (Stacey and Griffin, 2005:1) and the tensions between (1) the abstract and generalised ways in which I often talk about what I am doing, and (2) my actual embodied and often messy experiences. This section introduces the theories that inform the DMan programme.

Method: Collaborative, reflexive, and critical autoethnography

I have always found the stories people tell about their experiences fascinating, and they have helped shaped and broadened my understanding of what might be happening. These richly portrayed accounts of what might be happening for them have been part my management practice for some time. However, it was not until joining the DMan programme, with its central methodological strand of ‘taking experience seriously’, that I started to think about my work in such deeply reflexive ways. My research method follows a reflexive autoethnographic approach (Bruner, 2004, McIlveen, 2008); within that approach, I recognise that there is no way of understanding my organisation from the standpoint of a detached observer and that instead, I must work to understand it from my experience of participating in it (Stacey and Griffin, 2005:2, 22).

Reflexive summaries

In this section, I thematically and reflexively summarise each project as the basis for my arguments.

Arguments

Here, I present my arguments on how research in mental health services is dominated by an ideology of certainty; that is, research can close down discussion in favour of bureaucratic ends, which may lead to conflict and the breakdown of working relationships and, in turn, make the research itself hard to deliver. Research management also requires exercising practical judgement, engaging more fully in political action, and immersing oneself in the social melee of human relating. Questioning the theoretical and social conditions under which objective knowledge is produced can improve the quality of research, rendering it more useful in the long term.

Contributions to theory and practice

The final part of the synopsis describes my contribution to knowledge and practice, and sets out suggestions for further research.

Project 1: The boy with a B in woodwork

Introduction

This project is a reflexive narrative of my personal and professional experiences, focusing on the assumptions and ways of thinking that have informed my work. It is autobiographical in that it reflects on how I have become who I am and how I have engaged with various intellectual assumptions over the years. Through this narrative, I share the cultures, societal traditions, and ways of thinking that have shaped me and I engage reflexively with these. In this project I state the questions that have informed my inquiry and demonstrate my engagement with the academic thinking that shapes the DMan programme.

Who am I?

Growing up

I was born in the 1970s, and for the first 18 years of my life I lived in small villages in mid-Devon, UK. I am the second child of five children.

My parents were very religious and belonged to a nonconformist Christian sect. We children grew up in the duality of a traditional church and my parents' liberalism. Their liberalism was manifested in an 'open house, regardless of beliefs' approach; in contrast, the church they (and later, I) belonged to claimed to be the only true church and did not permit worship with others who held different beliefs. My parents were heavily involved in running activities at church and in the local community. Our house was always full of people during the week, with formal church services on Sundays. We children were expected to be fully involved, but I did not enjoy church, and lived a double life — I went to church at the weekend, but never mentioned it during the school week. I remember reading my dad's school governor election statement, in which he described his Christian beliefs. I was horrified that it was so public. What if my friends found out? What if this resulted in being bullied? Or, worse still, what if people challenged me about what they thought I believed and judged me on how I behaved?

Although there was plenty of discipline while I was growing up, both my parents were quick to forgive and they were always there to support, encourage, and rescue. I recall several occasions on which I was collected from the side of the road, broken bike or broken body, having had to use my emergency call money at a roadside telephone box. I found it hard to please my mum, and we argued a lot. I recall finding it difficult to measure up to what I understood her academic expectations to be, but I was grateful for the efforts she made to support me with my homework, especially in English and mathematics. While I was not as clever as my older brother, and sometimes felt judged for this, my mum would defend me if needed — even to the point where I protested or felt embarrassed. Riding home from school one day, I came off my bike after a dog ran out and chased me. I limped home with a large tear in my school trousers. On seeing me and hearing what had happened, my mum put me and my bike in the car, drove to the dog owner's house, and explained fiercely that this was unacceptable. As a 14-year-old, I was so embarrassed; being in the spotlight felt so uncomfortable.

I grew up riding bikes, not only to school (five miles each way) but also for racing and touring. I did the same sports as my older brother, and I still have the scars from trying to outdo him when doing jumps in our field. By the age of about 14, I was regularly racing at mountain and road events and, with the support of my mum, taking part in long-distance walking events. Summer holidays involved working at the local meat-packing factory where my dad was the company accountant, and then escaping to spend my earnings at the end of the summer. As part of the seasonal student workforce, I packed sausages, lamb chops, liver, hearts, and kidneys into small plastic trays for days on end. Once we had saved enough money, my brother and I would embark on cycle-touring adventures. One summer, we bought a tandem and took the ferry to Spain; our plan was to ride home through France. After about 500 miles we succumbed to insurmountable technical challenges, and my dad drove, with my mum as navigator and with her firm grip on logistics, through France to collect us. My brother and I rode that tandem a lot, but, despite my asking, I was rarely allowed to ride up front as ‘captain’. Mum, with tolerance and grace, continued her role as a navigator and guide as I learnt to drive a few years later, patiently teaching and nurturing new skills.

At school, I was a ‘middle set’ child, almost invisible: neither exceeding nor falling below the minimum standard, I received neither the accolades of the gifted nor the punishments of the naughty. I learnt to accept I was not ‘academic’ in the way I thought others in my family were. I worked hard though, diligently taking the extra lessons that my mum organised for me during lunch and after school. In doing so, perhaps I was trying to earn recognition for my efforts or simply be a little less invisible. On Wednesday afternoons I did double woodwork (and got a B, my best result), but the best day of the week was always Friday: I was one of the lucky ones who was on the outdoor pursuits programme, and on Fridays I went out in a minibus with Mr Michaels and 14 classmates. We learnt to ski, cave, orienteer, climb, sail, and canoe. One summer, to break free from the meat-packing factory, I secured a seasonal job as an assistant canoeing instructor. With that, I decided that being an outdoor pursuits instructor was the life for me. I scraped through with enough GCSEs (secondary school exams) to get into college, where I spent three years training to be an outdoor pursuits instructor.

Being outside fed my desire for freedom. To be in wild and sometimes savage conditions with a sense of mastery (rather than control) was hugely rewarding. For the first time, I felt I was out of the shadows. Being at one with nature sounds clichéd, but although I found hanging from a rock face or sailing in 40mph winds stressful and exhilarating, what I enjoyed most was the emotional and cognitive peace I experienced. However, when it came to applying for jobs at the end of college, it became apparent that there were few available. When I failed to get into university to further my theoretical knowledge, I was disappointed; it reinforced my belief that I was not academic. I was unsure what to do next.

To Exeter, via London

In the summer I finished college, an opportunity arose to live in France for a year while learning how the French ran sports centres. It was a year full of rich experiences, many of which I enjoyed, but I returned to the UK with a growing list of careers that were not for me, so it was back to seasonal work while I took stock. My parents, led by family interests, and their commitment to our hobbies, began running a business providing mountain bike race administration, and I spent many weekends working at the side of a racetrack, seeing the 'back room' and spending time with some of the country's best cyclists. One person, Joe, a *soigneur* (a person who gives training advice, massage, and other assistance to a cycling team, especially during a race) was especially influential and inspirational. I would often observe his larger-than-life presence in the midst of the finish-line scrum, collecting up his riders and administering care and attention. I was enticed by that world and, after quizzing Joe over several weekends, I started part-time training in massage, sports therapy, and nutrition. I qualified two years later.

For 18 months I worked for several of professional mountain bike teams at national and international races. I loved the carnival of the professional mountain-biking circuit and being behind the scenes, but living in Devon was logistically challenging. In 1995 I moved to London on a trial basis and started temping work in the city centre while I found my feet. I met Mary through our church network. She lived with her mum, dad, and four brothers, but was working as a nanny nearby. We spent a lot of time together, getting to know each other, and we married two years later.

In early summer 1996, my dad went to the doctor's because he was not feeling too well; the next day, he was rushed to hospital with some kind of undetermined blood cancer. He was given two weeks to live. I moved back home. Various church elders came and went; prayers were said. The doctors and nurses were busy providing him with care, and within a couple of weeks, my dad had gone into remission and come home. This lasted for four or five months, but in the week before Christmas, his symptoms returned and he ended up back in hospital. On Christmas Eve, the oncologist managed to identify the type of cancer, consulted with a specialist centre, and started an aggressive form of chemotherapy. By late afternoon, my dad was in significant respiratory distress, and he was moved to the intensive care unit, where he was put into an induced coma. The foundations of my life were beginning to crumble. After a four-day bedside vigil, my dad died, surrounded by his family and the quietly beeping machines which finally fell silent. The ventilator kept pumping until a second doctor came to turn it off. My life was shattered, numb, silence.

I felt inadequate as my dad died: inadequate that I could do nothing to stop it. But perhaps I also felt inadequate in his presence, or in the memory of his presence. He was remembered as an amazing man, a tireless contributor to the communities he belonged to. Hundreds of people came to his funeral. Dark days followed, and yet somehow life carried on. I think my own experiences of suffering, and grief in particular, led to my interest in working in mental health services.

Married, and living in London again, I set about building my sports therapy business and secured some regular work in central London. It was about 80 minutes on the Underground each way. At weekends, Mary and I would often visit Mary's family, who lived a short train journey away, and I spent time getting to know her brothers. Her eldest brother was intellectually gifted but had chosen not to go to university; instead, he worked in a local factory, and enjoyed making social commentary on factory life. He gifted me a copy of *The Idiot* by Fyodor Dostoevsky (2004), and I set about reading it on my daily commute. I had never read anything like it — although my mum loved reading and shared this love with me, always making book recommendations, they were nothing like this, but rather 'easy reading' fiction. Reflecting back, I do not think she thought I was not clever enough but more likely that as someone who struggled reading, she just wanted me to enjoy books.

I was formally diagnosed as dyslexic when I was about 13. I have childhood memories of reading the Bible out loud with my family, something we children hated. I was not good at reading out loud: words would appear in the wrong order, and I remember several fierce arguments erupting because I was corrected for missing or adding words. It took me a long time to overcome the impact of this. When I mentioned to my mum that I was reading *The Idiot*, she seemed pleased, recalling that she had enjoyed reading many similar books as a teenager. I am not sure why my brother-in-law chose to give me *The Idiot*, or what he might have been trying to tell me. The story of a good prince who made everyone's lives worse and achieved nothing had an odd resonance; there was a sense of familiarity with how I perceived my life. I could also see the prince as representing the values of compassion and human love, functioning as a kind of 'Jesus' on earth who absorbed the sins of others, and I noticed Dostoevsky's criticism about Russian society harming these values. This combination of criticism, parody, and rejection made a lot of sense to me, despite struggling with some of the Russian names. Over the two years that followed, I worked my way through my brother-in-law's bookcases, reading many existential and philosophical works of literature – classic and contemporary – from Russia, America, and Europe. My desire to read, expand my world, think and learn was strong. I never thought of my brother-in-law as a big brother, and he did not behave like one, but for the first time I felt that someone I was close to could see academic potential in me.

In 2000, Mary and I moved from London to Exeter. There, I set about building a new massage therapy practice. I took on some work with the local drug rehabilitation project, supporting problematic drug users with a combination of nutritional therapy, massage, and coaching.

What is 'truth'?

I wanted to build on my knowledge of using complementary therapies to help people. I recognised that I felt a sense of inadequacy about not being able to do enough for my dad. Following his death, I had been weighed down by a sense of guilt: had I known more, I could have helped more, and perhaps prevented his death. Driven by this motivation, I started a new training course. I now realise that my feelings of guilt were probably how I made sense of my grief; I was not responsible for his healthcare or his death.

During this training, in a lecture on psychology and philosophy our teacher was talking about the skills involved in diagnosis, and argued that when you say that 'this is *the* truth', you are also saying that everything else is false, and we should be careful of thinking like this. These words weighed heavily on my mind, particularly given my religious upbringing in a community that held that what it believed was the only truth (and therefore, that all other religions were wrong). Through my reading, my mind was opening up to the idea that many things could be true, and, indeed, sometimes two things that seemed to contradict each other could both be true. In reading Aristotle's *Ethics* (1953), Plato's *Republic* (1955), and Descartes' *Discourse on Method* (1961), I could see a place for realism, scepticism, idealism, mysticism, and justice; reading Homer (1946, 1950), Ovid (1955), and Virgil (1956) showed me a world where gods bickered, punished, and helped, and where good ultimately triumphed; in Solzhenitsyn (e.g. *First Circle* (Solzhenitsyn, 1968)) I read about the worthy being punished in a totalitarian regime; and Buddhist and Hindu scriptures taught me to see 'god' differently. I could also see that 'my' god of love was also the god of war and destruction. During this time, and through the books I was reading, I was beginning to understand that sometimes good people did bad things, and sometimes bad people did good things; that sometimes life is just not fair, and that instead of asking 'Why me?' when it came to suffering, I should be asking 'Why not me?' This was at odds with the fundamental Christian beliefs — on sin, punishment, and forgiveness — that I had inherited and grown up with.

Tackling religion and science together is a complex task, and one I cannot explore in detail in this work. However, in my efforts to understand a wide range of theories as part of this project, I listening to the *In Our Time* podcast (BBC, 2015-2021). The episode on Karl Popper (Bragg, 2007), exploring Popper's theory of 'critical rationalism' and the concepts of falsification, provided a helpful lens through which to reflexively understand my experiences. Critical rationalism is a philosophy that states that claims to knowledge can, and should, be subjected to tests that may falsify them. Falsifiability is the capacity for a statement, theory, or hypothesis to be contradicted by evidence.

My disillusionment with the church was growing. I started a journey of radically deconstructing my Christian beliefs, recognising that while they seemed important, I had never felt entirely comfortable with them. I wanted to test them, find the evidence for or against them, and prove them true or false; more importantly, I wanted to work out how I could live with what I found. However, Popper resists the idea that theories could be proved true, writing:

> *"The more we learn about the world, and the deeper our learning, the more conscious, specific, and articulate will be our knowledge of what we do not know; our knowledge of our ignorance. For this indeed, is the main source of our ignorance — the fact that our knowledge can be*

> *only finite, while our ignorance must necessarily be infinite." (Popper, 1963:38)*

My quest for certainty, although enticing, may have been misguided, although it may reflection of a wider historical pattern of thinking, where positivist science emerged as a response to religious truth. It also demonstrates the pragmatic idea that knowledge is fallible and evolves over time.

John Caputo, a philosopher-theologian and a colleague of Jacques Derrida, has written on text and its meaning (for example, Caputo, 2007), and I found this helpful. I learnt to see the contradictions, gaps, and differences within a text, and I tried to use these to create fresh understanding. I could see how the language of my beliefs was bound and shaped by its context: words have meaning only because of their relationships with other words and those who speak them. I felt I had found a way to truly understand the relationships between me, others, and the Bible. This gave me the language, confidence, and opportunity to name some of the conflicts and differences I had had with the teaching of my community. I felt this new understanding gave me the permission and confidence to move on from the simplified narratives of good and evil, right and wrong, life and death, truth and untruth.

I found solace in Herman Hesse's *Siddhartha* (1922), a book about a young man and his spiritual journey of self-discovery. It explained Buddhism in a way I found accessible. Its representation of contrasting spiritual teachings and practices, and way Siddhartha is depicted as very much part of the world rather than abstracted from it, was helpful to me. I learnt from *Siddhartha* lessons that had so far eluded me: whatever we do, we cannot escape suffering; if we seek, we find nothing because we become obsessed with our goal; and 'I can think, I can wait, I can fast' – a mantra that I found especially powerful. To me, *thinking* meant reading, observing, learning, and acting accordingly; *waiting* meant being patient when things were not going well; and *fasting* was about endurance, resilience, and freedom from the things that bound me. However, this emerging sense of peace was leading to tension between all this new knowledge and my actual life. It was during this time of my life that my deeply ingrained religious beliefs started to unravel. One church teaching I had heard many times as a child and as a young adult was that we are 'of the world, but not part of it'; that is, we are human, but we should separate ourselves from the world in order to live a pure and righteous life. The books I was reading were in stark contrast to this: they told stories of people who were utterly immersed in the world they inhabited, living with the good and bad, right and wrong, and sorrow and joy that came their way.

This growing knowledge — that is, a practical, dynamic, theoretical, and fallible understanding of how I might live — coupled with my growing unease with fundamentalist religion led to me becoming increasingly at odds with my church community. They were simply unable or unwilling to engage with me and all the questions I had. They would tell me that I just had to have faith and follow the rules, but my 'faith' was constantly diminishing, and I could not find a way to either verify or live with these beliefs. By 2009, Mary and I had left the church, breaking with long-established traditions and ways of thinking. I felt great sadness (as well as relief) about this ending, and I tried to maintain my friendships with those I thought I was especially close to, but without a shared interest those friendships soon faded.

During this period of my life, I found new role models and developed a broader and more nuanced understanding of compromise, and of life. I also experienced the unravelling of the concept of truth as I had learnt it as a child and a young adult. I no longer felt guilty or inadequate concerning my dad's death, but I was still trying to break free from the shadows of my older brother. I could see that despite some rich life experiences I had led a sheltered life, and I was beginning to see through my religious world view. It is not surprising that through loss, separation, and new beginnings I found some freedom, in particular to think beyond the constraints of my earlier years.

My brother-in-law giving me a copy of *The Idiot*, and later, a colleague Claire recognising my capability to '*do something using my head*', on a research project stand out as moments where my academic potential was recognised. As I reflect on this now, themes of recognition and misrecognition are important.

'Why don't you get a job?'

One Tuesday in early 2001, Mary came home from work and, on hearing about another quiet day, compassionately and in kindness asked, *'Why don't you get a job?'* As my massage practice was proving slow to build, I thought this would be a sensible thing to do.

The following day, I looked at jobs and one stood out: research administrator, Department of Mental Health. I visited, met the small team, and sent in my application. I was offered the job, and started working mornings at Devon Partnership NHS Trust (DPT). My team consisted of my manager, John (a consultant academic psychiatrist, and Director of Research); his PA, Martha; and a collection of visiting medics and psychologists who seemed to come and go as they pleased. I set about trying to transform the administrative processes, absorbing myself in a mix of problems and tasks that required intelligence, flexibility, and creativity. In the afternoons I continued with my massage therapy work.

One of the visiting medics, Claire, took me under her wing. She was an academic forensic psychiatrist, and she was interested in my drugs project work. In 2002 she secured a research grant from the local police force to understand patterns of Ecstasy use. I was named in the application, and this led to an additional part-time job at the University of Exeter. This was exciting, but I felt I lacked legitimacy: the highlight of my schooling was a B in woodwork, I had failed to get into university, and I had a collection of various vocational qualifications. But I read — not just books, but within the first few years of starting my admin role I had read hundreds of research protocols. Claire was a great mentor who nurtured me and believed I was capable. With guidance and support I designed a survey, a sampling strategy, a recruitment plan, and an interview schedule. Within a few months, nearly 800 completed questionnaires had been returned to us. I was shown how to use statistical software, spent several weeks entering the data, and produced descriptive statistics. After this we moved on to the qualitative interviews. After listening to and transcribing Claire's first interview, I conducted the next few myself.

Moving into management

In early 2003 a new consultant medic, who was a specialist in suicide and self-harm prevention, joined the clinical team I was working alongside. Mike was clearly ambitious, and he came across as arrogant. He had just finished a contract as a research physician with a pharmaceutical company, and before that he had worked in a large London teaching hospital. He carried himself in a way that implied he was intellectually superior. He would make quick judgements about what was going on, and he was able to influence groups of people to agree with his way of thinking. I could see how he influenced decisions by working things to his advantage. As part of this process, he would often come and talk to me, weighing up what he thought against my organisational insight and knowledge. We worked well together, using his knowledge and influence to win academic and commercial clinical trial work.

Later that year, I was invited by John and Mike to apply for a new post they had created that reflected my contribution to the department. My experience was recognised, and I was successfully appointed to a new management post. During 2003 and 2004, Mike and I began to work more closely together. By 2004, I was working full time in the NHS, so I took the decision to deregister as a massage therapist. Later that year, Mary and I had our first child. Not long after that, a good colleague and mentor from the drugs project died suddenly. He was a father-mother figure, and the grief I felt was acute; it reignited the emotional turmoil I had experienced following the death of my dad.

In 2005 I started an MSc in clinical research. The first critical appraisal module represents another influential point in how my thinking developed. Critical appraisal is a type of quality assessment of the evidence presented — in this case, in scientific publications. These quality standards act as a way of understanding bias (selection bias, information bias, and publication bias), validity, methodological error, and confounding factors. The process of critical appraisal seeks to find research that is robust and generalisable (Boccia et al., 2007, Al-Jundi and Sakka, 2017). In a structured way, I learnt how to identify the best evidence using a range of transparent factors, draw from a variety of sources, and use this systematic process to build my own views, opinions, and decisions. I found it interesting that these quality standards represented a particular paradigm of thought, but, because this was not discussed, the standards were not transparent. A paradigm is a shared world view that represents the beliefs and values in a discipline and guides how problems are solved (Denzin, 2005). Quantitative research paradigms are described by some as based on the philosophy that every phenomenon in the world can only be explained by the positivist paradigm; that is, there is only one truth and its explanation can only be reached by using empirical statistical methods (Park et al., 2020). At this point, I was not aware of the different paradigms that exist (positivist, constructivist, pragmatist, feminist, and so on), and, despite having begun to question my own understanding of truth, I found comfort in discovering that there might be a way to find out what was actually true.

Meanwhile, John had been offered a professorship in another university and Mike had become the new director of research and development (R&D). Mike and I had been working alongside each other for a while and we got on well; his arrogance had softened a little.

Mike was happy for me to take full control of all R&D activity and, as new funding opportunities opened up, we continued to be successful in securing enough to invest in building the team. Most of the clinical academics in the department had moved on, but Jessica, a researcher, remained. We had an interesting relationship: she made it clear that she considered me an imposter in an academic environment, yet she was happy to benefit from the environment I created and the money I was bringing in to the department. She was also happy for me to project-manage research grants she was responsible for. Her quest was academic purity; however, I was never clear about what this meant and she was not in a 'pure' academic department because she was employed and funded by the NHS. She would sometimes spend hours deciding which words to use in a paper or grant application, but the timelines I had to meet for funding bids did not afford us this luxury. There was always an underlying conflict between Jessica and others in the team, and she clashed in a similar way with Mike. Mike and I would spot opportunities, quickly pull together funding bids, and draw Jessica into the project to give it 'academic credibility'. We were successful on several occasions, although I often thought that Jessica was having to compromise her academic ideals and values by lowering her standards to win money to secure her ongoing employment. As I reflect on this now, the theme of compromise emerges.

We would talk about our work in team meetings, and I proposed an idea for a self-harm intervention research project. I felt, and indeed still feel, a connection to work in this field. Over the years I have witnessed and experienced the emotional consequences of self-harm and suicide, and in my various roles in the last two decades I have found myself in a privileged position that allowed me to do something about it. Jessica made it clear that she did not understand the idea and was not particularly interested in the work (she was a qualitative researcher, and I was proposing a quantitative study). However, begrudgingly, she agreed to lead the application if I would write the first few drafts. Our application would not have been successful without Jessica's contribution, but Jessica and I knew we needed co-applicants with a broad range of experience. I identified and called a number of local academics, ignoring formal academic etiquette and inviting them to join our funding bid. In this way I put together a team, and we were successful in securing a £250,000 research grant. Two years later, I followed the same process and secured a £100,000 research grant. Although I was part of the team and put a lot of effort into the bid-writing, I felt as if I was ghostwriting for Jessica. Even so, I was comfortable working behind the scenes while others received recognition for our success, because ultimately I could see the benefit for the people we were working with clinically.

Jessica was building a reputation as a leading researcher in her field, and I was securing funding with and for her, in addition to project-managing many aspects of her work. In all this research work, I became increasingly interested in suicide and self-harm prevention research. I chose to investigate the media reporting of suicide for my MSc dissertation, and Jessica agreed to be my supervisor.

One pattern that I can see emerging in my narrative is that I have the capacity to allow relationships to shift over time, even when they do not begin especially well; as was the case with Mike and Jessica. This reflects my willingness to both find the best in people and find common ground to move forwards on. I also wonder if my willingness to compromise a little (here, for example, enabling Jessica's success while I remained in the shadows) allows me to achieve much of what I actually want, whether that is for myself, my team, or people we work with clinically.

Patterns of thinking further shaped by my MSc

During the period of my MSc, Mike, Jessica, and I led a project on suicides in public places. My MSc dissertation followed on from this; it was an in-depth study into the theoretical underpinning of media guidelines for reporting on suicide. In part, my interest was driven by a curiosity about whether guidelines that made sense and should be implemented needed an evidence base. I can see that this statement includes assumptions: (1) that 'things make sense', when for some, based on beliefs, experience, or values, those things might not, and (2) that for something to be done, it needs to be supported by a particular type of evidence.

For my dissertation, I followed a methodology pioneered by Professor Trisha Greenhalgh (Greenhalgh et al., 2005, Greenhalgh et al., 2009), a professor of primary care and director of an interdisciplinary research unit at Oxford University and grounded in what Thomas Kuhn describes as 'incommensurability' (1962). Kuhn, a physicist and philosopher of science, was perhaps one of the most influential thinkers of the twentieth century, and describes incommensurability as the inability to compare things from starkly different conceptual frameworks (or paradigms) (Bird, 2004). What struck me most about Kuhn's work was his insight that if one is to understand a particular approach to science, one must know about the intellectual tradition within which that approach to science sits (Kuhn, 1962). I took this to heart, and subsequently I have always tried to make sure I have an understanding of the intellectual traditions of those I am working with. Jessica and other colleagues helped me to broaden and deepen my understanding of different research paradigms. They helped me understand that although the rich, deep experiences and narratives of people providing and receiving healthcare can be distilled into simplistic causal statements, one should not ignore the importance of context, perspective, and dependencies, or, importantly, the impact on oneself of being in and thinking on such things. From my standpoint today, when I recall that lecture about truth and my response to it, I realise now that it was foundational to this way of thinking. My shift away from the positivist paradigm (which much of my day-to-day work was grounded in) and towards a more constructivist or pragmatist paradigm greatly helped me at work; I sought to build a balanced representation of different views, trying to see multiple versions of the same events and not attaching myself to one particular methodological approach.

My research exploring media theory drew several theoretical threads together, in particular those of critical appraisal (Al-Jundi and Sakka, 2017), language (Meyrowitz, 1985, Meyrowitz, 2008, Richardson, 2007), discourse (Richardson, 2007), positivist empiricism (e.g. Stack, 2005), and post-positivist thinking, which I will now explore further.

Prior to my MSc, I had not given 'the news' much thought, simply assuming that it presented unbiased information; however, as I read more on media theory, I began to see that 'news' was far more than this. As stated by Denis McQuail, a media theorist I studied for my MSc, *"When news is considered as narrative, we can appreciate the ways in which it draws on and retells the recurrent and dominant myths of society"* (McQuail, 2005:381). I began to understand that the main function of these narratives was to give the receiver a framework that helps them make sense of information, experience, and fragmentary observations. I could see that the skill of news storytelling was to enable the reader to see a particular perspective. This built on my earlier learning to strengthen the idea that what we consider to be facts or truthful claims cannot be separated from the social, historical, and cultural contexts and relationships within which these 'facts' are constructed or produced. I could also see that language, as Derrida puts it, has a force, and a text cannot be seen as a static structure but is a dynamic one, turning the page *"into a simultaneous network of reciprocal relationships"* (Derrida, 1967:28).

Ralph Stacey, a retired British organisational theorist, professor of management at Hertfordshire Business School, and former director of the University of Hertfordshire DMan programme, discusses the development of facts in an article published on the Complexity and Management blog. Drawing on the work of Ludwig Fleck, Stacey makes the point that:

> *"in taking the common-sense view of what a fact is we lose sight of our own role, collectively and historically, in constructing a fact and developing a fact and this leads us to regarding a fact as simply something we have no alternative but to accept: it cannot be questioned" (Stacey, 2012a para 9)*

In my MSc, I found tensions between the empirical research process, the experience of individuals, loyalty to a research tradition, and resistance to the opportunity of finding new understanding, and these spilled into my relationship with Jessica. She had reservations about the conclusions; as I reflect on this now, I can see that my work, despite being methodologically robust, challenged a 'thought collective' that she was part of, which I think she felt bound to defend. As Stacey (2012a para 9) writes, *"challenges to thought styles lead to fierce arguments and the potential for exclusion from a thought collective"*. As I reflect on what this meant for my relationship with Jessica, I am still left wondering. We continued to work together on one or two projects, but in my email archive one of our last exchanges constitutes

Jessica declining funding I was offering. It seems to me that Jessica's position strongly reflected the dominant discourse within the NHS in this clinical and policy area.

In the NHS, evidence is categorised according to the National Institute for Health and Care Excellence (NICE) hierarchy of evidence framework. Meta-analyses of large quantitative randomised controlled trials are seen as the definitive way to prove something. The aim is to create context-free scientific evidence that explains universal truths about what might generally work in ideal circumstances (NICE, 2012). An aim of research in the NHS is to distil complex, messy work into idealised statements about whether something is or is not effective. These statements then form the basis for national treatment guidelines and pathways. This empirical, reductionist approach does little to unravel the complexity of what might be experienced in practice. In the NICE description of types of evidence, a quantitative review ranks higher than a qualitative review, and this is reflected by researchers. For example, in my dissertation I explain that Stack (2005) emphasises the importance of his Suicide and the Media review as the first quantitative review in the area, implying that it was somehow more reliable. Perhaps I am beginning to feel the same tension that Jessica felt. I now run a department that is focused on delivering large clinical trials, and the NHS needs to know which treatments are best for (the majority of) people. However, I have noticed that in the implementation of an evidence-based treatment, the focus is on how to deliver (and measure) the intervention among as many people as possible. Rarely do we stop and ask the questions 'For whom?', 'How might a treatment work?', and 'What context or factors might prevent it working?' This too is important work.

By the time I finished my master's in 2010, I had spent nearly ten years reading and listening, absorbing information like a sponge. I recall a meeting in which I was asked if I was a psychologist, and, not long after that, being asked when I had left medical school. I was intrigued: understanding the intellectual traditions of those I worked with so I could communicate with them effectively had the effect of people assuming I was 'one of them'. I felt chameleon-like in my adaptations, although I was working to genuinely understand people and engage them from their viewpoint.

Best research for best health

In 2006, the government published a new research strategy, *Best Research for Best Health*. Within months, the government started to roll out new funding streams, and Mike and I quickly put together a new research strategy. One of the ways in which Mike and I work is to meet and discuss what we need to do, after which Mike 'directs' by sketching out some key concepts, and I build on his sketch to create a fuller document. Over the years I have learnt to discern how much time I should leave between receiving such a document and starting to work on the details, or even if I should work on them at all. Developing these judgement skills has been extremely important in managing my relationship with Mike. Between 2006 and 2020, we followed a simple plan that has helped our mental health trust move from ranking low for research performance to being a top performer.

A work ethic of ‘be kind, be generous’ has prevailed throughout this time. From 2006 onwards, my team has grown considerably (to 25 people), and turnover and sickness remain low. I recognise that my ghostwriting habit may be a patterning of childhood and teenage behaviours, working behind the scenes to secure success for others — whether on the back of a tandem or writing a research grant application — and using this to achieve success myself while showing kindness, generosity, and flexibility. To develop this thinking further, it is helpful to think about power and interdependent relationships, which the German sociologist Norbert Elias writes about in his book *What is Sociology?* Here, Elias describes the way in which power can tilt in favour of one person or another depending on who needs whom the most (Elias, 1978:74). In other words, power is not something that belongs to an individual; rather, it is a structural characteristic of relationships. Elias describes the concept of ‘figurations’: a term describing *“networks of interdependent human beings, with shifting asymmetrical power balances”* (Mennell, 2009). He claims that humans (and groups of humans) are interdependent and that they need each other (to varying degrees) for different reasons. The degree to which one person needs another is what constitutes power relations, and these relations may shift. I can see this in my relationship with Jessica: the interdependency of our relationship meant that power would sometimes tilt in her favour (I needed her academic record to secure funding), while at other times it would tilt in my favour (she needed my expertise to manage the funding once it had been secured).

What I have found important is not Power *per se*, but when power moves in my direction, people listen when I speak, and although I have found this uncomfortable at times, I have learnt to be more aware of when power is tilting in my favour, which has improved my ability to influence the norms and values of my team.

A new chapter: 2016 onwards

In 2016, Mike and I refocused our departmental plans; our strategic plan became to build our reputation as one of the best mental health NHS trusts to do research in. We moved from being a department that did research to being a department that did other people’s research; in other words, rather than employing academics to generate research, we worked in partnership with several universities to deliver their research with and for them. Meanwhile, Jessica took a job in a local university, and we subsequently saw little of each other.

The team also had a new director of strategy and transformation, and Mike and I had both worked to ensure that R&D would be part of the director’s work. This was a breakthrough point in R&D, because it put us on the same footing as the IT, estates, workforce, and quality improvement departments. It marked the beginning of our journey towards much stronger and closer integration with various clinical teams. Historically, R&D was seen by many as an outpost of the trust, working independently and full of clever people. It was seen as a silo, albeit an increasingly well performing one. The changing organisational and political landscape, combined with growing evidence that research-active NHS organisations had better patient outcomes, ensured that our integration was fruitful.

During the past five years, my team and I have been in a ‘steady state’ of securing funding, recruiting patients into research studies, teaching research skills, and enabling clinicians to be more active in research. As the team started to grow and become more successful, we began working with some of the most prestigious universities in the country. Although I have welcomed the recognition this brings (for me and for my team), it has also led to negotiating conflict, tension, and anxiety as part of my day-to-day work. These tensions relate to the opportunity we offer to work with clinical services to improve patient care, and the additional demands that this places on already stretched clinical services.

A significant aspect of my role in recent years has been to work as a ‘bridge’ or negotiator between my organisation, funders, and the academic research partnerships we have. A combination of length of service, experience of working in both NHS and academic organisations, and the ability to see the needs of all parties has meant that I have developed diplomacy skills. Sometimes these relationships can become intense and fractious.

One research project, caused a significant amount of conflict between my CEO and the professor running the study. We were struggling with clinical engagement: the recently restructured clinical leadership team did not agree with the research intervention and had begun to step back from the study. I attended several meetings with the clinical leadership team to persuade them that they should continue with it, that it would benefit patients, and that we would to overcome the challenges. I was still hopeful that we would be able to proceed, but I relayed the size of the challenge to the professor. I explained that I would keep trying to find a way to continue with the study. However, the professor sent an email to my CEO in the early hours of the following morning, and I was drawn into a conflict. My CEO replied, at 7am, with an email to the professor saying they were sorry that they felt the need to send such a partial and inflammatory email. The email continued in a tone of palpable anger and defensiveness. I then received an email and text messages from my CEO asking that we have a discussion. We agreed a time, and when we spoke it was clear that my CEO (who was also Mike’s line manager) was still angry; they demanded that I call the professor to explain that we would not work with him at all if this was his attitude, and told me that I needed to sort everything out. I agreed to talk to the professor, and later that morning we spoke. Rather than relay my CEO’s message, I found a way to articulate their concerns. It was a busy morning of stressful phone calls. We agreed that DPT would not be a site on this project (despite committing to this earlier), but that the professor was still committed to working together on a future project. I relayed the outcome to my CEO, who seemed to be satisfied with it.

As I reflect on this, I see that sometimes I am too keen to offer a commitment to find a way to make things work. Perhaps I do not want things to fail. Mike and I do talk about letting things fail, but in reality I am driven to want things to be successful, sometimes at any cost.

In describing this narrative, I can again observe patterns of power tilting: not only between me and the professor, but also between me and my CEO and between the professor and my CEO. Consistent with Elias' description, power was shifting between the three of us and between the 'us' and 'them' that our different alliances represented. My department has worked with this professor for many years, and, in partnership, we have managed almost £5 million in research funding. As a result, I recognise that on the one hand, I have an alliance with him and his university. On the other hand, I clearly have alliances with my CEO, who I might perceive as having power over me, and alliances with the organisation I have worked in for the last 20 years. Returning to Elias and what he describes as the 'We-I balance' (Elias, 1978:122-128), I can see clearly in this figurational model that the individual positions in these relationships cannot be treated separately. Elias describes how these relationships can be plotted by using personal pronouns; he goes on to explain that we can place people inside or outside the intercommunicating group by using the third person pronoun (Elias, 1978). Elias (1978) reminds us that there can be no *I* without *he*, *she*, *we*, *you*, or *they*, and that our relationships are in flux; our figurations are fluid. At *"the hub of the figuration process is a fluctuating, tensile equilibrium, a balance of power moving to and fro. This kind of fluctuating balance of power is a structural characteristic of the flow of every figuration"* (Elias, 1978:131). As I reflect on this experience through this lens, I can see that power is not a concept of substance but a concept of relationships. This narrative is illustrative of the type of work I am involved in on most days: negotiating with colleagues, managers, clinicians, and academics to support the delivery of their research activity. I can see how I am a part of many intersecting, intercommunicating, and interdependent groups, all of which have a fluctuating balance of power.

I started 2020 full of optimism: the chair of our organisation was ending their term, and the newly appointed chair was ready to make their mark on the trust's vision and strategy. Our R&D strategic plan was due to be refreshed; meanwhile, my senior team and I had made a couple of key appointments, including a new business and contracts manager, and we were working to secure our place on a new group of clinical trials. In January and early February, however, news of a coronavirus began to filter down to NHS organisations from the emergency planning infrastructure. In late February I was invited to join a COVID-19 response working group. I read up, rapidly trying to review early scientific publications from China, emergent modelling data, and a host of our own plans, including our emergency planning documents and our pandemic influenza documents. There were mixed views among senior managers, the executive team, and the board. In the week beginning 9 March, every working moment was spent attempting to get to grips with what was happening. The pictures from Spain and Italy were terrifying, but still there was a sense that people in the UK would be okay. I was asked to lead an executive briefing on 12 March and, pulling together a picture of what was happening, I presented an evidence summary to about 40 colleagues.

Many of those present thanked me for providing such a clear picture, and the briefing led to us making a number of decisions without waiting for government guidance. The world of research was centre stage, which meant I was centre stage; power had tilted towards me, and with the prime minister stating that research was a specific aspect of how the nation would respond, my team and I were elevated to a level of organisational relevance that we had not experienced before.

We activated our incident management team, enacting a command and control process with ‘gold’ and ‘silver’ commanders. I was made one of three silver commanders. As the country went into lockdown on 23 March, the National Institute for Health and Care Research (NIHR) shut down all research except urgent COVID-19 research. As a mental health trust, my team did not have the opportunity to contribute to much of this new COVID-19 research, and as part of my trust’s response to the pandemic, most of the members of my team were redeployed to clinical services.

My team and I have since been able to return to our research roles. Through 2021 my team has been trying to renegotiate our way into clinical services that are operating in a new ‘mid-pandemic’ model, while simultaneously participating in significant trust-wide organisational change and transformation programmes.

Reflexive summary

I have spent a lot of time over the years thinking about some of the big philosophical questions of life. Colleagues have helped me to broaden and deepen my understanding of different research paradigms. They have also helped me to understand that although rich and deep experiences can be distilled into simplistic positivist statements, one should not ignore the importance of context, perspective, and dependencies, and, importantly, the impact on oneself of being immersed in and thinking about such things. Reflecting on the point at which I began to question ‘truth’, I recognise that my thinking shifted from the positivist paradigm to a constructivist / pragmatist paradigm. I can see how this shift in thinking helps me in my day-to-day work. While working on this project 1 (P1), I encountered new thinkers; they build on those I began to engage with during my master’s degree and especially in recent years. Some of those I have come to rely on in addition to those mentioned in this project are Thomas H. Kuhn (1962), Karl E. Weick (1995), Barbara Townley (2008), Charles Taylor (1991), and Erving Goffman (e.g., 1963). I have learnt to be open to truths emerging from other paradigms.

Two of the themes I can see emerging are diplomacy and compromise, which are reflected in my management style today. As a researcher and as a research manager, I have seen qualitative and quantitative ‘research camps’ and groups of researchers and participants try to gain territory from each other, turning generating evidence to underpin the NHS into a game of winning or losing. As I reflect on my work as diplomacy (and perhaps as compromise, and allowing relationships to shift over time), I see that I am engaged in a rather complex political practice of keeping the conversation open and going between people (or camps) who are invested in a political struggle against each other with much at stake, while also establishing my own position(s).

Compromise and diplomacy are important aspects of my practice. With this comes 'hidden work' to keep people engaged in conversation with each other rather than getting stuck. In addition, an emerging theme is centred around death, endings, grieving, and suffering, which also encompasses invisibility, exclusion, and stigma (for me, these are connected with belonging to a religious sect, not going to university, and being dyslexic).

When I think about what motivates me, it is perhaps as simple as alleviating suffering, in particular mental distress. In addition, I want my team and our work to be successful. I am fearful that failure might expose me as an imposter or lead to the invisibility or exclusion that I felt as a teenager and young adult. My childhood and teenage years were shaped by the desire for freedom from the community I grew up in, and the search for freedom from the limitations, expectations, and shadows of my family. Looking back over the last 25 years, I can see clearly that I have found new academic, sociological, and existential foundations for my life. Although some of these influences seem relatively new, the roots extend to my early teenage years. My desire to question why things are a certain way might be as much about challenging authority, power, and academic expertise as it is about challenging myself, and I have found significantly more confidence and freedom to question the 'unquestionable' over the years.

Being in the shadows, or in the slipstream, is a form of patterned behaviour I can identify in my life over the last 30 years or more. Until Mary and I moved from London, I felt I was in the shadow of my older brother. The oppression of comparison, holding myself to others' expectations, has shaped the way I think. Although I work in partnership with my director, there is a comfort in knowing he is there to make some of the bigger decisions and withstand the conflict this might create. I feel comfortable behind the scenes. Through this project, I have begun to think about how being in the slipstream throughout my childhood and young adulthood established this pattern in my work. A mediocre school education and no degree often caused me (and, I assume, others) to question the legitimacy of my opinion, capabilities, and position; there are always cleverer people out there. In the past year, as Mike and I have begun to think about succession planning, my challenge has been to stop thinking of myself as a potential deputy director, and instead think of myself as a potential director.

The process of religious deconstruction (moving out of the slipstream of God) that I went though was grounded in the new ways I was starting to think when I began my job at DPT. In spite of conflict between the positivist research paradigm and post-positivist research paradigms, these methods that have helped me find meaning in the incommensurability of humanity's experiences, and have been helpful in my own sense-making journey. There was no scientific evidence that the God of my upbringing existed, but I could not find a way of accepting God through more philosophical enquiry. I can see how the characteristics I show today — for example, deferring to a 'higher being' (God, my brother, my manager), showing kindness and compassion — have their roots in my upbringing; as much as I have deconstructed my religious beliefs, I have held on to aspects of some of them. In reading Plato, Aristotle, and many fiction and non-fiction books, I realised that I simply could not accommodate a belief system that said that things exist because they exist; the idea that the complexity of life can be distilled into simple, measurable events is wrought with issues. Even though it is not possible to compare and measure experiences that do not overlap, I have still tried to find meaning and make sense of my experiences. My discovery of how to think freely led to a desire for certainty; however, I am now much more comfortable with uncertainty.

Reflecting on this now, perhaps my search for meaning was linked to a search for freedom. I also wonder what my ‘search for meaning’ means: I have deconstructed aspects of my upbringing, but I have held on to other aspects of it. Perhaps my search for meaning has been about a desire to help others in tangible, concrete ways.

I can also distinguish a clear link between the lack of flexibility in my childhood and the flexibility that I want for people in my team. As the community that I am a part of has evolved, so has my sense of self. Learning about my dependence on others, my social self continues to be shaped and formed; I can see that I remain defined by groups I belong (and have belonged) to, including the church of my youth, the cycling community, my MSc peers, or, of course, my employment community.

Perhaps because of all the constraints I experienced during my childhood, I have learnt a lot about how to get into a situation where I can exercise agency. Sometimes this process means ‘positioning people’ (trying to ensure that influential or powerful people are in a place to act for me or my team) who are in the right ‘social class’ or have the right ‘credentials’ to achieve this; thus, it has become my habit to be content and comfortable with being ‘second in command’. I can see that my experiences reflect Elias’ theories, especially in his description of power as something that is relational rather than concrete. As I reflect on my management style at present, I can see that my practice — of tolerance, compromise, listening, sensitivity to a variety of needs, patience, and collaboration — has emerged as a response to what I had missed as a child, my experiences as a teenager, and my various professional relationships in my NHS career.

Finally, I need to comment on the lack of management theory in this project. This is, as might be obvious, a reflection of my eclectic, even unorthodox journey to a senior management role. Although I have learnt about various theories on several management and leadership courses, I have not found them especially helpful. The over-simplistic and linear descriptions of human behaviour, coupled with the reliance on tools to solve issues, does not fit well with my experience of trying to understand what is going on. I also feel uncomfortable with the a consistent narrative of ‘leadership heroism’; as I have described, I have spent a lot of time in the shadows. Stacey and his colleague professor Chris Mowles (2016) describe the dominant discourse of organisation and management theory (which I have pushed back against) in their book *Strategic Management and Organisational Dynamics*. They set out how we might see and think differently when the *“focus of attention shifts from the long-term, big picture, strategic, macro level, to the details of the micro-interactions* *taking place between living beings"* (Stacey and Mowles, 2016:8). When we move away from thinking about what we do in terms of linear relationships and simple causality, and begin to understand these micro-interactions, we can then understand *"how organisations are being both sustained and changed at the same time and what part of the activities of leading, managing, and strategising in this paradox of stability (continuity) and instability (change)"* (Stacey and Mowles, 2016:8).

Emergent Research questions

For my emergent research question it is helpful to set out (1) a context, (2) my professional role (the 'I' of the research), and (3) themes linking to my practice.

1. The context: an R&D department in mental health in the NHS
2. My professional role as an NHS senior manager
3. Themes from this project linking to my practice, which include diplomacy and compromise, and agency and freedom

Context

At the time of writing this project **(**early 2021), I am now leading (out of the shadow of my director) and looking at our research plan for the next few years. I am trying to be bolder, less constrained by the patterns I have identified in my thoughts and behaviours in this project, and thinking differently based on new knowledge and understanding.

Central to my work is the question of how my team enables those with mental illnesses and learning disabilities to take part in research. This process involves working across the organisation: with the board, service managers, clinical managers, individual clinicians and administrators, and, of course, patients. Research in the NHS is central to improving clinical practice; it improves care, creates new treatments, and helps to shape NHS trusts into better organisations. I spend considerable time working diplomatically to allow access, over and above the formal permissions and regulatory approval.

The research team I lead is considered to be successful, but we work with only a fraction of our patient population. Even though the clinical research we take part in is ethically approved and well designed, with patient participation built into that design, there is often a disconnect between the academic research, the participants, the NHS research teams, and the wider organisational setting.

Despite our successes, my team often struggles to find and recruit participants into clinical research studies. Reasons for this may include: (1) professional gate-keeping by clinicians, clinical managers, administrators, and managers disrupting access to patients, (2) relationships and identities within the organisation, (3) political factors, including organisational aims being different from research aims, and (4) fear of external scrutiny.

Through my research, done in the context of a community of inquiry within the DMan programme, I hope to answer the following questions.

Emergent Research Questions

1. What makes doing mental health research difficult?
2. How can (my role help) my organisation be successful at clinical research?
3. What affects the successful delivery of clinical research?
4. What factors (for example, political, fear of scrutiny, structural, relational) have an impact on clinical research activity?

Project 2: The impact of scrutiny

Introduction

In P1, I described my childhood and my career to date, focusing on my quest for truth — or, at least, a better understanding of what truth is. I reflected on the tension between the positivist and post-positivist paradigms, paying particular attention to how this impacts me in my current role as a research manager for an NHS trust. I explored some of the tensions between different 'research camps', while recognising that I am engaged in a rather complex political practice of keeping conversations open between people (or camps) who are invested in power and political struggles with each other, with much at stake. I do this while simultaneously trying to establish my own position.

In this project I make an account of, and seek to understand, a recent event which illustrates the *"ongoing, iterated processes of cooperative and competitive relating between people"* (Stacey and Griffin, 2005) and the tensions I experience between having to manage and conduct work in an empirical positivist paradigm and the 'complex responsive process' of people relating. As I make sense of this tension, I describe how I use my skills of diplomacy to navigate it.

In this project, I use the term *research* to encompass research, clinical audit, audit, service evaluation, and other forms of inquiry.

Narrative summary[1]

The narrative is an account of working with a collaborator to deliver a clinical service audit, the method of which which was deemed rigorous, objective, and likely to result in incontestable truthful statements about the service. The results were extensively rebutted and dismissed by the service's clinicians via a letter. To bring the work to conclusion I met with a clinical colleague from the service, to try to find some common ground and to draw the work to an end. We were not successful, in that we could not agree on the methodological and ontological basis of the report. I was asked to drown the report, but due to how important I and others thought it was, I enlisted the service's clinical director (who had commissioned and was happy with the report) to enforce its adoption and required response by the service's clinicians.

---

[1] The full narrative is redacted. In it I describe how conflict arose from the undertaking of an audit and how this revealed the political nature of research. The narrative included my attempts to stay in relation, the demonstration of differing thought collectives, and the tensions and actions that emerged from differing group identities, ideologies, and allegiances in the effort to achieve the preferred outcomes of the work.

Making sense

Defending my work and avoiding failure and meaninglessness

In P1 I wrote about my fear that failure might expose me as an imposter; yet I chose to engage fully with this work, even though I did not have to and despite knowing that the clinical area in question can polarise views. As the project unfolded, the risk of conflict with the clinical team became more apparent, but I had confidence in our method. I can see that this audit might also have raised a number of questions about 'value': not only 'value for money' but also the value of the service itself, with some of the results opening it up to scrutiny.

I can see now that framing our work as objective and non-contentious might have stemmed from me reverting to my quest for certainty, for abstract simple truth. What drove my commitment to this work? It was certainly more than being asked to get involved by the clinical director and commissioner of the audit. On reflection, there were two main drivers: the desire to use my privilege to help those who are marginalised and on the fringes of society; and the chance to use the best tools at hand to make the 'hidden' obvious so improvements could be made. These motivations give my work meaning, and to be involved in meaningful activity (which I and others find meaningful) affords me status and tilts power in my favour, which enables me to do the work I do. In the context of the research I am involved in, I often find myself torn between the best method, the most acceptable method, and the most powerful method for shedding light on something. Although I do have methodological preferences, I am often agnostic about the method used — perhaps due to my 20 years of experience in research management. An early module from my MSc taught me the mantra 'research question first, method second'. As I reflect on this, I can see that my previous experiences of the service and its less-than-acceptable overall performance, in addition to having access to a method that would readily expose its inadequacies and shortcomings, probably drove my commitment to this project. Of course, I did not think this was the definitive project for explaining everything in the service, but that point was never made clear in the report.

I sometimes still find myself identifying as an outsider, and at the time I could see that those being cared for by this service might also feel like outsiders, not belonging anywhere. Here was an opportunity to make a difference, to help improve people's care, using the best tools to hand in this unique context. I had to be pragmatic when I thought about the quality of the work. There were strict limits on our funding and time, in addition to the pandemic-related restrictions. These factors had a clear impact on the breadth, depth, and quality of the work. There was also limited continuity of engagement with the team, as it changed over the duration of the project; reflecting on this, especially in light of clinical service's letter, my collaborator and I should have managed this differently. It is also important to reflect on my lack of confidence in the service. As the service currently operates, I'm not sure I would want a family member to be cared for there, so perhaps I was biased towards aligning myself with a project and method I knew would expose its inadequacies most effectively, even if this would not reveal the full picture.

Thinking about this now, despite the narrative appearing to have resolved in a way that demonstrates that my collaborator and I did good work, I still feel a rising anxiety about its likely failure. By this, I mean that it failed to be useful, to be helpful, or to improve care for those with poor experiences of our services. This rising anxiety is interlinked with questions about how I can do the 'right thing'. I also think that some anxiety remains because the narrative has still not been resolved: this work now exists as a facet of my relationship with the clinical team, and it will certainly have an impact on my future relationship with them. In addition, I worry about whether I have what it takes to be a senior manager when dealing with events such as this: how do I sustain my relationship with a team and protect the quality of the work at the same time?

Acting politically

Hannah Arendt, a German Jewish refugee, social theorist, and political philosopher, describes the things we do as 'labour', 'work', and 'action' in her book *The Human Condition* (1958). Labour, work, and action take place in public, in relationship with others. According to Arendt, when speaking and action occur, a 'polis' arises (Arendt, 1958:198); in other words, speaking and acting are political acts. While Arendt's work tends to focus on people in politics, it is also important to remember that politics arise when people meet, either within or without institutions; indeed, the public arena is the place where reality discloses itself through people acting politically together.

Margaret Canovan, writing about Arendt's published and unpublished works (Canovan, 1992), describes an Arendtian position where some ideals do not fit with 'political action'. For example, Canovan argues that *"goodness cannot take public form, and may indeed be positively dangerous to politics because it is incompatible with taking responsibility for the public world"* (Canovan, 1992:182). According to Arendt, goodness is 'anti-political', but she also asks, *"who can deny its importance?"* (Canovan, 1992:182), exposing the genuine tension or paradox within moral and political experiences. At the same time as guarding against 'political evil', we have to take responsibility (do good) in the public world (Canovan, 1992:176-183). In my narrative I can see this tension between being a 'good citizen' and being a 'good man'. David Runciman, author, broadcaster, and professor of politics at Cambridge University, also speaks to this point in his book on political hypocrisy (Runciman, 2008). He argues that hypocrisy is far more nuanced than simply not practising what you preach, and is better described as someone playing with truth: not only by making claims about oneself that are not true, but also by concealing the truth about oneself by sticking to a type of truth in public (that is, only speaking the bare minimum to get by) (Runciman, 2008:54). Runciman also describes how the social benefits of hypocrisy (derived from faking virtue or good intentions) can be used to effect good in the world, but cautions that if hypocrisy is not controlled, the consequences can be harmful (Runciman, 2008:46). To act politically and do good — something I am often called on, and want, to do — may mean living in a paradox and in hypocrisy. I find this hard to sit with, and it provokes considerable anxiety.

In my narrative I can see the ebb and flow of this anxiety and identify how it emerges in my interactions with the service, the clinical director, my collaborator, clinicians, and colleagues. I can see it in my initial reaction to the potential consequences for me, my role, and the relationships with my colleagues. Perhaps my collaborator felt this anxiety as well, and her response to that was to withdraw. I too felt an urge to withdraw when faced with what (at the time) felt like a direct and personal attack. Were we being frightened into self-silencing? Were we being cast as enemies? In a meeting with another colleague I can see the anxiety ebb; exploring multiple points of view and coming up with a plan helped me to regain agency, recognise the value of our work, and think about how to continue the conversation with the service. Had this colleague responded along the lines of ‘Well, I think they have a point’, my next steps would have been different. The response, and having some space to think, allowed me to breathe some perspective into the situation. While I was still anxious about talking to my clinical colleague, I would be doing so with a greater sense of confidence in the report (despite its limitations) and feeling better equipped to understand his perspective. The clinical director’s final response quite possibly eliminated all my initial anxiety: knowing the work had senior backing and would be publicly defend gave me a sense of being back in the comfortable safety of the shadows.

With regard to the shadows, it is interesting to recognise the ‘double bind’ I find myself in. The rising anxiety of acting politically in the public realm leaves me wanting to withdraw into the shadows, sacrificing my engagement with a project; but in withdrawing, I am left with a sense of meaninglessness and of failing to take responsibility. In the context of my narrative, the apparent absence of anxiety or doubt in the clinical director’s response may reflect the certainty with which they act politically; they might have been willing to ‘not do good’, sacrificing their reputation and their relationship with the clinical team because they felt that the political act inherent in the practice of scrutiny mattered more than doing good. Interestingly, on this point, Runciman (2008:50) notes that people are often happy to fake virtue (and in doing so, do good things), because ultimately it will be consistent with their selfish interests; pretending to be virtuous (and in doing so, doing good things) can be a way of getting ahead and of gaining power and status. From the perspective of his peers, the clinical director might be perceived as someone who does good things while at the same time is able to deal with difficult issues. In addition, I think that the clinical director would also have been mindful of how they might give an account of an unfavourable study like this (in the context of the wider national debate and concerns); what if they were perceived to have colluded in ‘drowning’ the report? That position could have affected their wider relationships much more profoundly.

Acting politically, defending my position and interests, and doing good, is a difficult diplomatic balancing act for me, especially given that I care significantly about the political outcomes *and* the ‘good’ outcomes. How far does one go in allowing the other to save face, to not be hurt or embarrassed? It would have been relatively easy to have acted in a solely political way (as the clinical director did) or in a politely hypocritical way (as Runciman describes), yet I tried to do good *and* act politically. Did I end up being hypocritical, only speaking the minimum of truth? Did I guard against political evil? Did I selfishly protect my ambitions? Did I submit to the violent act of allowing myself to be silenced or shut down? As Arendt reflects, power and violence are opposites (Arendt, 1969:56), so violence is anti-political. It destroys the public space for speaking and action through shutting people down. Arendt argues that when "*true politics reigns, there is rational persuasion, not violence"* (Bernstein, 1988:96). On the other hand, when violence reigns, it destroys power (Bernstein, 1988:98). These are issues I will explore later.

So what were my own interests, and how did these sit with or against my clinical colleague's interests? George Herbert Mead in *Mind, Self and Society* (Mead, 1934) writes:

> *"We are definitely identified with our own interests. One is constituted out of his own interests; and when those interests are frustrated, what is called for then is in some sense a sacrifice of this narrow self. This should lead to the development of a larger self which can be identified with the interests of others. I think all of us feel that one must be ready to recognise the interests of others even when they run counter to our own, but that the person who does that does not really sacrifice himself, but becomes a larger self." (Mead, 1934:386)*

Mead's ideas about gesture and response were, at the time he was writing, a different way of thinking about sending and receiving information. It explains the unpredictable quality of communication. It is interesting to compare Mead's theories of gesture and response and Arendt's theory of acting politically; in action and in speaking, we cannot know in advance how our communications, our gestures, will be taken up — and, as such, we cannot control the meaning that emerges about the subject being discussed. At the same time, action and speech reflect how our identities are constructed by others (Canovan, 1992:132). The gesture can never be separated from the response; therefore, my response to the letter and the response from my clinical colleague were the same response — the gesture evoked a response in me that was similar to the response evoked in my clinical colleague. As a result, our actions were entangled in *"the web of relationships"* (Arendt, 1958:181).

It appears that scrutiny can cause one to question oneself. In something of a paradox, it is clear in my narrative that I, the observer, became the observed — the scrutiniser became the scrutinised. In recognising the web of relationships in the workplace and extending from it, I can see the innumerable, conflicting wills and intentions. I can also recognise that because of this, as Arendt puts it, our actions almost never achieves its purpose, but, they tell us more about those 'heroes' at the centre of each story (Arendt, 1958:184).

Animating questions

Having reflected on the narrative, I find myself drawn to questions about power, politics, diplomacy, and doing good. In my role as a senior manager with responsibility for delivering research, I am part of an ongoing paradoxical process of engaging in politics and trying to do good. I recognise that depending on where I am positioned (in terms of power, identity, and interests) the act of research (or audit or evaluation) in my organisation is sometimes seen as a bureaucratic scrutiny that both legitimises and alienates; the well-intended or misguided quest for the generation of a universal truth is something that reduces the ability to act in nuanced ways, but makes patients' lives better. Research, audit, and evaluation are perhaps acts of hypocrisy that raise many more questions while simultaneously providing a sense of certainty.

To frame this complex situation as a question in order to make further sense of it is no easy task, but I am drawn to asking a superficially simple question: What really happens when we do research?

Therefore, in the following sections I will build on my initial reflections on the impact of research activity at work (beyond the well-rehearsed statement that it is 'good'). I will do this by exploring several aspects that might explain how I find myself navigating and understanding the role of research activity at work, people's reactions to research, and how the scrutiny that accompanies research activity intersects with my relationships.

Theoretical exploration

Research camps and thought collectives

The narrative in P2 is not about research *per se*; but it is centred around irreconcilable methodological and ontological differences, and the parts that my clinical colleauge and I played in navigating these. As Joshua Meyrowitz, a professor of communication who draws heavily on Goffman's work, writes, it is as if we have to

> *"string precarious rope bridges [between our different methodological towers, where] those who attempt to squeeze through the windows to reach out toward one of the other towers still confront the daunting risk of crashing to the ground where they become novices again, faced with a steep climb toward mastery of a new set of literature, theories, assumptions, methods, and terminology that was functionally nonexistent from the perspective of their initial research camp" (Meyrowitz, 2008).*

Stacey (2012a), drawing on the work of Fleck, and Meyrowitz (2008) both describe how those who bring challenges to a thought collective are often seen as traitors or apostates who are no longer as welcome or trusted.

It is clear that the report that my collaborator and I produced belongs to a thought collective. It was a product of how the NHS was managed, how care was recorded and reported, and how the service (and indeed, most health services) was commissioned and managed. Much like the NHS as a whole, my organisation sits in a broadly positivist paradigm. That is, the ontological basis of the NHS is that reality is static and fixed and that the world is ordered according to an overarching objective truth: people become unwell, and an intervention can reduce suffering and/or make people well again. The epistemological foundation of the NHS is that objective, generalisable theory can be developed to accurately describe the work and that knowledge can be neutral or value-free. Treatment interventions are primarily developed through a methodological approach of randomised controlled trials; that is, through a process of prediction and control.

This is evidence-based medicine, and it is the approach that forms part of everyday work: managing waiting lists, planning healthcare, dealing with resource constraints, trying to achieve the best results for the most people for the least cost, and so on. As the Lord Darzi of Denham, a prominent leader in the NHS, writes:

> *"Evidence-based medicine (EBM) is the systematic, scientific and explicit use of current best evidence in making clinical decisions. Whilst the terms 'evidence-based' and 'evidence-based medicine' did not enter the medical literature until the early 1990s, it was Professor Archie Cochrane and his 1972 book Effectiveness and Efficiency: Random Reflections on Health Services that started the realisation that patient care should be based not on the individual beliefs of the doctor, but on objective evidence." (Darzi, 2008)*

The EBM foundation of the modern NHS brings with it several challenges, particularly as I reflect on this in the context of the history of mental health diagnosis, treatment, and research. There is insufficient space to detail this context here, except to note that while modern psychiatry and psychology have roots that go back many hundreds or thousands of years, it is only since the 1950s that official diagnostic manuals listing a myriad of diagnoses have been agreed. These manuals are reviewed periodically, resulting in some diagnoses being removed (such as 'homosexuality' in the late 1970s) and others being added (such as 'internet gaming disorder' in 2020). Prior to the 1950s, there were only a few broadly descriptive categories of 'insanity'. Care in the modern NHS, including in mental health services, is based on the belief in the possibility of direct and objective descriptions of symptoms. These descriptions, along with corporate values and professional standards, mean that staff draw on similar theoretical or educational frameworks. Without this approach, there would probably be chaos, with, in Darzi's words, care being provided based on individual beliefs. Although the EBM foundations and current practices of the NHS are strong, in mental health care we walk a rocky path, with fashion and ideology on one side (including the distrust of those in authority) and evidence-based care on the other (Geddes et al., 1998). Decisions to allocate resources are increasingly informed by research evidence of what interventions are the most effective; in practice, this has been interpreted to mean that only randomised clinical trials make the grade (Barnes et al., 1999).

As I reflect on the narrative in this project, I notice one of my biggest challenges was that I could see my clinical colleague's perspective clearly, and the validity of many of the points made challenging the report. Following the approach being proposed would have strengthened the work. As such, and by applying the skills of acting diplomatically, I felt able to join in this thought collective, or at least to step on to one of those precarious rope bridges. By 'acting diplomatically', I refer to attempting to hold my clinical colleague's point of view and its context alongside other views and contexts, while trying to weigh up which view should take precedence in this specific context. To do this, I had to pay particular attention to my own views, the power dynamics, and the expected outcome. Consequently, although it would have been good to make the report fuller, this was not the work that my collaborator and I had been asked or funded to do. In addition, although I feel that I could accommodate this plurality of views, I did not get the sense that my clinical colleague or the service could or would. The EBM narrative dehumanises the work we do; it moves the discourse from being individualistic yet interdependent to being one of generalised homogeneity. Perhaps the experience of scrutiny has a profound potential for alienation: we struggle to recognise or be recognised, and, as such, the space for human engagement rather than dehumanised engagement is diminished. This process probably contributed to the ‘us and them’ discourse between thought camps that my collaborator and I experienced.

For Fleck, the key idea is that thinking can never be an individualistic pursuit (Fleck, 1935:98-99). Although thinking involves the individual and their experience of their reality, the individual cannot be separated from the body of prior knowledge shared by a particular group of individuals (Fleck, 1935:100). This body of shared knowledge mediates every instance of thinking and makes knowledge production an essentially social process (Fleck, 1935:98). Hence, we have a ‘thought collective’: a group of individuals exchanging ideas and thus developing and nurturing a particular ‘thought style’ (Fleck, 1935:39). Fleck goes on to argue that the development of truth in scientific research is an unattainable ideal, because different researchers are locked in to different thought collectives, so pure and direct observations cannot exist: when in the act of perceiving something, the observer is always influenced by the context and environment to which they belong (Fleck, 1935:99). Yet, despite this, at least on the surface, clinical care in the NHS is based on a single thought collective or style: that of ‘truth’ generated by scientific healthcare research.

A ‘truth’ is a relative value, expressed in the language or symbolism of the thought collective to which it belongs, and subject to the social and temporal structure of the thought collective (Fleck, 1935:40-41). Therefore, to state that a specific ‘truth’ is true or false is impossible. It is true in its own collective, but often it is incomprehensible or unverifiable in others. At the same time, within the NHS there is something of a collective sense of belonging, and people in the NHS appear to be from the same thought collective — at least on the surface. We claim to hold the same corporate values; we all use EBM and follow the same clinical guidelines; we use the same words with broadly the same meanings; and yet, there are also irreconcilable underlying differences between our conceptions of what things mean or how things should be done. There is simultaneously a pursuit of individual thoughts and beliefs and a compliance with corporate expectations.

In adopting a Fleckian perspective and looking back at our report, it is nothing more than the reflection of a specific thought style (e.g. EBM), which directs observation towards data that appears to be evidence only because we are predisposed by the thought style to perceive it as such. The NHS sometimes lacks a discourse about how this positivist EBM paradigm needs to coexist with other post-positivist paradigms. Instead, we (and I) face an overwhelming pressure to oversimplify. Abstract simple truths draw us in and beguile us into thinking in concrete, linear ways, in which cause and effect are easily mapped, understood, managed, and counted. I can see that I sought protection and defence in this approach. Had my clinical colleague been willing to ‘meet me’ (see some value in the report) in the way I was trying to ‘meet them’ (acknowledge the challenges), we might have been more able to establish some common ground. Another way of looking at this is to consider that my clinical colleague might have been trying to ‘meet me’: the rebuttal might have been a way of rendering the work plausible, and I might have been unable to comprehend this because of my hypocrisy of believing our work to be truly virtuous. As Runciman describes, hypocrisy is a pretence of not only virtuousness (in this case, defending my interests) but also forgetting the pretence, which constitutes self-deception (Runciman, 2008:51). Was I so bound up in defending my interests that I could not see (or forgot, or deceived myself about) the hypocrisy of my situation? Whether or not this was the case, I find it interesting that we arrived at a curious position in which my clinical colleague appeared to perceive *my role* (facilitating the existence of the report) as nothing other than ‘the enemy’ but to see *me* as someone to continue a relationship with, as shown by an inquiry into how my PhD was going for me. In arriving at this position, perhaps we recognised our collective hypocrisies but chose not to voice them (further).

Communicative interactions and power

Communication in the workplace often takes place through emails and letters, many of which have a formal tone. The process of communicative interacting constitutes relations of power. As I wrote in P1, Elias claims that power is not something that one possesses, but it is a structural characteristic of human relating (Elias, 1978:78). In the process of relating, we enable and are enabled, and we constrain and are constrained — the power tilts (in this case, towards and away from me, my collaborator, my clinical colleague, the clinical director, and the service). The figurations we find ourselves in establish powerful feelings of belonging; this forms our ‘we’ identity, which is inseparable from our ‘I’ identity. In the process of relating, as Mead explains, we form, and are formed by, individual and collective identities (e.g. Mead, 1934:179, 199). These identities reflect complex patterns of power relating. This perhaps accounts for the emotional response: a threat to my work is a threat to all the research groups I belong to; a threat to my clinical colleague’s work is a threat to all similar clinical work.

At the time, I thought that my colleague’s question about who the letter had really been sent to was strange. Initially, I assumed that it had been sent to my collaborator and me, because it had been addressed to us. However, as my colleague and I talked it through, we wondered if the the underlying purpose of the letter was to shore up the foundations of the service’s thought collective; it could also have been a dress-rehearsal, reflecting Goffman’s description of how individuals might prepare, in their ‘backstage’ area, for a future role in their life (Goffman, 1959:114-115). Was my clinical colleague caught up in a game of trying to gain power in his group? With another senior clinician close to retirement, was my clinical colleague working to secure standing as an authoritative leader who could defend the service against untruths? Perhaps my clinical colleague was writing the letter to this other senior colleagues, or even to the entire staff group, to demonstrate a degree of loyalty and responsibility towards the department as a whole. I wonder now if my clinical colleague was also being critical of other senior clinical colleagues — frustrated that they remained powerful, yet did not prevent this piece of work from happening. Perhaps my clinical colleague felt the team needed other powerful figures who could challenge others in the team, and was gesturing to colleagues that there was someone to take up a voice to protect the department external threat, cleverly demonstrating a tough personal and someone who could hold a position. This may reflect a strong desire in my clinical colleague's efforts to gain power in the department. If there is any truth in this, my clinical colleague might have got just the response needed: a long conversation with me, which could subsequently be told to other colleagues, demonstrating power in rejecting the bureaucratic scrutiny that this project brought.

In my conversation with my clinical colleague, the power dynamic was confusing and complex. Firstly, we had worked together previously and I had then been in a hierarchical position above of authority. Secondly, my clinical colleague was a clinical expert; I was representing (the positionally powerful) clinical director and my collaborator, while my clinical colleague had the backing of senior clinical colleagues in the service. Thirdly, I was (perceived to be) able to influence the future of the report. In every part of the conversation, I can see how power tilted and flowed between us and how we used our individual, shared, and collective identities to move the conversation to an outcome we found individually or jointly favourable. In the end, though, I agreed to take a request to the clinical director that the report was dropped and further attempts to publish the work were blocked. My clinical colleague presented me with a double bind: stop your bureaucratic scrutiny, yet use your bureaucratic powers to resolve this in my favour. I agreed to this, although I knew that the clinical director would not accept either of these requests; perhaps I was taking an easy way out. I was right: the clinical director used their senior position in the organisation to force acceptance of the report and close down any further debate.

In the complex web of human relating, and in the figurations we find ourselves in, it is important to recognise the thought collectives we belong to, and how they may influence what we say and do. Human action is always evaluative, and these evaluative acts are formed and informed by values and norms, which together constitute ideologies (Stacey and Griffin, 2005:5). As employees of the same organisation, but each working in different teams and having received different training, we — that is, the clinical director, my collaborator, my clinical colleague, and I — have been socialised to take up the norms of the particular groups to which we belong. It is clear, however, that we each belong to more than one group, each with its obligatory restrictions on how we act. In this section, I have been able to explore a little of how different ideologies allow us to think, speak, and act in a way that aligns with a particular thought collective.

Although my collaborator and I knew some of the reasons the audit needed to take place, I do wonder if there were reasons I didn't know about, and whether those unknown reasons might also help to explain the power struggle I experienced. For example, was my clinical colleague revolting against the power of the clinical director? In ‘attacking’ my collaborator and me, was my clinical colleague implicitly attacking the clinical director?

When it comes to defending our work, I have shown through my experiences that we draw deeply on the thought collectives and ideologies that we identify most with or which provide us with the biggest political advantage to serve our interests. While my clinical colleague and I drew on these differing thought collectives to shore up our relative positions, we were not so entrenched that we were unable to engage in conversation, and it this that I will explore next.

Dialogical and/or dialectical engagement

I was curious when my clinical colleague told me that our conversation was the first time anyone external to the service had spoken to (rather than emailed) about this work. I wonder if the earlier emails resulted in a sense of alienation. It was clear that being in conversation was important for us both, but the nature of the conversation has led me to reflect that the methodological and ontological differences in the positions that my clinical colleague and I had taken up might not fully represent those we actually held or felt able to share.

The nature of the power relations we find ourselves in cause us to choose one thought collective, or relationship, over another. We then judge, and are judged by, what we see through this lens. It is therefore easy to ‘pigeonhole’ someone; we see their presenting identity and think, ‘Ah, so you’re one of *them*’, and respond using a predetermined script. Elias describes how we can use personal pronouns to plot our relationships, placing ourselves and others inside or outside the intercommunicating group (Elias, 1978:122-128). In my conversation with my clinical colleague, we seemed to have found ourselves cornered in our ‘I’ camps, trying to hold a fixed position. Somehow, we had divorced ourselves from the Eliasian principle that holds that there can be no *I* without *he*, *she*, *we*, *you*, or *they*, that our relationships are in flux, and that our figurations are a process that is a fluctuating, tensile equilibrium — a balance of power moving to and fro.

This made it hard for my clinical colleague and I to move beyond a Hegelian dialectic engagement: a two-sided back-and-forth debate with a linear pathway to a conclusion. In our discourse, we held contradictory views, and we each tried to establish the truth through reasoned arguments — each of us trying to establish primacy, and each of us drawing from the figurations we were part of. I attempted to tilt power in my favour by calling on the clinical director, the regulator, and the scientific method; my clinical colleague attempted to tilt power in their favour (both in our relationship and in their relationship with the clinical team) by calling on other scientific methods, the wider patient community, senior clinicians, and the trust’s solicitors.

Although I did not realise it at the time, I can see now that I wanted to move beyond this dialectical engagement into a dialogical process. I was trying to establish an environment where our differences could coexist but where we agreed on which points had salience in these particular circumstances. As I now explore what the process of dialogical engagement involves, I can better understand my other colleague's question to me, including: What did my clinical colleague and I think about ourselves, my collaborator, and the clinical director? What did we think others thought? Why was a given communicative act performed: why did we say the things we said? Why did the things that were written need to be written?

My colleague's questions reflected that people often borrow words, phrases, and ideas from other people (or the thought collectives they belong to), which raised the question of who was doing the talking. More specifically, which voices were evident in the letter? These questions enabled me to see beyond how people speak and what they aim to achieve by speaking, and to understand beyond the communication itself. They enabled me to attend to the self (dialogical self), internal dialogues, self-talk, misunderstandings, trust and distrust, the production of knowledge, and relations between groups in society. To understand this further, it is helpful to look in more depth at what dialogical engagement is. In the 1920s, Mikhail Bakhtin, a Russian philosopher and literary critic, moved from the philosophical characteristic of his earlier work to the concept of 'dialogue' as he began to engage in the work of Fyodor Dostoevsky (Bakhtin, 1984). According to Bakhtin, dialogue comes from the relation between self and other, and Bakhtinian dialogism holds that since life is shared with others as an event, we participate in it through dialogue (Coghlan and Brydon-Miller, 2014). It is viewed as a social process of meaning and language, which shifts the focus away from the structure of language to how it is used in everyday life. Bakhtin's fundamental premise is that all language is saturated with the discourse of the other. The dialogic self is always in relation to the other, and because of this, we can only understand something from the perspective of something else (Bakhtin, 1984:182-186, Coghlan and Brydon-Miller, 2014).

In the tradition of Fleck, Kuhn, Meyrowitz, and Goffman, I have described how thought collectives might have functioned in my narrative and my relationship with my clinical colleague. When I look at the same narrative from the perspective of Bakhtinian dialogism, I can see how multiple voices (mine, my clinical colleague's, senior clinicians's, the clinical director's, and my collaborator's, published papers, the experiences of others, and our own experiences) formed part of a conversation where our sense-making and "*is thus expressed as a continuum of networks of statements and responses. Statements are always informed by earlier statements and anticipate future responses in an unfinalizable flow*" (Coghlan and Brydon-Miller, 2014).

This may explain why, despite the conversation being finalised between us and by the clinical director, it has not actually stopped; we remain in dialogue even now, and especially for me as I write this.

There is conflict here in trying to finalise the unfinalisable: research takes a 'point in time' experience and generalises this out of a temporal-spatial context to something universal and timeless. I can see that perhaps for my clinical colleague, the report was finalistic, yet did not accommodate all voices. The report was pragmatic in scope and delivery, and it could never have accommodated all voices; indeed, it would have been wrong to expect it to do so. Perhaps one reason my clinical colleague and I continued our conversation far beyond the time we agreed was that we were each striving to accept the report. For me this meant not underplaying its limitations, and for my clinical colleague it meant adding significantly to it. Ultimately, with the external constraints and political relationships we were both in, we did not (or perhaps could not) agree a position that was acceptable at that point in time; or, in the words of Gadamer, as quoted by Bernstein, we could not find a way to *“strengthen the other’s argument as much as possible so as to render it plausible*” (Bernstein, 1989).

The act of being in conversation is relational, not just between those directly involved in a conversation, but with others who have been in historical conversations and who might be in future ones. In this way conversations are social and continuous, saturated in and shaped by the conversations of others. Although we may enter into a conversation with a fixed idea of our values, norms, or ideologies, and we may appear to be firmly rooted in a particular thought collective, these positions may not actually be fixed; conversations are dynamic, and positions may shift. While conversations appear to end, and decisions are made that appear final, this is at best a superficial understanding. Conversations may well end, but they are not final, and my practice has been to either try to find a way to keep the conversation going or leave it in a way that allows it to be picked up again. In adopting this approach, I need to ensure that I conduct myself in a way that causes the least possible hostility; even though, when I reflected on my narrative, I was probably selfishly protecting my ambitions and views. I will now explore what it means to act diplomatically.

Diplomacy at work

The dictionary definition of *diplomacy* is (1) the art and practice of conducting negotiations between nations, and (2) skill in handling affairs without arousing hostility (Merriam-Webster, (n.d.)). In the context of my role, and the work I find myself involved in, I am particularly interested in the second meaning offered here, and how this relates to the political activity of research taking place across the organisation. In my use of the word ‘political’, I am referring to activities that are associated with making decisions in groups and to other forms of power relations between individuals, such as the distribution of resources or status. This is what I will now explore.

As my colleague reminded me, research is a political act. As such, I recognised that I was engaged in a rather complex political practice of keeping the conversation open between myself and my clinical colleague. Research, evaluations, and audits are not just technical activities — a position I tried to hold in this narrative — but also inherently political because they are conducted in a context where, as Barnes et al. (1999) remind us, many parties have a stake in the outcome. My clinical colleague and I represented our thought collectives and were both invested in the power and political struggle, and I can see that we both felt that there was a lot at stake. While I was representing my thought collective, I was simultaneously trying to establish my own position, which was to ensure that my work remained meaningful. Although our conversation took place ‘in private’, with only the two of us attending the meeting, it was not a private conversation, but also reflected and formed our social identities. Research is a political act, but it takes place in a context, and within the rules and practices of a particular thought collective. Although research is done behind closed doors, it is a public act.

In *The Human Condition* (1958), Arendt describes how labour, work, and action take place in public, in relationship with others; that is, not in our household, in secret. Arendt describes the public sphere metaphorically as a space. However, conceptually, it is not so much a space but a discursive medium for politics, where we bring that which has formed us relationally and socially. To act is not something that can be done in isolation from others; that is, it cannot be done independently of others who, from their different perspectives, can judge the quality of what is being done. In this context, the work that my collaborator and I did and my conversation with my clinical colleague were public actions, and, as defined by Arendt, political acts.

Arendt (Arendt, 1958, e.g. pages 178–9, 184–6, 199–200) stresses that action is primarily symbolic in character and that the web of human relationships is sustained by communicative interaction. Without the presence and acknowledgement of others, action would cease to be a meaningful activity. Action, to the extent that it requires ‘public’ statements, making oneself known through words and deeds, and eliciting the consent of others, can only exist in a context of interdependence.

On the one hand, through language we are able to articulate the meaning of our actions and coordinate the actions of others. On the other hand, speech entails action, not only in the sense that speech itself is a form of action but also in the sense that action is often the means by which we check the sincerity of the speaker. Therefore, action without speech runs the risk of being meaningless, and speech without action lacks the means to confirm the truthfulness of the speaker.

This link between action and speech is central to Arendt’s description of power; that is, the potential between people when they act together (Arendt, 1958:199). This potential is:

> *“actualised only where word and deed have not parted company, where words are not empty and deeds not brutal, where words are not used to veil intentions but to disclose realities, and deeds are not used to violate and destroy but to establish relations and create new realities.” (Arendt, 1958:200).*

However, while engaging in speech and action we can never be sure what kind of self we will reveal. Only retrospectively, and through the stories that will arise from our deeds and performances, will our identity become more fully manifest and our sincerity and truthfulness be judged (Arendt, 1958:191-192). This storytelling, the weaving of a narrative out of the actions and speech of individuals, in part constitutes the narrative's meaning, because it enables the retrospective articulation of their significance and importance. What we reveal may, or may not, cause hostility.

When we become absorbed by our immediate aims and concerns, we are unlikely to be aware of the full implications of our actions. Therefore, we are often not in a position to assess the true significance of our actions, or, indeed, to be fully aware of our own motives and intentions. It is only when an action has run a certain course, and its relationships to other actions have unfolded, that its significance can be made fully manifest and it can be embodied in a narrative. This process may take some time, just as the success or failure of the audit my collaborator and I conducted may not be known for some time.

As I reflect on the ideas that our speech and actions are representations of social identities and ideologies and that the meaning of our speech or action may not be known until they are heard and seen, I am struck by just how hard acting diplomatically is. In entering the conversation, my clinical colleague and I had differing views on what we wanted, despite sharing some common values. I can see my reticence to come to a hard position of finality, at least publicly. This might have been because I felt that I lacked authority or that I had allowed power to tilt away from me, or it might have been because I could see that there was a risk that the story told by the audit could become the only story told and listened to about the service. Deep down, I know I am uncomfortable with this kind of outcome or finality.

Harm from good intentions

'I didn't mean for our work to be received as such a threat, to cause such harm as seen in such a visceral and defensive response' is a sentence that I have not spoken out loud or written until this point, but it is one I have thought on several occasions. I wanted our work to be well received, to be useful, and to spark future conversations about how the service could improve. With good intentions, I thought that by improving the understanding of who is in the service, their characteristics, and their outcomes, the service managers would be better placed to make decisions about how to run the service. Yet I am left feeling that this is not the case. Our differences still feel unreconciled, despite the clinical director's clear intervention stating that the report must be accepted and acted on.

I see similarities and differences in the work of Fleck and Goffman. While Fleck, and subsequently Bernstein, write about how fiercely defensive people are of the thought collectives they belong to, Goffman draws attention to the idea that just as a member of a group is expected to have self-respect, they are also expected to sustain a standard of considerateness; they are expected to go to some lengths to save the feelings and the face of others they interact with; and, furthermore, they are expected to do this willingly and spontaneously because of emotional identification with others and with their feelings (Goffman, 1955).

I can also see how, in Goffman's words, my clinical colleague and I were engaged in a process of 'impression management' (Goffman, 1959:203) as we attempted to present an acceptable image of ourselves (or our thought collective, or ideologies) to the other, while also defending what we had come to represent at the time of our call.

In the interactions between me and my clinical colleague, despite clear differences and some conflict, we worked hard to maintain a standard of considerateness towards each other. My initial impression was that the clinical director was less concerned about being considerate. Reflecting on this now, I can see that I might have formed this impression because they made their position clear, very quickly, in a decisive way; this was in contrast to my own approach of keeping things open for as long as possible. The clinical director and I, as well as my clinical colleague and my collaborator, each had different ends in mind, but none of us were thinking about all the potential ends. Mead describes this well in his essay entitled "Moral Behaviour and Ethical Thinking" writing:

> *"we have to allow all the ends or values involved to get into our decision. When we think about the means to an end, the point at which we fail, if we do fail, in ethical thinking, is when we ignore certain values. The important thing is to bring all the ends involved into our thinking." (Mead, 1938:9)*

This is part of becoming a larger self. However, as we bring all the ends to mind, and incorporate the different values into our thinking, we should remember that: *"the moral question is not one of setting up a right value over against a wrong value; it is a question of finding the possibility of acting so as to take into account as far as possible all the values involved."* (Mead, 1938:10)

I can see the complexity and conflict of this in relation to research activity more generally. Surrounding the methodological certainty and the ideological dominance of clinical trials and EBM in the NHS, there are socially formed, interdependent people, all with slightly or significantly different ends in mind. The difficulty this causes is that in the stories we create through our speech and actions, a single story emerges and is treated as the only one.

Summary

In this project, I set out to explore the impact of scrutiny when research takes place. At the start of this process, I had a narrow view that scrutiny applied to the thing being researched, and not to the research team itself. Despite my awareness that clinical research and audit activity are scrutinised (in particular, before they are funded, approved, or published), in writing my narrative for this project, I somehow failed to recognise the personal scrutiny that my collaborator and I had been subjected to. It was only through the process of reflection and receiving feedback from my learning set that I began to comprehend that scrutiny was far broader than I had conceived at the beginning of this project. I can see now that in addition to scrutiny of the actual clinical activity, there were three other broad areas of scrutiny: (1) scrutiny of the participating clinical team, (2) scrutiny of the research team, and (3) scrutiny of the theoretical foundations that underpinned the research.

How we (that is, my clinical colleague, my collaborator, the clinical director, and I) responded to the scrutiny brought about by this audit reflected several factors: the thought collectives we belonged to; the context we were in; known and unknown political pressures; hidden and visible motives; the ends we had in mind; our values; the norms we adhered to; and the ideologies we lived by. Our responses reflected the many conversations we had been part of, were part of, and might be part of; as such, even though the conversation ended and events were concluded, I have since found it hard to recognise the conversation as actually finished. The statement that 'research is political' gave me the biggest cause to pause and reflect: prior to that, I was attempting to hide this aspect of the audit, or, perhaps, to hide from this aspect of the work. I sought refuge in a simplistic idea that the method, rigour, and bureaucratic management of the work would render it meaningful and believable. I also thought this approach might diminish the challenge the work posed to the clinical team. I can see that to defend the service, my clinical colleague took a position that attempted to break from the single narrative account of the service that was being presented, perhaps in case that narrative became the only one that was presented about the service.

The foundations, culture, and practices of the modern NHS show that research, audit, and evaluation are essential for high-quality clinical services, and it has been useful to think about how political and how laden with assumptions even the most controlled research is. Abstracted research, randomised trials, and systematic reviews are central to running clinical services; however, alongside these, and often hidden, is a much more complex narrative of interdependent clinicians and managers negotiating meaning in the context of how things need to be done.

I have found that both taking part in and leading research increases the scrutiny of what is (and what might be) going on, whether methods or motives. When research findings seem to contradict what people know to be true (or think is true) in their everyday experience, this can create conflict; in particular, because these differences might pose a threat to how individuals and groups think. Exploring these differences through the concept of thought collectives has helped to broaden my understanding of what 'truth' might be: a truth for one thought collective might not be a truth for another.

Therefore, in exploring the question of what really happens when we undertake research activities, I have found that:

1. The visible and hidden thought collectives we belong to shape our responses to things that are done with, for, and to us.

2. Political freedom means the sense of being able to influence things — and, importantly, the loss of political freedom means the loss of that sense of influence.

3. Engaging with the multiple voices that are present in a narrative (dialogical engagement) is a useful way to pay close attention to what may or may not actually be going on, and what this might mean to the participants in the narrative.

Walking the tightrope of doing good and acting politically is perilous and sometimes causes harm — it can be a form of violence. Leadership *“is often undertaken in a hostile environment covered up with positivity; […] it is informed by strategies that create relations of dependence and domination; […] it is inseparable from the exercise and experience of power”* (Vince and Mazen, 2014:194). As is often (or may even always be) the case, power struggles play out when people come together to do something. I have shown how power moves through speech and action, and how acts of violence can prevent both speech and action, and destroy or disrupt power in a particular figurations.

Research is often presented as an important and significant NHS activity, and as one that creates better outcomes for patients. Although this is true, it is also true that research is disruptive, powerful, and political. While research is often described as serving the greater good, as researchers (and, more generally, as people), we are serving our own interests, which are driven by the thought collectives we belong to, our ideologies, and the things we do to tilt power in our favour. Navigating this is difficult; over the years, I have learnt to act in a way that enables shared meaning to be negotiated and to adopt others’ shared values. Speech and action reveal who we are, but we cannot know how this will be received and responded to until it is received and responded to. Acting diplomatically might also mean that we have to engage in hypocrisy, in that we recognise the ‘game’ we are in but we continue to play it.

An individual’s identity can be threatened by the coexistence of different values, a strong threat to their existing values, and the power balance tilting in another’s favour. Fear and insecurity caused by the perception of such a danger tends to intensify the trajectory towards undesired consequences. This can create further hostility and conflict, where an individual becomes unable to create enough distance from the situation to analyse it and save oneself or to continue to act diplomatically.

In wanting my work to be successful I have had to reflect on how interactions can be driven by personal motive, and how conflict emerges between independent and interdependent pursuits, and how constraints on how we think can be dismissed or delegitimated with ease. Our technocratic, bureaucratic, positivist methodologicalist organisation places the most importance on instrumental reason. In the politics of corporate life, we find ‘safety’ or a defence in following the rules and the established hierarchy, and sometimes we do not think about this or consider anything beyond the ‘I’. The paradox of individualistic purpose and objectives is that we look at our work only within the narrow parameters of our own work. We justify — to ourselves, each other, or the groups we belong to — taking certain courses of action to do what we have been told to do. We (knowingly or unknowingly) choose actions from the narrow parameters of our experience, our project, or our thought collective.

Project 3: Bureaucracy, recognition, and violence

Introduction

In P2 I gave an account of an interaction with a colleague in the context of research activity within a clinical service, and I explored the impact of scrutiny when research takes place. At the start of this process, I had a narrow view that scrutiny applied to the object of the research and not to the research team. In making sense of the narrative, I recognised that I had been unable to comprehend the personal scrutiny I had been subjected to.

I found that when research findings seem to contradict what people think to be true, it can create conflict. This is especially the case when these apparent contradictions might seem to threaten how individuals and groups think. Exploring these differences through the concept of thought collectives helped to broaden my understanding of concepts of truth in the workplace; a truth for one thought collective might not be a truth for another.

In exploring the relational dynamics in addition to the implications of EBM for healthcare, I found that the thought collectives we belong to shape our responses to the things we do or are a part of. Through P1 and P2, I explored how the balance between being in the shadows and having political freedom also involved the balance between feeling safe and having influence. I noticed that for me, being in the shadows creates both the illusion of safety and a sense of frustration; I am able to act, yet I am unable to progress the work I lead in the organisation beyond a certain point. By engaging in (Arendtian) action, I am acting politically, and this has challenged my idealised notions of safety, kindness, and goodness.

By drawing on the work of Fleck (1935) throughout P1 and P2, I paid attention to how my colleagues and I frequently fall into different thought collectives, and I reflected on how the values and beliefs we hold form the ideological positions we take.

I have recognised that in wanting my work to be successful, I have been driven by personal motives, with conflict arising between those involved and our interdependence as social beings. I was struck by how external constraints in the way we think can be embraced, dismissed, or delegitimised, and by how in the politics of corporate life, ‘safety’ can be found in following technocratic or bureaucratic rules.

In this third project, and in a continuation from P2, I make an account of and seek to understand a recent event that further illustrates (1) what we are doing when we do administration, and (2) how this leads us to be caught up in institutionalised patterns of interaction, which sometimes turn out to be violent. There is, of course, a broad spectrum of violence — from armed conflict, to oppression and coercion, to bullying and harassment in work or social settings. My observations and reflections through P1 and P2 have led me to notice a type of ‘bureaucratic violence’ that seems inherent in the work we do. I will come back to these concepts later in this project.

Narrative

When I joined my organisation, as I described in P1, there were many academics linked to my research department. However, only a few of these academics have continued to be part of my work, and there are only a few who I would happily make time to see. Jon, a psychiatrist, is one of these. Over the years, Jon has become increasingly outspoken and explicit about the frustrations and challenges of working in NHS mental health research — both in his trust and in the wider local health research system. I have often marvelled at his confidence to make forthright statements with seemingly little regard for the political consequences: something I have struggled to do for fear of losing common ground that I try to hold. Jon wears his learning and position lightly, and with genuine humility. I have a lot of respect for him, and because of this I am always happy to extend support to him and his team. This was how I became involved in a situation that he and his team (led by Melissa, a research manager in a sister organisation) were trying to deal with.

The HRA, the UK's health research regulator, has set out the legal process for obtaining research ethics and governance approval. The guidance defines the HRA's responsibilities and those of the various organisations involved in conducting clinical research. In brief, the process involves the HRA ensuring that appropriate ethics approval is in place and completing several checks. Research is then granted HRA approval and moved to individual organisations, which confirm whether they can or cannot take part in the research.

Melissa invited me to a meeting she had organised with her information governance (IG) colleagues to find a better way of working together. Before this, I had shared with Melissa some details about how we approach IG in my organisation, and Melissa was keen for me to bring this experience to the conversation with her colleagues. Jon was also going to be in the meeting. I joined the Microsoft Teams meeting for an agreed time slot, but I immediately found myself immersed in a heated debate about due diligence; there was considerable friction between the research team (Jon and Melissa), and Mike and Lucy (whom I had not met) in the IG team.

Mike was in the middle of a presentation about the organisational responsibilities for ensuring that data governance checks on research were completed. The meeting did not appear to be going well; it was behind schedule, and the tone felt accusatory. It was as if I had walked into a stand-off. Mike was presenting detailed slides on various responsibilities, and it seemed that the presentation was being used as a weapon of truth to press home key messages. I tried to readjust my Teams layout so I could see more of the people and less of the slides, but Teams made that almost impossible. As I listened, I noticed a low-level 'flight or fight' sensation rising in my body. In this heightened state of awareness, and as I listened, I heard a restrictive, risk-averse, 'worst-case scenario' approach to managing data that left the organisation. I felt a great affinity with Melissa and Jon; although they had explained that they were having a difficult time with IG, it was not until I arrived in the meeting that I felt a sense of being trapped in a Kafkaesque nightmare.

R&D in the NHS is rich in governance processes. Following the malpractice in the 1990s and early 2000s (such as the falsification of data, and organ retention scandals), the government introduced a comprehensive new set of standards in 2001 that we (that is, the NHS research community) needed to comply with. Ethics, approvals, and other checks were shaken up and amplified. The pendulum swung from light touch governance to strict governance. Over the last 20 years (2000-2020), especially as the clinical research industry has grown, the R&D community (of which I am a member) has settled somewhat, and the HRA-managed system for research approvals now seems proportionate to the work we do. In general, the higher the risk of harm, the greater the scrutiny. As a research host organisation, we are notified about approved research for which we need to review our capability and capacity to provide support. In reviewing our capacity, we also need to ensure that the appropriate standardised agreements are signed. This should not involve duplicating any governance approvals.

Within ten minutes of being in the meeting, I was asked by Melissa to comment. When I had agreed to join this conversation, I had known that Melissa wanted me to take her and Jon's side: three against two might help them make better progress with resolving their issue, adding weight to what they were saying, and I was happy to assist. However, I was a little perplexed because I had not quite realised the extent of the challenges that Melissa was facing. I made a brief point about how R&D Managers rely heavily on the work of the HRA. I stressed that we do not duplicate the work that the HRA has done, because we are explicitly and contractually told not to do that. My position was (and still is) that if the HRA tells us that a research study meets an acceptable standard and it is feasible to run it in our organisation, we take the work on and start as quickly as possible. I explained that this did not reflect a lack of understanding of the IG requirements; rather, it was an attempt to balance these pragmatically with other requirements, in particular the performance standards we are held to.

After my first comment, Lucy responded along the lines of: *'And who are you? Well, I can see you are Tobit Emmens from Devon Partnership Trust, but what exactly do you do there?'* I experienced these questions as somewhat passive- aggressive, though that may not have been the speaker's intention. I felt as if I was really being asked: 'By what authority do you come here and make these comments?' I answered by describing my role and explaining that I was at the meeting to support my R&D colleagues (Jon and Melissa) while they recruited a new R&D manager. This seemed to be accepted, but from that point on I felt a little on edge; I felt that I needed to think carefully, weighing and measuring my responses, interjections, and comments.

As the conversation continued, it became increasingly clear that Mike and Lucy held a position where they saw themselves as personally responsible for any information that left the organisation and believed that the strictest of data protection requirements should apply. They made it clear that they were responsible for checking and approving contracts that involved data moving between the organisation and the researchers. They also maintained that they should do comprehensive due diligence as part of this process. They claimed that it was not sufficient for the HRA to *state* that they had done the work: on behalf of the trust, Lucy and Mike needed to check that the HRA had *actually* done the work. Lucy reiterated that when they asked an HRA representative if they checked the details and evidence of an organisation's IG processes described in a data protection impact assessment, the answer was 'no', they did not check those documents. Lucy implied that this demonstrated incompetence in the context of ensuring patient data was safe.

Melissa held a position that the checking had already been done by the HRA, so IG were adding to the bureaucracy considerably, which was needlessly slowing down research approvals. This inevitably led to delays with starting the research, meaning that the project would take longer, cost more, and might have to be stopped.

Mike sat there, on screen, turned away from the computer, with his arms folded. He said that the regulator was not doing its job properly, and even if it did, IG would still have to do proper due diligence. He continued by arguing that we could not simply trust that the HRA had done what it was meant to do, because, in his view, the HRA did not even do what we thought it should do. To Mike, this represented a huge risk, especially if anything were to happen to the data we shared with other organisations.

As the conversation continued and Jon and Melissa tried to push back against the additional demands being placed on them, Mike repeatedly challenged Jon about whether he knew who held two senior statutory roles in the organisation (Caldicott guardian and senior information risk officer — SIRO). Jon said that he did not know (although I think he did know) and had not heard of the SIRO role; he went on to add that he did not care. This clearly made Mike more exasperated. Mike's challenges to Jon sounded like veiled threats, as if he was saying, *'You don't have any authority here, and if you can't answer these questions, I will have to escalate some concerns I have about you.'*

Jon's response made me feel a little uncomfortable. I had worked with Jon for many years, and I knew him well (and still do). He is outspoken, especially when it comes to 'organisational bullshit' and corporate injustice. However, I sometimes find myself wondering whether this is partly a performance that aims to elicit a response and move things on. I could see that Jon was riling Mike and Lucy, pushing them with responses that seemed to take them beyond what they were comfortable with or gave them exactly what they needed in order to justify their approach to IG. I found myself trying to interject to provide some balance and find some central ground, but I was not particularly successful. Melissa looked exhausted by it all. I knew she just wanted to get on with her job.

The meeting continued, and I was called on to talk about how we do things in Devon. There were no significant questions, but Lucy made a simple statement along the lines of: *'That's interesting, but just because Devon does it that way, it doesn't mean we are going to do the same.'* I felt judged in this exchange, as if my position was inadequate.

As the meeting was drawing to a close, Jon, not hiding his frustration, said that he would write to the HRA about the position we found ourselves in and ask for their advice on what to do. Mike's response was sharp: *'You can't do that, you need approval from someone in the Exec to do that.'* Jon simply replied, *'I can do it, and I will, and I can copy in anyone you want.'*

I interjected with a suggestion that rather than go straight to the top of the HRA or the Department of Health and Social Care, we might be wise to work through the national forum for R&D leaders in the NHS (the UKRD), as they might have some advice or experience they could share. I was thinking that it would also be good to work out whether this was a local issue or one that was being experienced more widely. If it was a local issue, I wanted to see if we could find a way to resolve it locally.

The meeting ended — more because time was up than because anything had been resolved — and I was feeling quite perplexed. Our approach in DPT seemed to be significantly at odds with the approach that Mike and Lucy were trying to enforce. I needed to gather some facts and check my assumptions, and I wanted to check that Melissa was okay.

I was feeling quite worried: had DPT missed something as an organisation? What would it mean for DPT if the IG team was right? What if the standard we thought we were working to was unacceptable? What if I was running a department in a way that inadvertently exposed my organisation to the risk of information loss?

That afternoon, I had a couple of conversations with my IG team, briefly presenting the issues, seeking to check some of the details and whether we, as a research team, had missed anything. I wanted to check details relating to data-sharing contracts and legal responsibilities, build my knowledge, and check my assumptions so I could support Melissa more effectively. Perhaps I was also seeking reassurance that we were doing things the right way.

My first step was to talk to my colleague Kelvin, DPT's chief information officer. Kelvin helpfully set out some key guiding points for future conversations. In addition, he shared that in DPT, he had tried to create a helpful and understanding environment, where we could use the tools available to enable rather than constrain. He spoke about how managing data risks does not mean reducing them to zero. He shared a few more thoughts; in particular, that Mike and Lucy appeared to be 'risk-averse' and therefore their approach was likely to be restrictive rather than enabling. In Kelvin's experience, IG teams are often risk-averse when they have no support or engagement from senior people in the organisation and when there is a lack of training at the senior level. He explained that this often manifests in IG teams reminding people regularly about the risk of £20 million fines if the organisation gets it wrong. This made me smile, because Mike and Lucy had both mentioned the risk of getting fined. Kelvin shared some ideas about who we might want to engage with at a senior level, and finished by reflecting that working with people who have this mindset is exhausting. This conversation with Kelvin was helpful in that it gave me a better sense of the context within which IG works. It also helped me to move beyond some the frustration I felt about people not being helpful. As I reflect on this now, I think moving on from the frustration comes from understanding how historical, cultural, and organisational practices affect the quality of interactions between people.

Kelvin suggested that if I wanted to discuss this further, I would do well to speak to Jason, the trust's IG manager. My conversation with Jason was helpful, because it answered one of the key technical contractual questions I had. In this conversation I was reassured that our position as an organisation had a sound basis. Given that trust in other institutions was raised as an issue by Mike and Lucy, I talked with Jason about how he felt about trusting other public institutions. I wanted to test my own way of thinking — that I was happy to work on the basis of trust — against Jason's way of thinking. His view was that we have to be proportionate in our due diligence, but, importantly, we need to recognise that most (if not all) of the organisations we work with are legally obliged to comply with IG and data protection law. In addition, Jason shared that the previous IG manager for DPT, who was formerly Jason's line manager, found Lucy *'quite terrifying'*. I am not sure why he told me this, but I think it helped with my understanding of the situation, and it resonated somewhat with my feelings; it gave me a better sense of how Lucy might using fear and powerful rhetoric as a management tool. The conversations with Kelvin and Jason were reassuring: they gave me a much better basis for understanding what might be happening, and although there was no easy solution to Melissa's problems, I felt that there were some concrete steps that could be taken to explore a different way of interacting.

Having gathered some contextual information that helped me to form a broader view, I felt ready to call Melissa not just to find out how she was feeling about the situation, but also to help her find a way to respond to the challenges she was facing. I felt I was able to separate myself from the immediate frustrations of her situation, but it was hard not to get drawn in to gossip about Mike and Lucy. Melissa was exasperated and wanted to be able to get on with her work without experiencing these kinds of delays. She explained that Jon had asked her to write a letter but that she did not know what to say or who to send it to. She was frustrated about the agitated, non-collaborative approach on Mike and Lucy's part, and the passive-aggressive way in which Mike and Lucy were trying to set the agenda. Melissa also expressed that although the meeting had been intended to be a workshop where we could find a collaborative way forwards, it had turned out to be a three-hour meeting without breaks and with many detailed discussions about minutiae, which felt like going down rabbit holes. Melissa said that rather than working together, they had been in a 'them and us' situation, where the IG team trusted nobody and Melissa and Jon just wanted to get on with work that had been delayed for weeks. I brought the ideas from Kelvin and Jason into our conversation, and these appeared to be helpful and well received; talking through the organisational culture and (potential lack of) management support provided some insight into what might have been going on for Mike and Lucy.

A week or so later, I received an email from Melissa to thank me for spending time on this supporting her and for *‘keeping her sane’*. She outlined that they had indeed sent a letter to the HRA and the UKRD to ask for clarification, and they had received a response that supported her and Jon’s position. She also shared that the conversation had moved forwards, with the IG team engaging a little more positively. Melissa was feeling optimistic, not least because two studies that had been held up had since been approved.

Making sense

When I look at the narrative in this project, I see some clear parallels with the narrative in P2. It details an interaction that occurred with someone whose ideological position was different from mine. In doing so, it reveals that I saw these differences as a threat to aspects of my work that were (and still are) deeply important to me, but that I also wanted to engage with this difference. Comparing this narrative with my P2 narrative, I can see that I engaged in a similar way: by listening, inquiring, and searching for shared ground where the conflict and differences were not so significant that they would prevent meaningful discussion.

Research governance has dominated my professional life for over 20 years; therefore, in making sense of my narrative, I first want to explore a possible ideological basis for the bureaucracy I encountered. I want to use this as a stepping stone to explore (1) how bureaucracy relates to my narrative through the themes of recognition and violence, and (2) what some of the possible implications might be.

Feeling vulnerable

In the situation described in my narrative, I was supporting Melissa and her organisation, and the challenges she was experiencing did not directly affect me or my team. However, the interactions with Mike and Lucy left me with a nagging sense of doubt about whether the way I was managing things was actually wrong. After the interaction, I went through a process of ‘backstage’ conversations with key experts in my own organisation. This served two purposes: firstly, it gave me the necessary information and knowledge to support Melissa better; and secondly, it provided reassurance that the way we were doing things in my team was appropriate and legally acceptable. The process of speaking with Kelvin and Jason was similar to the process of speaking with Nick and the clinical director as described in P2, and it helped me to manage the ebb and flow of anxiety. It quietened an inner voice of doubt, while giving me the words and the confidence to continue supporting Melissa. This anxiety may tie in closely with my lifelong journey in and out of the shadows and the light of visibility. In other words, as the clinical director put it, when you lift your head above the parapet, people notice you and it is easy for others to take shots. One reflection I have on this is that I continue to question my authority and credibility — after all, I am just the boy with a B in woodwork.

Mike and Lucy appeared to be unified in their position, in particular their application of administrative processes to ensure their successful and complete mitigation of risk. I found it easy to frame Mike and Lucy as bureaucratic gatekeepers who were hindering work that I felt to be important. As I reflected on the encounter afterwards, I found myself recalling themes from Kafka's *The Castle* (1926), which I had read as a young adult: a desire for rules to be followed flawlessly, yet an apparent contradiction between the official word and what is happening in reality. I found myself becoming more and more frustrated with the situation.

As I make sense of this narrative, I am left with a curiosity about the apparent difficulty that those of us working bureaucratically have with engaging in ways that do not harm relationships, especially when we appear to have differing ideologies regarding bureaucratic processes.

Clashing ideologies

To explore bureaucracy further and to frame my sense-making, my DMan supervisor recommended that I turn to Barbara Townley, a professor of management and author of the book *Reason's Neglect* (Townley, 2008). In this book, Townley draws a distinction between the administrative and bureaucratic structures and the 'bureaucratic rationality' that underpins them. She writes:

> *"Bureaucratic rationality is identified as domination through knowledge, or that which allows things to be known. It is the mundane, seemingly insignificant acts of semantics, drawing definitional boundaries, rules, procedures, codes, protocols, writing the world in formalised terms that enable it to be known, become predictable, and be acted upon."*
> *(Townley, 2008:65)*

Townley goes on to say that it is this rationality that allows bureaucratic structures to function as they do, but as they function they increasingly become a disembodied form of rationality that has no regard for the person and appears to be "*a view from nowher*e" (Townley, 2008:65). I find myself agreeing with Townley here; in particular, her argument that the rules and processes that are designed to make the uncontrollable controllable go unquestioned and seem abstracted from real-life interactions.

In my narrative, managing risk appeared to be the personal responsibility of Mike and Lucy; as such, they managed it through administrative processes that they controlled. At the same time, and in line with Townley's perspective, the more this process functioned, the more disembodied it became from the people associated with it.

Mike and Lucy's approach to administering their rules denied Melissa the opportunity to do her work. I recognise I am making several assumptions here; in particular, that how Mike and Lucy worked was driven by an ideological position, or, as Fleck (1935:42-43) describes, a thought collective with a type of social conditioning unique to their profession. Any threat to their bureaucratic control (or their thought collective) further fortified their thinking and their enforcement of their rules. This prompts me to ask many questions, e.g. Why did Mike and Lucy behave in this way? What benefits did they gain from this approach to managing information risk? Were they patterning past behaviours and responses in their approach this situation? Perhaps they felt it was how they could have a voice and be recognised. Did the way they were managed leave them feeling powerless and unrecognised? Was this a basis for how they managed their work?

Recognition and status

Reflecting on Mike and Lucy's response, I am left thinking that there was more to upholding the administrative process than the procedural function it served. By this, I mean that it might not simply have been about checks and balances, due diligence, and approvals, but also about ideologies, knowledge, power, status, risk, fear, anxiety, relationships, the suppression of conflict (at the same time as creating it), and relational dynamics. There was much more at stake than the straightforward consequences of rules not being followed.

The German philosopher Axel Honneth, whose work focuses on social-political and moral philosophy in relations of power, recognition, and respect, describes what might happen when people experience misrecognition (2005b). Misrecognition can damage one's relations-to-self, which, in turn, diminishes one's autonomy; to be misrecognised is to be violated. Honneth describes how, as long as one has agency, one has the possibility of being motivated to engage in a struggle for recognition (Pilapil, 2013). It makes sense to me that a threat to one's ideological foundations can leave one feeling violated, and that the relative autonomy we have leaves us engaged in this struggle.

When I think about what might have motivated Mike and Lucy to take up the positions they did, and indeed, what motivated me to take up my position, I am struck by Kelvin's comment about a possible lack of senior leadership support and engagement. This might reveal a form of misrecognition among senior leaders of Lucy and Mike's value and moral norms, as well as the importance of their roles, which likely manifested in their approach to their work. On the one hand, this might seem to place the blame on the leader; on the other, it reveals an underlying assumption I, and I think others have held that in order to do one's job in a large organisation, one needs good senior support. Another plausible perspective when it comes to misrecognition is related to senior managers in an organisation leaving the complexity surrounding the work with more junior staff. Senior managers may stress the importance of having robust systems and processes to ensure good IG, but they may also be unable, or unwilling, to engage in the complexity, dilemmas, and paradoxes that inevitably arise in daily interactions. What if Mike and Lucy's managers simply expected them to deal with IG matters (with no errors) and were unwilling to engage in dialogue about any problems they encountered? This might have put them under pressure to achieve the impossible. I wonder if it was plausible that Mike and Lucy, bound up in this misrecognition, substituted recognition from their managers with a type of recognition created through the restrictive way in which they did their work. By acting as gatekeepers, they ensured that people recognised their importance. This might have been the only power advantage they had; and, they had weaponised it.

Bruising encounters

At face value, the formal response that Melissa received from the HRA, stating that her IG department was ‘wrong’, was a brutal way to end the conversation. However, on reflection, it is unlikely that this allowed everyone involved in the conversation to move on. Despite some time passing, I imagine that even at the time of writing this, Mike and Lucy feel bruised by this interaction with an external authority; they may or may not feel inclined to comply with the instructions to work differently, and they may be still robustly defending their position.

The deterministic and finalistic role that the HRA played (or was forced to play by Jon) makes me wonder if what happened needed to happen in this way. My reaction to Jon wanting to write a letter was to try to find another way of resolving the issues they were experiencing. In this instance, I felt uncomfortable about Jon pushing for such a direct and blunt resolution, especially considering that the purpose of the meeting was to find a better way to work together. However, I had previously found myself in a similar position of recruiting someone to take a finalistic action despite wanting to keep the conversation open (see P2). As I reflect on this, I can see that I often might want things to go my way, recognise that this might be a violent act, and so enlist or recruit others to act in a certain way to aid me. I do this so I can remain in relationships with those I am opposed to. At the same time, I am ready to recognise that sometimes things will, and need to, go another person’s way; therefore, I need to be ready to reappraise my view and position in case I need to adjust them or take up new ones. In addition, I can see that I am keen to slow conversations down so that we can stay with the issues a little longer than the usual management practice in the NHS permits. In slowing conversations down, we might help to create a space for re-evaluating our interpretations of the situation. The statement that I might need to take up a new position is not intended to imply that I flit from one position to another; rather, as I become increasingly aware of my own prejudices and blindspots, I might need to respond in a different way.

Whether intended or not, the use of intimidation or fear through powerful rhetorical argument as a management tool for maintaining control became somewhat paralysing in how I approached Lucy; it was hard to find ways to engage with what sounded like a watertight argument, and I had to think carefully about how I responded. The risk of sounding dismissive, disengaged, or relativistic was acute. My diplomatic response of trying to balance the requirements, which had the pragmatic intention of opening conversations up, could actually have been received as a robust provocation to order and control. Here, history and temporality play a key role. Perhaps Lucy had previously found herself in similar situations, in which someone would engage in a seemingly diplomatic way only for the matter to be closed down. On reflection, I can see how Lucy’s response might also have been influenced by whether she felt I had a genuine interest in her and her ideological position. Furthermore, it might also have depended on Lucy’s sense of whether I was prepared to disagree with Melissa and Jon should the situation require me to do so.

The finalistic nature of the actions I encountered felt violent, yet they appear to play an important function of protecting some key aspects of the work I am trying to do. I am referring to aspects that are easily marginalised by the threats posed by other people and groups; for example, by Mike and Lucy. As I reflect on this in my role, it raises deeper questions about how secure the practice of research actually is in my organisation, and about my role in relation to this. Although my organisation has a long and successful history of delivering research, sometimes I feel quite vulnerable in my role, which leads to the perception that our work is also in a vulnerable position within the organisation. This feels particularly prescient at the time of writing because my manager (Mike) has recently left and joined a new organisation. This has prompted some significant rumination about how the last 20 years of managing and delivering research together might wither to nothing without his executive championing, and, with that, I would lose the sense of pride, dignity, and meaning in my work. What lengths might I go to in order to protect this legacy and fight off any form of threat to our relative stability?

Making sense: summary

In reflecting on this narrative, I have seen how institutionalised patterns of behaviour can become embodied in a bureaucracy that can be violent. This is despite my belief that my colleagues (including Mike and Lucy) and I set out to achieve the opposite; that is, to help people, not harm them. It is possible, however, that Mike and Lucy set out to stop people (in this case, Melissa) ‘breaking the rules’ and pursued this ideological position with commitment and vigour regardless of the human and relational cost. As I reflect on this, the risk, or perhaps even the fear, of violence links to my desire to act diplomatically. My learnt patterns of acting with diplomacy, which stem from navigating my way through family life and school, along with a fear that all I have worked for might crumble, mean that I often feel the need to tackle situations like this with caution.

Through my theorising, I have found that it is misguided to look at an administrative process as something that is relatively straightforward, simple, decontextualised, or objective. In addition, as I have reflected on bureaucracy as it features in my narrative and sense-making, I have found that is easy to reify the abstract concept of ‘bureaucracy’. It is clear that the administrative processes that feature in my narrative are tied up with individual, social, societal, and organisational values and ideologies that are likely to be in conflict. Power, status, recognition, fear, risk, and violence are intrinsically bound to the people who manage administrative processes and the administrative processes themselves; the potential for violence and harm is structurally tied to such processes.

For those of us working in bureaucracies, the challenges of engaging with our clashing ideologies in ways that do not harm relationships lead me to two emergent themes that I will now explore in more detail: (1) recognition, and (2) violence.

Animating question

Having reflected on the narrative and this process of making sense, and holding in mind my overall research theme of *Politics, diplomacy and doing good: exploring the relational dynamics and implications of evidence-based medicine*, I want to extend my inquiry to explore the following question: what role do recognition and violence play in the administration of healthcare organisations?

Theoretical explorations

Bureaucracy and ideology

As a teenager, I helped in the family business of bike race administration by mailing out details to those who had registered for a race. We processed and stored information in a particular way. I did not ask why; I was told what to do, and the reason we needed to do it — riders needed confirmation that their entry had been received and they had a place. I do not know how my parents designed this administrative system, but my dad was an accountant and I imagine it was informed by this.

As I reflect now on how the administrative work I oversee today is done, I notice that I am not often part of a conversation about how and why we should do this in a particular way. This is not to imply that these conversations never happen; however, the HRA expects us to administer research governance quickly, and this is reflected in Melissa's response that she just wanted to do her job. I want to explore this in more detail and try to separate, as Townley (2008:65) puts it, the bureaucratic process from the bureaucratic rationality that underpins it.

In the early to mid-1900s, a number of management theories became popular. These invariably came from industrial pioneers, one of whom was Henri Fayol, a French mining engineer. Fayol was one of the first people to make comprehensive general statements about administrative management (in contrast to Taylor, who made general statements about scientific management). In the late 1800s and early 1900s, Fayol began to describe the functions and principles of management as he understood them. Fayolism, as it has become known, categorises the six functions of management as (1) planning, (2) organising, (3) commanding, (4) coordinating, (5) controlling, and (6) forecasting (Stacey and Mowles, 2016:59). The principles of Fayol's managerialism cover how work should be divided and delegated, discipline and rule-following, fair pay, hierarchy, and morale. These aspects of Fayol's theories continue to underpin modern management and the work we do today, although, of course, there have been many developments and iterations of administration and management theory over the last century. Furthermore, as Stacey and Mowles describe in their book *Strategic Management and Organisational Dynamics* (2016), the roots of management theory go back much further than the early 1900s, and they are entwined with the philosophy and thinking of the Enlightenment and the industrial, scientific, technological, and information revolutions (Stacey and Mowles, 2016:43-65).

Built on these foundations, healthcare research governance has become more formalised and regulated over the past 20 years for various historical, political, and social reasons (for example, the organ retention scandals of Bristol and Alder Hay, and the misconduct of MMR vaccine research). Trisha Greenhalgh, along with her colleagues Sara Shaw, Petra Boynton, and Anne Slowther, prominent UK-based health service researchers, set out a comprehensive history of research governance in the UK in a series of three articles in the *Journal of the Royal Society of Medicine* (Shaw et al., 2005, Shaw and Barrett, 2006, Slowther et al., 2006). As I described in my opening narrative, the administration (or governance) of health research encompasses complying with ethical, IG, scientific, data security, and financial standards and documenting that compliance. There is indeed a lot of ‘paperwork’ to get through in order to do research in the NHS; this is for good reason, including past loss of public trust and serious harm caused by poor research. I can see how this sits well with the functions of management set out by Fayol, but it also involves layers of bureaucracy, which can be time-consuming and burdensome. While there are layers of bureaucracy involved with research governance, (Shaw et al., 2005, Shaw and Barrett, 2006, Slowther et al., 2006) there is also a history of serious harm caused to patients because of weak research governance processes. They recognise that not all research always has the interests of patients at heart, and that there are sometimes significant financial incentives. In addition, they describe the potential benefits of good research governance, which include a reduction of fraud and misconduct, the protection of vulnerable groups, and financial probity. For me, their work emphasises that it is easy to oversimplify bureaucratic processes by categorising them as either good or bad, and reinforces how important it is to have thoughtful and nuanced conversations when working with complex administrative processes.

The bureaucracy that Shaw et al. describe is, as Stacey and Mowles (2016:231) argue, rooted in the management theories of the 1940s and 1950s. Every discourse and theory on management involves assumptions about human individuals. Kant’s philosophical position, as described by Stacey and Mowles (2016:53), is that people are autonomous rational individuals who can choose their own goals and the actions by which to realise them. Many of today’s management theories rely on the Kantian notion of autonomous individuals *“who are primary and prior to the group, and concerned with the control of systems”* (Stacey and Mowles, 2016:55-57). Here, Stacey and Mowles are describing how these management theories are centred on personal autonomy. In general, ‘personal autonomy’ refers to the capacity to be one’s own person, living independently according to reasons and motives that are taken as one’s own, not influenced by external forces. Stacey and Mowles (2016:56-58) describe these theories as forming the dominant discourse of management studies across all sectors. I can see how this discourse has shaped the way we work, without us noticing. Yet the assumptions and ideologies that underpin these management theories are, in my opinion, less than helpful when trying to understand the relational dynamics at work, particularly as we try to move from viewing ourselves as independent to seeing ourselves as interdependent. Or, to use the terms of Stacey and Mowles, the dominant discourse of the last 150 years of management theory has done little to address the challenge that *“the observer of a human system is also simultaneously a participant in that system”* (Stacey and Mowles, 2016:231).

I find myself in conflict here: years of participating in management and leadership training programmes have reinforced these ideals of autonomy, control, and stability, yet the reality is that my experiences of day-to-day work do not resonate with this view. The experiences I have described in my project narratives are rich in relational dynamics, which constrain and enable how we find ourselves responding when we are caught up in political games and conflicts at work.

This brings me to the struggle that Melissa, Jon, Mike, Lucy, and I faced, and how the conflict we experienced reflects the paradox of cooperation and competition described by Mowles in his book Managing Uncertainty, Complexity and the Paradoxes of Everyday Organisational Life (Mowles, 2015). Management and administrative activities are often undertaken in ways that are consistent with the practices described by Fayol, and this is in keeping with the claims that "*most areas of human experience can be managed"* (Mowles, 2015:120), and subsequently *"orthodox organisational literature offers a variety of tools and techniques to identify, analyse and treat organisational conflict so that it is harnessed towards increasing organisational performance."* (Mowles, 2015). This becomes problematic at work when conflict arises; conflict happens when the things we are managing become unmanageable or an impasse is reached. In this way, the paradox of cooperation-competition transforms into conflict. As Mowles (2015:139) continues, the most productive way of dealing with the challenges we face at work is to participate in them as fully as possible. However, all too often, as was the case with Mike and Lucy, we retreat into our camps (surround ourselves with ideologically similar people), ready the fortifications (our bureaucratic or management tools), and resist efforts to genuinely engage with what is being said or with each other. What strikes me here is Mowles' use of the phrase *"participating as fully as possible.* What I think Mowles means is that we have to find a way to live and work in a world of ideologies and ambiguities: a world in which we recognise there is nowhere to stand outside the struggles we experience. Where we recognise our own perspectives and prejudices, and where we acknowledge that it is impossible not to be affected emotionally by our encounters with others but that this is not always a generative or helpful experience.

However, modern-day management theories emphasise the individual and perceived independence of our actions, and this implicitly allows us not to engage in the difficulties we face at work. However, as Mowles (2015:130-132) argues, drawing on the work of George Simmel and Lewis Coser, 'affect' is an important part of understanding the complexity of conflict, because it is impossible not to be affected emotionally by our involvement in work. Simmel, a sociologist and contemporary of Max Weber, and Coser, who went on to develop Simmel's work, thought of conflict as an elementary form of socialisation; through our arguments, our relationships develop in both dialectical and paradoxical ways. This process creates both harmony and divergence. According to Mowles (2015:130), Simmel thought unity and divergence are both needed to create stability in relationships. Discussing the work of Afzalur Rahim, who aligns with organisational theories that recommend an instrumental, linear, and sequential approach to diagnosing and managing conflict, Mowles argues that Rahim's view is that conflict should be managed and controlled to the point that no conflict is ever extreme enough to disrupt work (Mowles, 2015:123-124). However, Mowles also argues that if we fail to engage with conflicts that arise in the workplace — particularly due to an immersion in Kantian management theory, which states that these conflicts should be managed or avoided by following well-managed processes — the stability we seek so that we can 'just do our work' evaporates. Furthermore, conflicts and emotions that end up being buried have a habit of resurfacing with increased vigour. Through developing an understanding of the ideological foundations of administrative systems, and in recognising that these foundations are now integral to the way my organisation operates, I am able to see that conflict and the desire to avoid or manage it are rooted in the work we do.

In some cases, particularly in my narrative and my wider experience, creating bureaucracies seems to be a way of expressing ideological beliefs. These ideological beliefs are the background, inherited, or learnt ideas we possess about how the world should function and how we should function within it. Just as the bureaucratisation of IG management has an ideological basis, so too does the de-bureaucratisation of research governance. These practices and beliefs inherent to ideologies create a sense of identity, and with our sense of identity being closely tied to the work we do, we create the condition for recognition or misrecognition. This is what I want to explore next.

Bureaucracy and recognition

In my efforts to understand Mike and Lucy's response, I went through a reflexive process of thinking about what happened, as well as seeking out views, opinions, and legal guidance from colleagues within my own organisation. This, along with feedback from the HRA, led me to believe that our differences were something other than the interpretation and legality of the governance rules we needed to follow. If this was the case, there might be other reasons behind how Mike and Lucy were responding. In fact, there might be other reasons behind the way we all acted.

Mike and Lucy were in a position of power and influence over how Melissa's work proceeded; given that the law did not require them to act as they did, what purpose, benefit, or opportunity did it afford them? To answer this question, I believe it is helpful to look at the political and cultural context of managers in the NHS.

Successive governments, the press, and the general public all appear to have a long-standing fascination with 'NHS bureaucrats'. The popular press has long vilified NHS managers and the money-wasting bureaucracy they represent. As such, I, along with Mike, Lucy, Melissa, and many others, find ourselves working in this context of low public esteem in NHS managerialism. Woven through who we are (our identity) and how we act at work is a desire for recognition. Indeed, Mowles argues that:

> *"most people are trying to contribute to the broader undertaking of which they are part and to see their organisation thrive; they are part of one organisation with their colleagues to which their success is bound. At the same time they are invested in what they are doing at work, and they want to succeed personally, and they strive for recognition and status." (2015:121)*

To understand the concept of recognition within the tradition of the DMan programme, I will turn first to Taylor and then to Honneth: two key authors in this area, both of whom write from a philosophical position.

Recognition at work

Taylor (1994:25-73) argues that recognition is a vital human need and that it relates to how our identities develop based on feedback, as well as how we recognise and respond to others. I agree with Taylor here, and, reflecting on how the practices and beliefs inherent in an ideology create a sense of identity, so too does recognition.

Taylor's writing on recognition is helpful in that he encourages us to take two steps. The first involves taking a historical step back to find ways of understanding what recognition means in the twenty-first century. The second, consistent with much of Taylor's writing over many years, is to pay attention to the rise of the 'individualised identity': the ideal of being authentic or true to oneself. He continues that with the collapse of social hierarchies, honour has been replaced with dignity. No longer do we give someone recognition due to their status in the world (as we did prior to modernity), but we are expected to treat someone with dignity and respect regardless of their social status. This, Taylor argues, is behind the rise of individualised identity. Taylor claims that self-fulfilment is at the heart of the modern concept of being authentic, which in turn seems to render the whole tradition of common values and social commitment ineffective (Taylor, 1994:25-27, 31). What I think Taylor means is that the conditions that allow for giving and receiving recognition have changed from being social to being individualised. Taylor continues by arguing that the basic need for recognition has not changed, but the conditions under which attempts to be recognised are made have failed (Taylor, 1994:33-35). In his view, the reason for this is that identity formation is a dialogical process; that is, identity is formed socially and in dialogue with others, and it is not the independent journey of an individual. The dialogical development of our identity means that its development is far from individualised and independent; in fact, it is social and interdependent:

> *"We define our identity always in dialogue with, sometimes in struggle against, the things our significant others want to see in us. Even after we outgrow some of these others — our parents, for instance — and they disappear from our lives, the conversation with them continues within us as long as we live." (Taylor, 1994:33)*

This makes sense to me, and when I reflect on how I see Mike and Lucy's experience, I have assumed that their relationships and identity within their organisation have not developed dialogically, but individually. This is not to say they do not have social relationships with their colleagues; rather, the individualisation of their work and the responsibilities they hold has created an opportunity for them to become misrecognised. Thinking again about this, if Taylor's point is that identity inevitably arises out of a dialogical process, perhaps the dialogical process that Mike and Lucy have found themselves in has left them with a highly individualised sense of 'being on their own'. This is in contrast to the dialogical process that I have been in with Mike, where we have experienced a mutual process of ‘having each other’s backs’.

Misrecognition, or the failure to give someone their due recognition, might result in someone feeling degraded and neglect their right to be treated in a certain way. This may be a much more common phenomenon than I had considered, especially when the bureaucracies we develop (or find ourselves in) create the reasons for us to be recognised while simultaneously creating the environment and context for us to be misrecognised.

Honneth, in his book *The Struggle for Recognition* (2005b), takes Hegel as a departure point to build his theory of recognition as a combination of love, rights, and solidarity. Consistent with Taylor, he argues that our social lives are governed by the need for mutual recognition. Honneth claims that at the centre of social conflicts is our struggle to be recognised. As with the work of Taylor, Honneth prompts me to think about the question, ‘If I cannot be my true authentic self, then who am I?’ and, in doing so, directs me to the different qualities of the self as established in relation to others. This dialogical process of identity formation, Honneth (2005b:121-130) argues, is based in self-confidence, self-respect, and self-esteem. He describes self-esteem as a solidarity that is distinct from love, friendship, and legal recognition. He claims that solidarity is where honour and dignity within a community of values gives recognition, which, in turn, makes identity formation possible. Affective approval and encouragement form the basis of feeling esteem:

> *“Within the status group, subjects can esteem each other as persons who, because of their common social position, share traits and abilities that are accorded a certain level of social standing on the society’s scale of values.” (Honneth, 2005b:123) … “Relations of social esteem are subject to a permanent struggle, in which different groups attempt, by means of symbolic force and with reference to general goals, to raise the value of the abilities associated with their way of life. To be sure, it is not only the power of specific groups to control these means of symbolic force but also the climate of public attention (never easily influenced) that partly decides, in each case, the temporarily stable outcome of such struggles.” (Honneth, 2005b:127)*

I find this extract interesting in that Honneth talks about social esteem being subject to a permanent struggle. I think this is akin to the battle of opposed ideologies and the difference between thought collectives that I have recognised in this narrative and in my narrative from P2.

When it comes to social relationships, Honneth argues that they require ‘symmetrical esteem’ (Honneth, 2005b:121); that is, approval and encouragement need to be felt by all those in the relationship. However, the tendency is for esteem to be individualised, which again creates an environment in which people are misrecognised. The social relations of symmetrical esteem between Mike and Lucy, Melissa and her organisation, and me, broke down in this encounter. Our differences felt far more pronounced, and our individualised needs rose to the fore.

I am left wondering if, by acting in the way they did, Mike and Lucy can directly and with impact say: *‘Look at what a good job we are doing. You need to recognise that if we did not do this, the organisation would be exposed to so much risk that it would be bankrupted within no time at all.’* (Without IG controls, or with poor ones, this may actually be a fair assessment of the risks involved.) In some way, they are struggling for recognition and esteem; their relationship with the organisation, perhaps due to previous events, created an environment where there was limited potential for recognition. I am reminded that I joined a long-running conversation for just an hour or so, and probably should have sought to clarify assumptions and context during the meeting. Perhaps they felt this was the only way they had a voice. The way they are managed, or the way the organisational context affects them, might make them feel powerless. If, due to external factors, the value of their roles is not adequately recognised in a way that leads to honour and esteem, they may well be adapting how they carry out their work in order to increase the recognition that comes from within the organisation. I find it interesting that if this is the case, it makes the situation worse. Similar to how attempts to manage conflict out can result in more conflict, attempting to force recognition may increase the likelihood of misrecognition.

In my experience, recognition and misrecognition are important in our social relationships. However, I am noticing that my self-interests, and the interests of others, often end up in conflict; our ideological positions are (or, at least, I have assumed they are) different. It is these bruising encounters, acts of bureaucratic violence, that I want to explore next.

Bureaucracy and violence

On the DMan residential weekend in October 2020, we read and discussed a paper by Russ Vince and Abdelmagid Mazen entitled “Violent Innocence: A Contradiction at the Heart of Leadership” (2014). I recall being a little perplexed: it was my first residential on the programme, and having read this paper and the other required reading, my head was full of new ideas and concepts. I had never thought about the violence involved in leadership. I had seen and experienced poor behaviour, and even psychological harm, but I had never thought of these things as acts of violence. I can now see that I was struggling to think beyond a narrow description of violence as physical.

The management literature and training courses I encountered through previous management programmes tended to focus on individual leaders and on positively framed models describing ideal behaviours and actions. Their message was ‘follow the steps, and have the right emotional maturity, and work will be conflict-free and productive’. More recently, my team and I have undergone training on conflict resolution. This training has focused on understanding one’s own behaviours, strengths, values, and preferred ways of working, and then recognising these attributes in others. For example, we recently undertook core strengths training (Scudder, 2019). The premise of this training is that by understanding how someone else works, one can respond in a way that does not create conflict. My team and I found this model appealing; however, it does not reflect the "predictable unpredictability" of human relating and organisational life that Mowles writes about in his book *Managing in Uncertainty* (2015:98-99) or the many other contextual factors affecting our work. In reading the paper by Vince and Mazen (2014), I became acutely aware of the unintended consequences of the way my team and I work.

In this paper, Vince and Mazen (2014) introduce 'violent innocence' as a construct that is helpful in understanding the interpersonal and organisational processes of projection and denial that are connected to leadership, especially when we think about our self-interests and the interests of others. As they put it: *"We think that it is unhelpful to claim that leaders are orientated towards self-improvement without a corresponding acknowledgement that they are also, at the same time, orientated towards self-interest."* (Vince and Mazen, 2014:203). Through the conversation around this text, it became clear to me that some leadership and management is indeed violent, and that this violent aggression is often dressed up a moral superiority. It is this type of aggression that Vince and Mazen (2014) describe as violent innocence or symbolic violence. Over the past 12 months, I have found this concept of violent innocence increasingly helpful as a way of describing the violence that is present in our relationships at work, and it has increasingly informed my way of thinking. It has become important to me to pay attention to the everyday ignorance of violence and how we justify the way we work through *"both the individual denial of violence and the organizational 'structure of innocence' that hides and condones violence"* (Vince and Mazen, 2014:204). What perplexes me most, especially given that conflict seems to be inevitable when we have ideological beliefs, is that I might be responsible for violence done to others without my knowing it.

Having written the above, however, I have been experiencing nagging doubts about the plausibility of talking about symbolic and structural violence at work. Doubts about this were also shared by other DMan students during a subsequent residential weekend. Therefore, I want to describe why this is a plausible way to explain what may be happening.

During a conversation about my DMan work with my neighbour (who lectures in gender, politics, and decolonisation at the local university), I asked about the validity of my attempts to frame administrative or bureaucratic struggles as a type of symbolic and/or structural violence. I explained that I found it difficult to think of the violence caused in our relational struggles as comparable to violence caused by acts of genocide. My neighbour suggested a paper by Philippe Bourgois, an anthropologist whose work I had not read since the early 2000s, entitled "The Power of Violence in War and Peace: Post-Cold War Lessons from El Salvador" (Bourgois, 2001). I found the paper harrowing; the level of distress it caused me made me feel physically sick, and I was moved to tears by the accounts and reflections of the tragedy, pain, and suffering of the revolutionary Salvadorian peasants. The violence described is both extreme and commonplace, however, and Bourgois helpfully sets out his view on differentiating the forms and expressions of violence. These different discourses on violence presented by Bourgois (2001) include his own classification of ‘direct political violence’, which he defines as violence purposefully administered in the name of political ideology.

The concept of structural violence was first described by Johan Galtung, founder of the research field of peace and conflict studies, in 1969 (Bourgois, 2001:7). The term relates to the political and economic organisation of society in a way that imposes conditions of emotional and physical distress. More recently, Bourgois has argued that structural violence has been used as a way to *“highlight the economic inequalities that promote disease and social suffering”* (Bourgois, 2001:8).

The concept of ‘symbolic violence’ was developed by Pierre Bourdieu, a twentieth-century French sociologist, and describes a type of non-physical violence manifested in the power differential between social groups (Bourgois, 2001:8). Bourgois, citing Bourdieu, claims that symbolic violence is *“exercised though cognition and misrecognition, knowledge and sentiment, with the unwitting consent of the dominated”* (Bourgois, 2001, chart 1).

Finally, Bourgois introduces the concept of ‘everyday violence’, adapted from the work of the medical anthropologist Nancy Scheper-Hughes. Bourgois provides a narrow definition of everyday violence as the expression of interpersonal aggressions that *“normalise violence at the micro-level*” (Bourgois, 2001:8-9).

Bourgois skilfully and reflectively weaves these expressions of violence into his narrative, showing in particular how even acts that appear to be innocent, and on face value administrative, can cause great harm. Several examples are provided in Bourgois’ (2001) article: the denial of work visas causing someone to give up their children; the administration of Valium to keep a child quiet causing permanent brain injury; the presentation of a photograph at an academic conference resulting in an attempt to expel an academic from their tenured position; and how one country’s foreign policy, economic policy, and logistical support led to the death of 75,000 people in El Salvador during the 1980s. These accounts of violence felt so far removed from my life as a research manager in the NHS in 2021 that it would have been easy to dismiss them as irrelevant to my work; yet I was convinced that they were more relevant than ever. Everything we do has the potential to escalate into the most extreme version of itself; it is just that we find a way — through cultural, ideological, and social factors — to keep things in balance (that is, to keep our most extreme thoughts in check). Bourgois concludes:

> *“Political, economic and institutional forces shape micro-interpersonal and emotional interactions in all kinds of ways by supporting or suppressing modes of feeling and manifestations of love or aggression, definitions of respect and achievement, and patterns of insecurity and competition.” (Bourgois, 2001:28)*

For me, this statement reinforces the idea that acts of ‘innocent violence’ at work are on the same spectrum as those that led to the massacre of revolutionary fighters and their supporters. In this way, it is both possible and plausible to describe the use and misuse of administrative powers in a corporate setting as a form of symbolic and structural violence.

As I reflect on the work of Vince and Mazen (2014) and of Bourgois (2001), and how this relates to my narratives (both P2 and P3), I am struck by the normality of the destructive relation of power in the workplace. Vince and Mazen (2014) describe how hostility is often covered up with positivity, and this can be seen in my narrative: the hostility (or conflict) is explained away on all sides by well-intended statements about the value of our work — mine and Melissa's focusing on the positive value of research in the NHS, and Mike and Lucy's emphasising the positive value of keeping data safe and secure. Vince and Mazen (2014) and Bourgois (2001) all draw attention to our experiences of power, as manifested in dependence and domination.

If it is implausible to manage conflict and cooperation through an evidence-based management approach consisting of conflict-resolution tools and measures (for example, as detailed in the core strengths training my team received), and if, related to this, violence exists in the workplace as I have described, then what are the possible alternative responses? Violence can be answered in different ways. For example, we can respond equally with violence; indeed, this might be what happened in both my P2 and this P3 in the responses from Peter and from the HRA. Alternatively, as Vince and Mazen (2014) suggest, we can respond by moving away from the idea of 'emotionally mature', positive, individualised managers/leaders focused on self-improvement, and instead consider the darker, complicated, and contradictory feelings that emerge at work, where we might want to both empower and undermine people (Vince and Mazen, 2014:203). This shift — responding without violence, but acknowledging that violence is a possible outcome — might be met with scepticism; especially when considering that, in my experience, the emotional, legal, moral, and culturally justified response is to defend oneself. This position, combined with the threat to our individualised identities, may be what causes us to respond initially to an act of 'innocent violence' (in my case, work being dismissed or progress being blocked) by defending ourselves, rather than letting it happen and engaging relationally with the perpetrator.

Judith Butler (2020), an American philosopher and gender theorist, argues that we might respond to violence not with a passive resistance, which enables the violence to continue, but by taking a different approach — that of nonviolence. Violence, she suggests, is *"the name given to those efforts to undermine and destroy prevailing institutions"* whereby violence *"serves not so much to describe a set of actions as to enforce a valuation on them"* (Butler, 2020:137). The same holds true for nonviolence. In fact, 'nonviolence' is Butler's term for certain acts of refusal: *"ways of refusing to recognise illegitimate authority"* (Butler, 2020:139) and refusing *"the legitimacy of a specific form of rule"* (Butler, 2020:140). However, we should pay attention to the idea that refusing legitimacy is a way of refusing to recognise (or misrecognise) an individual.

Nonviolence, as Butler describes it, is a force; it is not a rejection of action, but a process of engaging with the negating power of violence itself. This echoes the work of Mowles, who argues that the suppression of conflict (violence) through management tools (passive nonviolence) may silence the conflict but does not resolve it; rather, it creates the circumstances for the conflict to continue (Mowles, 2015:122-123, 138-139). Just as Butler describes nonviolence as a process of engagement, Mowles describes how managers should engage fully with conflict by immersing themselves in the 'complex responsive processes of relating', noticing their own reactions and perspectives based on what they experience, and being honest about what they have at stake (Mowles, 2015:139). On reflection, my narrative shows that this engagement is what happened, especially in how I responded to Mike, Lucy, and Melissa during the meeting and to Melissa after the meeting.

Butler is interested in the place where moral and political philosophy meet, *"with consequences for both how we end up doing politics and what world we seek to help bring into being.*" (Butler, 2020:7). Her views on the social self have some similarities with those of other theorists discussed in the DMan programme, including Taylor and Mead. This is apparent in Butler's argument that what binds humans as selves is the social world they share: *"selves are implicated in each other's lives, bound by a set of social relations that can be as destructive as they are sustaining"* (Butler, 2020:9) in *"the idea of selfhood as a fraught field of social relationality"* (Butler, 2020:10).

With this in mind, I can see how administrative acts can be acts of violence, and that violence is responded to with self-defence. In my narrative, I think that all parties engaged in violence and in self-defence. When I look at this from Butler's perspective, there were no winners; each act (of violence and of self-defence) harmed all those involved. It may also be the case that the administrative obstruction I encountered was an act of self-defence in response to a preceding act of violence. From this perspective, it is hard to see a way out of a perpetuation of symbolic and structural violence that becomes ever more tightly woven through the fabric of an organisation.

Considering Butler's work on nonviolence and Mowles' work on the cooperation-competition paradox might enable us to respond to the everyday conflict at work, by finding ways to engage relationally with those involved in the conflict (rather than by using management tools). However, emergent conflict due to clashes in ideology or values is not always generative, so engaging relational requires practical judgement and reflexivity (Mowles, 2015:139).

Summary

Through this project, I have come to view bureaucratic ideology as the background ideas that we possess about the way in which 'the world' must function and how we function within it. Within this idea of how we function in the world, we attempt to control what happens and what is allowed to happen; within my narrative, I have clearly identified such attempts at control by Mike and Lucy, as well as by Melissa and me. Louis Althusser, a French Marxist philosopher born in Algeria, refined his theories of ideology in a work first published as an essay entitled "Ideology and Ideological State Apparatuses" (Althusser, 1970). In it, Althusser describes a theory of state and its various repressive and ideological apparatuses (RSAs and ISAs). Here, Althusser argues that state activity is both repressive and ideological. Repressive apparatuses ensures conformity through complex political-legal governing bodies, the police, and the army; the ideological state apparatuses function through education, cultural organisation, religion, and family. Althusser makes the point that both repressive and ideological apparatus function by ideology and violence (Althusser, 1970). These ideas resonate strongly with the experiences I described in my narrative in this project. While my encounters with Mike, Lucy, Melissa, and Jon were not at 'state' level, I can see the state mechanisms Althusser describes playing out locally: the complex political-legal systems and governing bodies that shape both research governance and IG are repressive.

What I find interesting, however, is that although these governance practices have complex, legalistic, enforcing, repressive, and controlling elements (aimed at keeping people and data safe), there often appears to be room to accommodate nuances in decision-making. This may increase the risks and responsibilities being managed by the governance process itself. While accommodating nuance in decision-making requires practical judgement, practical judgement is also ideologically driven. I also think that there is a paradoxical circle whereby the world we are immersed in shapes our ideological positions, which in turn shape the world we are immersed in; eventually, this reaches the point at which we cannot separate our beliefs, values, training, ideologies, and work practices, and we find ourselves in a thought collective that thinks and works in a certain way. I have found myself assuming that I know what kind of person an IG manager might be, in much the same way as I know what kind of person a research manager might be. These assumptions are risky, in that they obstruct the process of relating to each other as interdependent, and social beings.

In my inquiry into recognition, I have argued that what we do at work cannot be separated from who we are; we construct our own and others' identity and status as we interact with each other, and our struggle for recognition is a key dynamic in all human relating. This understanding of the self (as radically social) is fundamentally different from the Kantian understanding of the self as autonomous, which managerialism and bureaucratic rationality rest on. These different understandings of the self have fundamental implications for ideas about how we respond to conflict.

I have drawn on the experience of learning (with my team) a way of responding to conflict by using a tool to classify and understand values and motivations. This tool, while recognising that we work alongside others, is highly individualised and does not take into account the relational dynamics around recognition that I have drawn attention to.

Turning to Taylor and Honneth, I have explored what meaning 'recognition' might have in my experiences at work. Taylor and Honneth are in broad agreement about social processes in their theories of recognition, but there are also some key differences in their positions. For Taylor, the concept of misrecognition is the other side of the coin; he argues that *"our identity is partly shaped by the recognition or* *absence, often by the* mis*recognition, of others”* (1994:25). Honneth, on the other hand, provides a more detailed account of misrecognition, regarding it specifically as *“the withdrawal of social recognition, in the phenomena of humiliation and disrespect”* (Fraser et al., 2003:134). The misrecognition I identified in my narrative might reflect an absence of recognition through poor relationships with senior managers (Taylor) or it might be the result of the withdrawal of social recognition through humiliation and disrespect (Honneth), perhaps due to a societal view on ‘NHS bureaucrats’. It is Taylor’s position that resonates: given that our identity is formed in part by our belonging to a particular cultural group (or thought collective), individual self-worth is bound up in the value that others attach to this group. If the group is demeaned or held in contempt, its members will suffer real harm as a consequence (Taylor, 1994:25). I have argued that when this happens, the result is further violence through self-defence, as Butler describes in *The Force of Nonviolence* (2020:1-18). This process further entrenches people in their particular (or dominant) thought collective or cultural group, sparking an ongoing cycle of conflict. Over time this cycle becomes part of the narrative we construct about particular thought collectives; in my case, Mike and Lucy behaved as I expected IG managers to behave.

I have argued that the absence of an understanding of relational dynamics in the dehumanised bureaucratic rationality, as well as the individualised notions of management in managerialism, can lead to a dynamic between people that is characterised by a sense of violence. In my narrative, this violence constitutes threats, silencing, and escalation (of conflict), and this seems to be the way that difference or conflict is often dealt with more generally.

The dominant pattern of solving conflicts that arise as a consequence of a clash of competing but legitimate thought collectives can lead to the brutal enforcement of a solution in a way that is likely to lead to more conflict, or an escalation of the conflict, due to one party feeling marginalised, silenced, or misrecognised. As such, two problems may arise. Firstly, the process of reducing the complexity of NHS governance administration to that of following bureaucratic procedures is dehumanising. Secondly, this dehumanised, instrumental way of thinking and acting robs us of our human ability to listen and speak to one another in a collaborative way. My experience of these two problems, however hard I might try to resist them, is the emergence of conflict and the (perhaps temporary) breakdown of relationships, which leads to harm arising from well-intended acts.

Cooperation and conflict are essential qualities of social interactions; therefore, cooperating and competing ideologies are essential qualities of our institutionalised lives. Many individualistically centred theories of management offer tools that can help managers to ‘manage out’ conflict and uncertainty. However, if we acknowledge that cooperation and conflict are both important qualities of social interactions then the task is not to manage out conflict but to engage with it as fully as possible. This means paying attention to how we are affected by the conflict, as we are engaged in the struggle of clashing ideologies.

I have found that in our bureaucratic everyday, we are caught up in these institutionalised patterns of interaction, which so easily turn out to be violent. What is the defence against such violence? According to Arendt (Canovan, 1992:177-179), a possible defence is for people to identify as ‘good citizens’ rather than ‘good men’; that is, caring about the emergence of the wider pattern of the institution rather than simply caring about one’s own frame of thinking or group. In other words, it is a moral problem that bureaucrats have such a bad reputation; that ‘work’ is experienced and seen cynically as solely reproducing selfish and opportunistic agendas. Arendt argues that when this happens, we have failed to preserve the dignity of politics (Canovan, 1992:111).

Throughout this project, and in my P2, I have struggled to find some middle ground. I have an intuitive sense of it being important not to collapse the conversation, but to keep it going, and, in doing so, stay in relation. Yet, I feel the relief of a decision being made and a solution being enforced. It takes away the doubt, ambiguity, and struggle, even if it means increasing the height of the walls that separate thought camps.

A position that is held within the theories of complex responsive process of relating is that everything is relational. If there is nothing outside human relating, it follows that all human relating involves power relationships. Therefore, despite the age-old administration systems, tools, and instruments we use, it is relationships and experience — processual ways of knowing, not instrumental ways of knowing — that shape and inform our responses. Reflecting on this, I can see a need to explore the types of power relationships I am involved in. Although Elias’ theories on power (as discussed in P1 and P2) are helpful, I am beginning to think that framing power as only a structural characteristic of relationships, fluctuating, tilting, and flowing (1978:131), does not address how power moves in relationships. Mary Parker Follet, an American social worker and management consultant, describes her understanding of power in her book *Creative Experience* (Follett, 1924/2013). Follet’s argument that genuine power is ‘power-with’, rather than ‘power-over’ (Follett, 1924/2013:186) feels especially relevant; my diplomatic listening and my efforts not to rush into brutality are ways of trying to produce ‘power-with’ through integration with those I work with, rather than ‘power-over’.

However, the tension I have experienced is that I and my colleagues ‘just have to do our jobs’; that is to say, we just try to keep going. I am arguing that while this is often the only practical way to proceed, we should do so while paying attention to what others are doing, while resisting the temptation to instrumentalise our relationships and activities, and while remembering, as Follet describes, our tendency to want to have power over others (Follett, 1924/2013:187).

To finish, if management tools and techniques are ultimately limited in their usefulness, not least because they instrumentalise the work I do and the relationships I have, how *do* I manage? I have argued that I need to find a way of managing that is centred on the ability to think about my contribution to the group while being in the group; making visible, grasping, and subduing the things that cause the crises I experience. In addition, I have to accept my own contingency — I cannot subdue everything — and that ultimately, the world is unpredictable and uncontrollable.

As my P3 has progressed, it has become clearer that what I have been exploring is how the successes and failures of NHS research, despite a firm grounding in a positivist world of EBM, rest on the relational dynamics of those who are involved in the design, delivery, and management of that research. These relational dynamics are at the mercy of politics, sub-politics, self-interest, and violent acts, all of which are constrained and enabled through our social selves and our ideologies. This is important because the structure of research in the NHS — for example, bureaucracies, metrics, governance, the quest for objective truth, assumed shared values, and so on — operates to move swiftly past the relational in order to 'just do one's job' as quickly and efficiently as possible. However, just as the avoidance of conflict creates more conflict, so the avoidance of relational engagement increases the need and urgency for it.

My P3 project has strongly highlighted my need to further explore how EBM exists and functions in my organisation, reveal the complexity of what lies underneath, and take up these conversations with my colleagues.

Project 4: Out from the shadows of the evidence

Introduction

In P3 I wrote about a bureaucratic impasse I had found myself involved in while trying to support some colleagues to navigate aspects of research governance. I explained that the shift towards increased research governance was a response to some rather shocking failures resulting in participant harm, with people protecting their own interests and covering up their mistakes. I explored what might be at stake when people become involved in research activity. Although I recognise that evidence-informed clinical services are central to the UK health service (NHS), in my first three projects I have concluded that using evidence-based medicine (EBM) in a 'bureaucratic' or 'managerialist' way may not always be the best way to run, evaluate, or design clinical services.

Clinical service planning and decision-making are complex and relational processes that involve rules, procedures, administrative tasks, metrics, governance, passion, emotion, frustration, and — sometimes — success. In my experience, I have found that bureaucracy and practical judgement are both needed to enable research to be safe, effective, and successful. However, bureaucracy and practical judgement are often paradoxical: bureaucracy is often seen as constraining, while practical judgement is perceived as enabling. At the same time, the opposite might be true, depending on the power dynamics at the time. Through practical judgement, I have found the wriggle room to navigate the rules and regulations of the workplace. My experience of this paradox while overseeing research activity in my organisation is the emergence of conflict, and the (perhaps only temporary) breakdown of relationships, leading to harm arising from well-intended acts.

In an ongoing process of exploring the themes that emerged from my first three projects and resonated with my fellow students, I found myself settling on three: ideology, recognition, and violence. I could have selected other themes; and, indeed, some of those themes would have been easier to explore. However, I wanted to push the boundaries of what I felt comfortable with and challenge my sometimes idealised or reified thinking about research. I wanted to do this in a way that would lead to novel thinking about the relational dynamics I am involved in, to explore how EBM exists and functions in my organisation, and to 'lift the lid on it' to reveal the complexity of what actually lies underneath the veneer of well-ordered and well-governed research activity. I continue in this project by providing a narrative account of a series of events in which I and my colleagues struggled with deciding how to take a particular research project forwards.

Narrative

Chapter 1: Finding a position to hold

> *'…But it's what people want! In 34 years of working in mental health services, I have never felt so excited and encouraged by a model of clinical care as I have about Creative Dialogue; we just have to do it.'*

When I heard these words during a long-running and often heated debate about a clinical trial intervention that I have oversight of, I found myself in an intense state of paralysis: I agreed with this argument, and I did not know how to respond. On the one hand, the evidence base for Creative Dialogue was insufficient; on the other, there was passion, commitment, and enthusiasm for a new way of working. Meanwhile, I was trying to find some common ground and navigate an often-conflictual conversation through various bureaucratic organisational processes.

My organisation and my team have been involved in the JOURNEY (Creative Dialogue: Development and Evaluation of an Intervention for Mental Illness) project since 2018. It is a large-scale clinical trial of the Creative Dialogue approach, and it addresses the lack of high-quality trials and service evaluations for this type of intervention. The trial protocol[2] describes this history, while recognising that the principles, energy, and enthusiasm surrounding the intervention show the desire in for a fresh approach to treat mental illness. The results of the JOURNEY trial will be crucial in the future commissioning of Creative Dialogue as an intervention in NHS services.

Throughout the time I have been involved in the JOURNEY trial, I have had to sit with some tension and conflict. This is not the usual tension and conflict that emerge when we run trials, such as the daily challenges of forging relationships with clinicians and service managers, recruiting patients, and ensuring that the staffing mix supporting the trial is sufficient; it is a new tension, which has challenged my ideas of impartiality as a research manager and my belief in the EBM paradigm. Much is spoken of having ‘equipoise’ when it comes to clinical trials, and it is an idealised standard I have tried to uphold in my career as a research manager. Equipoise is traditionally defined as a *“state of genuine uncertainty on the relative value of 2 approaches being compared in a trial”* (Rabinstein et al., 2016). Like many of my colleagues, I have found the principles of Creative Dialogue and the underpinning philosophical approach engaging and resonant. Both Creative Dialogue and the approach of the DMan programme pay attention to the multiple voices and perspectives that are present in any conversation; as such, my idealised notions of ‘having equipoise’ or being impartial have been tested.

One of the challenges of the JOURNEY project has been that the clinical team involved want the intervention to be made available more widely across the organisation and outside the research process. This desire has been met with equal amounts of support and resistance, which has resulted in both a stalemate and periodic flashpoints of anger and frustration that no progress has been made. In April 2022 it seemed that we had reached boiling point again, and I met with my manager, Francis, also the chief medical officer for my organisation, to discuss what we might do next. I agreed to write a paper for our Clinical Advisory Group (CAG), with the aim of reflecting the different scientific and organisational positions, outlining the opportunity that Creative Dialogue offered, and helping to guide decision-making about a wider adoption of Creative Dialogue. Although the CAG does not have

---

[2] Protocol is not referenced directly, in order to maintain anonymity.

decision-making power as a committee, it is a powerful group of senior clinicians who have significant influence over organisational decision-making. I had an informal conversations with Clinicians, service managers, my research team, Francis and another colleague, Eloise. Eloise, a clinical director for mental health services, had responsibility for a significant service transformation project that affected the clinical team working on the JOURNEY project. I also had access to several reports, papers, and statements drafted by the JOURNEY clinical team, which described, occasionally in miraculous terms, the potential of Creative Dialogue. The purpose of these conversations was to get a sense of the political landscape I was in, understand some of the details, and gauge whether there were strong opinions about what a desired outcome might be.

Chapter 2: Bumping into Richard

At a conference a few weeks later I bumped into Richard, a consultant psychiatrist and lead clinician for Creative Dialogue and the JOURNEY trial, and his colleague Susan. It was good to see him and to meet Susan for the first time. After the usual pleasantries had been exchanged, I quickly realised I felt totally unprepared for the conversation that was going to follow. Richard explained how fragile his JOURNEY team was: short-staffed, misrecognised, and desperate to do more. He posed the question *'Why won't the organisation let us do Creative Dialogue care outside the clinical trial?'* I struggled to find an answer. How could they do more if they were short-staffed? How could they do more if they did not know if it worked? I could see his distress, yet I knew the constraints within the EBM paradigm and of the political landscape we were working in. *'The evidence base is not sufficient for the trust to roll the intervention out more widely,'* I stumbled over the words. *'We just don't know if Creative Dialogue is better than what we currently do; if we did, we wouldn't be part of a multimillion pound research project,'* I said, repeating a version of what I held to be true, and the outcome of my conversation with Eloise. I felt a bubbling up of anxiety about saying the right thing. I was trying to hold a line of evidence-based practice, but in the face of such passion for Creative Dialogue it was hard to stick to such a clear position. On reflection, in the heat of the moment I had to respond, yet I felt unprepared because I had not been able to test my responses with an ally to work through the details.

There was a point at which Richard seemed to be on the verge of tears. He was telling me that there were job opportunities on the other side of the world, and, with no support from the organisation, it would be far easier for him to pack up and move somewhere where he was appreciated.

This threat felt real; the last thing I wanted was to lose a valued clinical colleague. For the JOURNEY trial to be put in jeopardy would mean failing the participants and our contractual commitments. The threat also felt like a coercive bargaining chip being used by Richard to secure a favourable outcome. Perhaps Richard saw the look of concern on my face, and he reassured me that it would not come to this. Later that day, I received a message from him. He apologised for not being as calm as he should have been when we had the conversation, but expressed that it was hard to hear the ‘trust’s’ position put so starkly, especially as such an opportunity was being squandered.

Susan, a parent-carer representative and peer support worker, joined the conversation. She spoke passionately about what a difference the approach had made to a family she knew: it was as if, she told me, that after so many years they had finally been listened to, and that gave them hope. As I listened to Susan, I had a moment of insight — this situation was not that different from the experience I described in P2, where it can be hard to reconcile individual experiences (or beliefs) with research evidence. So much emphasis is placed on controlling for confounding factors; trial populations, despite being made up of autonomous interdependent individuals, are presented as a homogenous group. Although researchers do recognise heterogeneity, the positivist empirical methodological approach strives to find universal generalisability.

Towards the end of our conversation, Richard had made the point that the evidence base for Creative Dialogue was probably no better or no worse than the evidence base for any of the other treatments we offered. As I reflected on this point (both during the conversation and later), I felt stuck with the question of ‘if this is the case, where does it leave us?’ What if the evidence base we usually followed was no better than the evidence base for Creative Dialogue? I reflected further: if this was so, why was there such resistance to the Creative Dialogue approach? I also wondered what the power dynamic was; what was Richard expecting to get out of this conversation? What did he really think I could do? Was he trying to convince me that Creative Dialogue was the right treatment approach, or was he just sharing his frustrations?

I made a commitment to Richard and Susan to look at how I might better represent their view in the paper I was writing, reflecting both the real individual experiences and the process of doing research in the NHS. I was attempting to remain impartial; that is, facilitating a conversation as a process of finding a way through this issue that would be acceptable to everyone who had a stake in it. However, as I cycled home, I realised how my prejudices had shaped my response; I was beginning to feel quite critical of my official obligation to produce this report and was concerned about the risk that it would simplify things in a way that would make the decision easy, but the results hard to live with.

Chapter 3: A formal meeting with Richard

With a draft of my paper nearly ready, and with Francis happy with the content, I shared it with Richard before it was due to be formally discussed. Eloise and I agreed to meet and discuss it with him, Susan, and another colleague, Clive.

I went into this meeting feeling a little apprehensive about how Richard would react; in its draft state, my paper did not offer what I think Richard wanted but was a negotiated compromise. I was also apprehensive because I was finding it increasingly difficult to maintain a position of impartiality. Despite the lack of evidence that Creative Dialogue was a suitable alternative to existing care, I had heard passionate first-hand testimonials about how it had been transformative, and these were hard to reconcile with the EBM paradigm.

When I met Richard and his colleagues Clive and Susan, Richard's passion for Creative Dialogue was clear. He started by saying that he had a couple of issues with my paper. Firstly, I had referenced some research which found that although Creative Dialogue was well received by staff and patients, it was probably more expensive than a 'standard' clinical team. Richard contested this point, suggesting that I was misrepresenting the research. I drew his attention to a passage from the research report I had referenced that made this exact point. Richard accepted this, and we moved to the second issue: a more general point about the purpose of my paper and when they would be able to get on and do more Creative Dialogue. I reminded Richard and others on the call about the usual process we follow when running research studies: after the follow-up period in the study ends, but before any final results are made public, the delivery of the intervention stops. I explained that we take this approach because, despite our investment in the intervention, we do not yet know whether the intervention will be clinically effective or cost-effective. To continue would raise scientific, moral, ethical, and financial issues. Making this point drew us into a long conversation. Richard expressed that while he understood the trial process, he and his colleagues knew that the intervention was already working; they could see the difference it was making to clinical care every day. People providing Creative Dialogue based care knew that it was better than the alternatives. The frustration felt by Richard, Susan, and Clive was made clear.

Chapter 4: The CAG meeting

I joined the CAG meeting feeling much more prepared than in previous conversations. In my notepad, I had written an aide-memoire: *'How we make clinical decisions where there is a paucity of evidence. How do we account for personal opinions, strength of belief, political relevance, public opinion, and our practical judgements?'* At the meeting I introduced my paper, the situation we found ourselves in, and what advice we wanted from CAG. I also made it clear that I found the Creative Dialogue approach appealing: a position I was finding it easier and easier to hold. On reflection another reason I was stating my interest in the intervention so openly was to try to retain some of the complexity of what we were discussing; it would have been easy to lose a sense of nuance if we had rushed into a simple binary decision. Indeed, my CAG colleagues responded by recognising the complexity involved, the dilemma we faced, and the multiple voices. Although it was difficult, it felt incredibly important to me that we could discuss this issue in this way. We would have struggled more if we had rushed to arrive at a solution. We recognised that despite attempts to be 'scientific', there was a big difference between a neatly packaged intervention or a new drug, and the broad Creative Dialogue way of working.

I noticed that some of my colleagues appeared to be grappling with this, with one saying, *'Even if we like the intervention, we can't just do it because you think it is better, we have to <u>know</u> it is better.'* Richard retorted that the trust (perhaps he meant those of us in the meeting) was being myopic and deaf. *'If you don't let Creative*

Dialogue continue, there will be no team left after the trial, there will be no Creative Dialogue service,' he exclaimed. *'If we wait for the evidence, the team will be long gone!'*

The senior operations manager for the service argued that we should not rush headlong into implementing something before the trial results had been published: despite the power of the anecdotal evidence and personal testimonies, which should not be ignored, the research process could not be ignored either, and it was too early to adopt the treatment approach.

Richard was clearly frustrated and visibly unimpressed. With his head in his hands, he said: *'You say it's too early to adopt, but let's get serious — we do it now, or we don't do it at all, because we are losing people who can do it. Unless we do it now, we are going to disappear.'*

Making sense

Unlike the narratives in P1, P2, and P3, this one unfolded over a longer period; indeed, it was still unfolding at the time of writing. However, there are some thematic similarities. For example, in P2 I described how conflict can emerge when research findings seem to contradict individuals' experience, and in P3 I described how in the bureaucratic everyday, we get caught up in institutionalised patterns of interaction. I can see both these patterns in this P4 narrative. In P3, I also discussed the challenge I experience in simultaneously not wanting to collapse conversations and feeling relieved when a decision is made. In this P4 narrative, I described my attempts to contain my desire to oversimplify the issue so that a quick decision could be made. In the process of holding on to uncertainty and ambiguity, I found my position shifting, which I found uncomfortable. However, reflecting on this now, I am not sure whether my position truly shifted or whether my colleagues and I had created an environment where various positions were able to surface and be held lightly while we discussed their merits or disadvantages.

Some of the heat in my narrative arises from the tensions that emerge for me when I am confronted with conflict between two competing 'goods'. On the one hand, there is the necessity of impartiality in EBM; on the other hand, there is the necessity of critical engagement with the EBM discourse, which recognises that the idea of impartiality is problematic. In my view, the EBM discourse has the tendency to simplify complex issues in ways that are likely to compromise the quality of the work and dehumanise the process of relating. In my narrative, we found ourselves trying to balance different paradigmatic positions; efficacy, effectiveness, and evidence mean different things to different groups.

Creating a public realm

One way in which I engage with this tension, which echoes the insights gained from my previous projects, is by focusing on the importance of the quality of the conversation in the 'public realm'. This Arendtian term (Arendt, 1958:50) is briefly introduced in P2 as a place common to everyone, which appears whenever actions and speech take place. Canovan describes the public realm as *"a brilliantly lit stage on which common attention is focused"* where public action on concerns about the world can take place (Canovan, 1985:618). From Arendt's perspective, the phrase 'the world' represents civilisation as composed of buildings and machines, works of art, and lasting institutions.

My colleagues and I created a public realm where we could act on events arising in our 'world'; that is, our NHS organisation. In the public realm that we created, those in whose favour power tilted — my chief medical officer, Francis, me, and the clinical directors — expressed a need to be cautious about investing the time, resources, and energy required to adopt a new treatment approach outside the normal governance processes. Richard, Susan, and Clive demonstrated a zeal for the new treatment. I chose to put myself at the centre of events following a conversation with Francis, because I saw it as an opportunity to practise some of what I had learnt about myself and the complex responsive processes of relating during my participation in the DMan programme up until that point. Our conversation was ‘action’ in Arendt’s sense of the word; we interacted with one another, talked about our common concerns, proposed initiatives, and tried to influence events, and, through that process, we revealed ourselves as unique individuals, open to the judgement of our peers (Canovan, 1985).

Publicly, and especially in the written documents produced in our bureaucratic everyday, my organisation adheres to the principles of EBM. As mentioned in P3, this is an essential way of working that ensures that the NHS functions as expected, resources can be allocated, and outcomes can be recorded. One aspect of the simplification process of research that can be seen in my P3 and P4 narratives is, I think, acting as if this is the only way decisions should be made. It is certainly appealing to believe this; it means that work is orderly, controllable, and reasonable. It is perhaps also a way of managing risk and being ready to apportion blame should something unexpected happen. Yet, my narrative show that we found ourselves in a double bind, working in a way that on the one hand expects definitive proof (scientific evidence), and on the other hand recognises the implausibility of this expectation based on our actual experiences.

The bureaucracy of research

The governance arrangements for research (some of which I touched on in P3) reflect the desire for research to be governed in a way that is trusted by senior managers in the NHS, clinical staff, and the wider public. This means having not only rigorous academic standards but also transparent and standardised processes. Therefore, it was important to have a ‘public’ debate about how we needed to respond to requests to roll the intervention out more widely. Delivering research requires clear boundaries, especially when untested interventions are used. However, these clear boundaries fade and blur when we are doing the work.

These encounters are our organisational life, and we cannot escape becoming enmeshed in these interdependencies (Elias, 1978). Decision-making is not clear cut; we join in conversations that have been running for a long time, and which will continue without us when we leave them. My narrative demonstrates that despite pressures to make decisions, my colleagues and I found a way to immerse ourselves more fully in the challenge we faced and work through (or with) it. If there had not been this willingness to engage, I think that Richard, Susan, and Clive would have walked away from the meeting feeling as if they had simply disappeared.

Reification of research

Through this process of reflection, I can see that I might inadvertently (or, perhaps, with some intent) be falling into the same trap I am critical of. I am claiming that EBM can be viewed as a homogenous, unified position on the supremacy of one type of knowledge over another. Of course, some stark cases have shown that EBM is fallible; its problematic nature in the context of the misrepresentation of clinical trial results is well described by Jureidini and McHenry in their recent *BMJ* article, “The Illusion of Evidence Based Medicine” (2022). In this article, the authors argue that the ideals of good science and scientific integrity are threatened by corporations (in particular, pharmaceutical ones) in which financial interests trump the common good.

They also describe a threat to EBM that comes from the university sector, where academic leaders *"are forced to demonstrate their profitability or show how they can attract corporate sponsors"*. Academic leaders are equally sought out by industry for the influence and prestige that their university affiliation brings to the company (Jureidini and McHenry, 2022). In stark terms, they state:

> *"The preservation of institutions designed to further scientific objectivity and impartiality (i.e., public laboratories, independent scientific periodicals and congresses) is entirely at the mercy of political and commercial power; vested interest will always override the rationality of evidence."* (Jureidini and McHenry, 2022)

I also reflect that I might be reifying EBM in a way that creates an artificial dualism of EBM and practical judgement. In my narrative, while my colleagues and I try to approach clinical decision-making by following the EBM model, we are attempting not exclude the role of practical judgement. However, this is clearly a danger; practical judgement does get excluded. Davide Nicolini, a professor of organisational studies who specialises in information and social processes at the multidisciplinary IKON research unit at Warwick University, has written extensively about how healthcare managers use knowledge and evidence. He and his colleagues have found that while many healthcare professionals do use empirical evidence, those at higher pay scales are more likely to use practical evidence (local intelligence, benchmarking data, and expert advice), although NICE guidance and government clinical policy publications were important for decision-making (Clarke et al., 2013). These findings reinforce my reflection that behind the 'public' scientific narratives about how clinical decisions are made, there are 'hidden' practical judgement narratives at play. In my account, both types of narrative are woven into our detailed decision-making conversations.

Competing narratives

I remain intrigued by the simplified competing narratives of *EBM* and *doing things because we know they're right*. I wonder if there is a link between these simplified narratives and a lack of recognition, and if the less I and my colleagues feel recognised, the more rigidly we apply the rules we think we are working to. This certainly appears to have been the case in P3, and it could also be reflected in this project. I wonder if a sense of mutual recognition enables nuance and complexity to surface, allowing the relational nature of our work to be given more emphasis. I cannot help but think that an unintended consequence of research is that those participating in it, leading it, and contributing to it experience misrecognition and recognition at the same time. Perhaps, somewhat paradoxically, the more research is said to provide universal recognition (truth) the more it misrecognises the people who contribute to it.

Key reflections

I have four key reflections on my narrative:

Firstly, I can see that I have an appreciation of the capacity of those involved to sit with uncertainty and explore complexity together. At the heart of this capacity is my desire to ‘stay in relation’ while doing justice to the complex nature of organisational life. Haridimos Tsoukas, an organisational theorist says:

> *“We come close to grasping complexity when we restore the past to its own present and make distinctions that overcome dualisms, preserving as much as possible relationality, temporality, situatedness and, interpretive open-endedness.” (Tsoukas, 2017)*

I find this helpful. From this perspective, it is not possible to separate our historical, cultural, familial, professional, or personal experiences from how they dramatically shape the way we interpret and respond to the world around us. It is not only the importance of the past but also our imaginative acts of anticipating the future that embody the EBM quandary at the heart of my narrative.

Secondly, I notice (both in this narrative and historically) that at times I refrain from speaking up in the public realm (Arendt, 1958) in a way that could make a difference to the ongoing reconstruction of the dominant discourse. I often find myself in difficult predicaments about how clear a position to take in political situations; as I described in my first three projects, I have often used a network of colleagues to test my ideas first. In my previous projects I have recognised my position of acting in the shadow of others, yet in this situation I found myself unable to follow my usual ‘backstage’ process. After an event, I am often critical of myself for either speaking up in a way that was not helpful at the time or for not speaking up enough. To speak up means taking a risk and engaging with the potential conflict.

Through the DMan methodological process I am following, my supervisor commented that my experiences called out similar feelings and spoke about how it is sometimes easier to focus on collaboration than to ‘get one’s hands dirty’ by taking action that might be conflictual for a smaller minority. It is clear that the difficulty I face — judging how and when to speak — both resonates with others and reflects the challenges associated with working in an EBM way. By this I mean that speaking up might lead to disruption or conflict, especially when it challenges the simplified views held about EBM by bringing in more complex and nuanced ways of thinking about a situation.

Thirdly, the loyalties, roles, and obligations within the bureaucracies of the workplace affect our decision-making, and we might use these to both enable and constrain what we think and what we want to do. Recognition and misrecognition are important aspects to consider here. In relation to my narrative, it might be helpful to think of the loyalties, roles, and obligations within the concept of ‘thought collectives’ (Fleck, 1935): the proponents of Creative Dialogue have a type of group identity that impacts on how those within this thought collective interact with others. In this narrative, the ongoing negotiation of the status and worth of different kinds of knowledge reflects the situation in P2, where experiences of the same events are understood differently depending on the methodological or epistemological lens through which they are viewed. Paying attention to the complexity of a situation might allow us to think outside the limitations of the thought collective we find ourselves most comfortable in.

Fourthly, I notice how the conflict between empirical knowledge and practical knowledge or judgement plays out in relation to implementing evidence-based interventions. How information comes to be treated and used as evidence is relational. In a project led by Jacqueline Swan, Davide Nicolini and colleagues, which looks at how evidence is used in service redesign, the authors state:

> *"We have shown, as do others, that evidence-based redesign work is a socially complex activity, shaped by the application of certain capabilities, not just the type of information being used." (Swan et al., 2017)*

This makes it clear to me that the process of using an evidence base is both complex and social, despite appearing to be relatively simple when viewed superficially.

Making sense: summary

Creating and implementing 'evidence' is a complex, highly negotiated, social process, which requires those involved to speak and act, and thereby 'get their hands dirty' — or, worse, risk having them (metaphorically) chopped off. Reputations, integrity, money, and risk of inclusion or exclusion might all be at stake. In other words, we could achieve fame, fortune, and respect or face infamy and potential financial and professional ruin. The 'struggle' that I and my colleagues are experiencing is much more than an intellectual and philosophical one; the outcome of our conversations will have a real impact on our lives and, even more so, those of our patients. The contributions we make are shaped and informed by our experiences, beliefs, ideologies, thought collectives, and loyalties. All of these are brought into negotiations, whether overtly or hidden. It does not seem possible to hold simplistic or idealistic views on evidence purity, or to rigidly follow bureaucratic processes, without the potential to cause distress, irritation, conflict, or harm.

Animating questions

Bringing together the theorists I have identified as being relevant to my thinking in this sense-making process (Tsoukas, Arendt, and Nicolini) and those whose work has shaped my projects so far, my animating question is:

What are the ideological limits of evidence-based medicine in my organisation, and what happens when I and my colleagues reach them?

Theoretical explorations

The ideology of evidence-based medicine

To further explore the ideological bases of the experiences described in my narrative, I want to briefly look at two intersecting areas of research that are important when discussing EBM and the underpinning assumptions influencing how EBM is used. In doing this I will set out my assumptions about how research works, which are based on over 20 years of doing and managing research in the NHS. These assumptions fall into two main areas (1) the evidence on how to conduct clinical trials effectively, and (2) the 'second translational gap'.

Before doing this, however, I need to pay attention to my use of the word *ideology*.

Ideological beliefs

Through my research so far, I have formed a position that sometimes our actions and responses are shaped by our ideological beliefs. To understand this further, I need to answer the question 'What is ideology?' The term *ideology* has been in use for several hundred years and has been defined in different ways by various people (Sypnowich, 2019). However, there is a degree of consensus that an ideology is a body of concepts or the content and form of the thinking characteristic of an individual, a group, or a culture. As such, an ideology exists to confirm a particular socio-political viewpoint, to serve the interests of certain people, or to perform a functional role in relation to social, economic, political, and legal institutions (Sypnowich, 2019). Discussed by Claude Destutt de Tracy in the late 1800s, in the economic theories of Marx and Engels a hundred years later, by Mannheim in the 1930s, and by Althusser in the 1970s, the complex relationship between ideology and reality points to the human need for ideology. *"Ideologies are neither true nor false but are a set of socially conditioned ideas that provide a truth that people, both the advantaged and the disadvantaged, want to hear"* (Sypnowich, 2019). Through my first three projects, I have found differing 'sets' of socially conditioned ideas about how people use knowledge to serve their own interests (Klikauer, 2019) in my work and the conflicts I find myself in. The narrative in this project is no different.

Richard, Clive, and Susan (and other proponents of Creative Dialogue) were involved in the relational production of facts (or 'truth') from the thought collective they were a part of. At the same time, Francis, Eloise, other colleagues, and I were also immersed in the relational production of other facts that placed us in a different thought collective. However, what is important is that there was considerable overlap between these thought collectives. We were (and remain) in relation; we have shared in exploring the conflicting priorities of our work; and recognising these allowed us to continue to meet, discuss, and find some common purpose. It is important that, when drawing on Fleck's concept of thought collectives, we do not use his theories to simply critique or denigrate a particular ideology (especially, in my case, one I find myself disagreeing with).

Although Fleck does not write about ideology as such, the creation of 'facts' or 'truths' through ideological beliefs is a functional outcome of belonging to a thought collective. Returning to Arendt, in her 1967 *New Yorker* article "Truth and Politics"

(Arendt, 1967), when she talks about ‘truth’ she is generally clear on what kind of truth she means: historical truth, philosophical truth, trivial truth, real truth, hidden truth, old truth, rational truth, mathematical truth, half-truth, absolute truth, or factual truth. Arendt makes it clear that there is no ‘*the* truth’, and this abstract concept is transformed into something that shapes political action. Arendt continues her argument that ‘truth-telling’ is related to our understanding of the common realm of human existence, and how we share our thinking and experiences with each other (Arendt, 1967, Hill, 2020). This goes some way to explain the overlapping thought collectives that my colleagues and I are part of.

Arendt’s term ‘factual truth’ may help us further. She describes how facts and events are the outcomes of living and acting together, the record of which is woven into our collective memory. These records, and whether we challenge or uphold them, give us a sense of durability in the world. These factual truths build a common ground for us to stand on, so that each individual can share their experiences and make meaning from them. For me, Arendt’s concept of factual truth strongly aligns with Fleck’s concepts of a truth emerging from a thought collective, where what is true for one thought collective is not necessarily true for another. It perhaps also goes some way to explaining my claims that my colleagues and I belong to multiple thought collectives at work; we are immersed in our NHS world together, and given the relational nature of this, it is inevitable that despite our differences, common ground (and perhaps a common purpose) emerges.

This common ground might cause us to think of the NHS as a monolithic entity, however; and, as I have emphasised in my previous projects, it is far from this. In reality, there are many linked and interdependent identities within individual teams, hospitals, and wider organisations. I have argued that these different identities are ideologically formed (they can also be formed in other ways, for example, through a shared purpose or role), and in Fleck’s terms, that they create thought collectives or thought styles.

Stacey and Mowles (2016) describe the role that ideology plays in sustaining and maintaining power relations, drawing attention to the binary oppositions that characterise different ideologies. They argue that, at its most basic level, ideology serves to maintain a distinction between ‘us’ and ‘them’. Therefore, an ideological position is a form of communication that preserves the current order of things, ensuring that this current order seems natural (Stacey and Mowles, 2016:406-408). As I have argued, an outcome of a set of ideological beliefs could be the creation or joining of a thought collective. Therefore, I think that ideologies and thought collectives maintain and preserve the established power relations within the dominant discourse on EBM in the NHS. I must point out, however, that this statement is in itself a simplification.

In my narrative, I described how my colleagues and I sat with the discomfort of allowing the complexity of the situation to surface. On reflection, this gave me the space to try to think beyond the usual boundaries that constrain and enable my thinking. I was simultaneously pleased with and troubled by the outcome of the meetings I organised: pleased because of my interest in complexifying the situation, but troubled because others (Richard, Clive, and Susan) might not have agreed with the outcome at this point. Agreement (or otherwise) should not be underestimated because, as Fleck emphasises, it is not *often* possible to think outside the ideological position, thought styles, or vested interests that dominate: *"The individual within the collective is never, or hardly ever, conscious of the prevailing thought style, which almost always exerts an absolutely compulsive force upon his thinking and with which it is not possible to be at variance"* (Fleck, 1935:41)

Further, when we consider how ideologies maintain and sustain power relations, it is even harder to be aware of and reflexive about one's thought styles. However, such increased awareness or reflexivity might allow one to see more of the competing values or needs that are at stake for the plurality of people involved, and this may create disruption or conflict. This raises questions for me about what this means for clinical trials and research, and for working in an EBM way.

The evidence for effective conduct of clinical trials

Research is central to the NHS. Its modern foundations are built on the principles of EBM, and NICE sets clinical standards for care (referred to as NICE guidelines) based on the best quality evidence available. NHS trusts are encouraged to be research active, and this forms part of the regulatory inspection process. The Department of Health and Social Care has invested billions of pounds over the years in research infrastructure and research activity through its National Institute for Health and Care Research (NIHR), which has a direct influence on how NICE guidelines are produced and updated.

My team has been a continuous beneficiary of NIHR funding: the JOURNEY trial itself, and my team (which has supported the trial's delivery) are funded in this way. The success of clinical research in the NHS depends on the ability of research teams, including mine, to recruit sufficient numbers of participants into individual clinical trials. As such, even if a clinical trial is well designed and well funded, it will fail to meet its aims and objectives if it is unable to recruit suitable participants. Evidence suggests that recruitment problems occur in up to 63% of all clinical trials (Treweek et al., 2018), so it is clear that this is not an isolated problem. The body of research built on by Shaun Treweek (a professor of health services research) and his colleagues is largely focused on improvements in methodology and trial delivery that are believed to make research more successful. In this body of research there is often a focus on technical methodological aspects, such as better participant information sheets, remote (rather than in-person) follow up, and digital engagement to ensure that participants remain in the trial until it concludes. What stands out in this body of literature is how little attention is paid to relational dynamics in this work.

Traditionally, academics and clinicians work together to design and conduct research in the NHS. When the results are favourable, demonstrating efficacy and efficiency, they are likely to submit the results for inclusion in NICE guidelines or best practice guidelines. Occasionally, research outcomes are implemented prior to inclusion in any national treatment guideline, especially when the project has significant local engagement. Either way, an ‘industry’ exists within every NHS trust to support the implementation of new research or guidelines into clinical practice. In my organisation, this highly bureaucratic world involves committees, audits, reviews, and reports.

Most research activity in the NHS is entirely separate from the implementation activity, which often happens years later. My narrative describes why this is the case: when the research is happening, the outcome is unknown. Therefore, within the EBM approach, it is not appropriate to implement a new intervention until the published evidence suggests it is clinically effective and cost-effective to do so and, ideally, until the relevant NICE guideline has been updated to include the new intervention.

Today, when an intervention has been found to be effective, it is generally acceptable to revise clinical practice to incorporate it ahead of its inclusion in a clinical guideline. However, this is often a complex change process involving clinicians, healthcare managers, and commissioners; on average, the process takes between 10 and 20 years. This delay is described as a ‘translational gap’ (Morris et al., 2011).

Translational gaps in healthcare research

Over the past decade, there has been growing concern about the translational gaps in healthcare research. The first of these gaps is often thought of as the gap between bench science and applied health research. This has been referred to as a ‘rift’, a ‘valley of death’, and a crisis (Seyhan, 2019), and it emerges when basic scientific laboratory research is not ‘translated’ into research that allows treatments to be tested. As described above, the second translational gap is the gap between research and its implementation into clinical practice.

The time taken to implement research (the second translational gap) has not gone unnoticed; in 2006, the UK Government invited Sir David Cooksey to undertake an independent review that would advise on the best design and institutional arrangements for the public funding of health research in the UK (Cooksey, 2006). This review had far-reaching and profound impacts on how clinical research is done in the NHS. It laid the foundations for the establishment of the NIHR and new funding streams, and it formally recognised the second translational gap and made proposals to reduce these delays. To address the issue of research appearing to be conducted without concern for its practical application, an academic industry has emerged to understand what causes the second translational gap and what can be done to ‘close’ it.

One notable systematic review of complex intervention implementations was led by Elizabeth Murray (an emeritus professor of ehealth and primary care, and clinical director of the Institute of Healthcare Engineering at University College London) and Bie Nio Ong (a professor of health services research at Keele University and a former non-executive director in the NHS). In a presentation they argue that:

> *“To apply something new in [an NHS] setting is challenging because 1) the NHS is a highly complex organisation with different systems and*

> *ways of working; and 2) these new ways of providing health care are usually complex interventions, i.e. consist of multiple components" (Murray and Ong, 2015)*

In the full review, they describe a 'four-level model': external context, organisation-related factors, professional roles, and the intervention itself (Lau et al., 2016). Although relationships are mentioned specifically with regard to 'organisational' factors, it is clear across all factors. The authors (Murray and Ong, 2015, Lau et al., 2016) use the term 'underlying philosophy of care', which they define as incorporating the personal styles of health professionals; the relationships between health professionals; the perceived fit between the intervention and the preferred style of clinical practice; and health professionals' communication style, personality, and philosophical opposition or support of the intervention. In my narrative, it seems to be clear that our struggle with how to (and whether to) implement the intervention is still some way from what can end up feeling like an abstract academic debate. Every day in my organisation (and, I presume, across most of the NHS), work continues to review and implement new interventions and practices, and these efforts are caught up in complex relational processes that often defy the theoretical classifications made by academics. In my narrative on the discussion about how to proceed and make a decision, we did not appear to consider Richard's underlying philosophy of care, but focused on abstract concepts such as the safety of the intervention. Another way to describe a person's underlying philosophy of care would be the thought collectives that someone belongs to, and their ideological beliefs. I will come to this point in more detail later.

In the context of the JOURNEY project, my colleagues and I found ourselves in an interesting position. The frequently separate series of activities associated with doing the trial, followed by a pause and then the implementation of the trial results, were conflated due to the enthusiasm for the intervention expressed by some. At the same time, others made attempts to separate the research from the implementation (and I was in this group at the beginning of the process). An emerging group I found myself leading tried to find a different way — one that protected the integrity of the trial while allowing for thoughtful exploration of how the work could proceed in a less constrained way.

The social process of designing research, recruiting participants, and presenting findings produces concrete artefacts that later dominate decision-making, and this can be described as the 'reification of evidence'. Reification has different meanings. Honneth describes it as a *"forgetfulness of recognition"* (2005a), and this resonates with my narrative in this project. However, reification may be more than this, and as Timo Jütten (2010) argues in his critique of Honneth's work, we should not ignore the social-historical context in which reification might have occurred. The process of reification I am describing extends far beyond research, reaching into everyday organisational activity, and this is demonstrable in my efforts to produce an official document. It is not surprising that this happens, especially considering Fleck's (1935:41) argument that once we are immersed in a thought collective it shapes how we work and how we relate, while making it difficult for us to see this happening. I will now explore reification in more detail, including what function it may serve.

The reification of evidence-based medicine

When it comes to clinical trials of healthcare interventions — especially treatments for mental illness — complex, dynamic and interactional events are often (and out of necessity) subjected to a type of reductionist process. Indeed, we have to do this, because it would be impossible to study everything in a single inquiry. What is important, then, is how the complex and ambiguous relationships are described in *"manageable terms"* (Säljö, 2002, referencing Hacking 1999). Säljö, an educational psychologist whose research focuses on the socio-cultural perspectives of human learning, argues that there is a tendency among researchers to use metaphors, analogies, and terms that describe human activity in terms of physical objects (Säljö, 2002). He continues:

> *"The interrelationship between science and common-sense […] is quite intriguing. There is a kind of intertextuality in the Bakhtinian sense where everyday observations and scientific accounts converge and co-determine each other. For a scientific theory to gain widespread acceptance, it has to accord with features of common-sense notions, and it is precisely here that a ["]things ontology["] may serve as a device for grounding observations and claims in something that is tangible and concrete." (Säljö, 2002:400)*

This quotation explains something of how the metaphors and analogies that make up human action are thought of in terms of physical objects. I understand a 'things ontology' to mean either that we study objects instead of activities, or that we make objects in the process of studying activities. The complexity here, though, is that our research-based concepts or conversations have a material impact on what we do. Säljö's reference to Bakhtinian 'intertextuality' is another way of describing how a thought collective develops; that is, new knowledge is socially derived from historical knowledge. As described in P2, one of Bakhtin's (1984:182) claims is that we cannot understand a written work as if it is singular in meaning, because it is connected to previous historical and social uses. Säljö's (2002) argument that for a scientific theory to become more widely accepted it needs to accord with common sense is helpful when thinking about what might be going on in relation to the JOURNEY project (and perhaps more widely). The convergence of the theory of Creative Dialogue with the everyday common-sense experiences of my clinical colleagues and the scientific research methods of EBM is dissonant. Perhaps we were forgetting to recognise the differing historical and social contexts of the things or activities we were trying to promulgate. Although we were collectively trying to resist the simplification of the decisions we needed to make, there was a clear demarcation between the differing ways of thinking. In other words, there were at least two clear thought collectives in a dynamic power struggle. Those immersed in the Creative Dialogue work had power tilted away from them as the relationships and conversations of the EBM thought style were bolstered by claims of being scientific, neutral, objective, and, of course, representative of the prevailing way this type of work is done.

This demonstrates that research is not neutral, as Fleck (1935:102) emphasises in his description of how a thought style covers the meanings of words and that those meanings convey ‘truth’ and ‘facts’. These facts — or truths (Arendt, 1967) — are considered by members of the collective not as something formed by people but as ‘objective’, historical, and at the same time having contemporary relevance (Fleck, 1935). This embodies my own thought processes at the time. For political reasons, I was taking a position that held clinical trial research methods to be objective, not formed by individuals but having a kind of eternal truthfulness. Reflecting on why I might have thought in this way, there may be similarities with reasons I have described before: being lured into a sense of certainty, order, and control.

When I and my colleagues become forgetful of the intricate, dynamic, and relational nature of research activity, it seems that we deny that EBM itself is equally relational. In a later work, Fleck argues that scientific instruments can embody some results of a thought style, which can lead to thinking ‘automatically’ in a particular thought style (Fleck, 1986, Wojciech, 2021). It may be possible to take this one step further: ‘scientific instruments’ could also include the ‘scientific research methods’ that underpin EBM. In my narrative, we found ourselves patterning the relational dynamics of the EBM thought collective — that is, a focus on creating evidence products to use in our everyday activities.

The tendency to use research and research evidence as if it were concrete, neutral, and objective has consequences for the way my colleagues and I work, and my narrative demonstrates this. In something of a paradox, peer-reviewed published papers and guidelines have both a finite and an ever-changing dynamic nature. Published results reflect a fixed point in time and aim to give a definitive position, but much of the health services research concludes by recognising the need for more research.

In my narrative and, more generally, in my organisation, my colleagues and I fall into a way of thinking and working that reifies the results of research; that is, by treating research results as if they were concrete and objectively true. The outcome of this way of thinking is that it is easier to understand, plan, control, and deliver our services. At the same time, and as my experience of working with Richard has reminded me, my clinical colleagues are making dynamic decisions based on how a patient presents, using their experience, evidence, and sometimes their political judgement. This has prompted me to think more carefully about evidence use in my organisation, in particular who evidence is for and how it is used.

Nicolini and colleagues (2021) sets out that in practice, clinical service planning decisions rely on far more than ‘scientific evidence’, with other sorts of ‘practical evidence’ (case studies, opinions, budgetary information, etc.) being essential. He continues by arguing that despite supporters and sceptics of evidence-based practice having radical differences of opinion on what constitutes the ‘best type’ of evidence,

> *“authors in both camps often share a common view on the entity-like nature of evidence. In short, they talk as if evidence were a sort of substance — a body of facts or information with immutable properties or attributes that can be stored and deployed at will. This, however, contrasts with the view that in clinical work, as well as healthcare management and commissioning, what counts as evidence is disputed and subject to debate, conflict, and controversy.” (Nicolini et al., 2021)*

Here, Nicolini draws attention to the level of conflict that surrounds making evidence-based decisions and, importantly, the ease with which ‘evidence’ is reified by people across a wide ideological spectrum. He goes on to say that:

> *“diverging interpretations of the same body of evidence can be observed between individuals within one group and between groups and professions. (Dopson et al., 2002:42). Similarly, Hendy and Barlow (2013) find that managers re-interpret evidence to align it with existing professional practices and needs — rather than the other way around.” (Nicolini et al., 2021)*

This divergent understanding of the same ‘truth’ echoes Fleck’s work on thought collectives, and it is perhaps in the process of interpreting evidence that we begin to see it solidified into a thing. The acts of interpretation and implementation, both essential aspects of evidence use in the NHS, turn the social, dynamic process of research into objects that are fixed in time. This process of the reification of research is clear in my narrative. On the one hand, I was attempting to create an objective, reified official document setting out our organisational position; on the other hand, I was attempting to recognise that Richard and his colleagues were immersed in the dynamic experience of Creative Dialogue and the JOURNEY project.

Engaging in conflictual conversations about science and evidence means that recognition, or rather misrecognition, remains a plausible outcome. Richard’s anxiety that he and his team would just disappear if no progress was made speaks powerfully to the idea that to engage in EBM means to engage in the risk of harm arising, either as direct conflict or as subtler misrecognition.

As I continue to reflect on my narrative, I wonder if I, and some of my colleagues, were hiding behind ‘the evidence’ to help make decisions more easily and to avoid exposing ideological differences with other colleagues. This could have been a tacit ‘work to rule’, whereby we turned the rules that frustrate us to our advantage (something that resonates with my reflections in P2). However, in hiding behind the evidence (or lack of evidence), we risked exposing our ideological differences in a more conflictual way, without creating the processual space to understand what we were actually doing.

Moving beyond the ideological limits

Elias, whose work I have turned to a number of times, is clear in his critique of sociological categories and conceptualisation. His idea of ‘process reduction’ is an attempt to describe the tendency to reduce processes to states. This rationalisation is pervasive; in the language of everyday life, Elias writes:

> *“We say, ‘The wind is blowing’, as if the wind were separate from its blowing, as if a wind could exist which did not blow” (Elias, 1978:112)*

I have noticed that this tendency to reify everyday experiences also happens when we do research. For example, the intervention referred to in my narrative is a conversational process that takes place over 12 months, yet for the purpose of studying it, it is described as a series of discrete steps. As Nicolini describes, and as my narrative demonstrates, it is not surprising that through the process reduction involved in creating evidence, we make distinctions between the individual and their activity, between structures and processes, and between objects and relationships. We refer to dynamic and interdependent objects as static and isolated. This process causes conflict through our propensity to reify the outputs of research, yet we use it in an attempt to manage the ideological differences that emerge every day and are present in my narrative.

Ideological boundaries

My animating question had two parts to it: (1) understanding the ideological limits of EBM, and (2) understanding what I and my colleagues did when we reached these limits. So far, I have explored in some detail what the ideological limits of EBM might be; now I want to turn to the second part of my question. Of course, it does not seem possible to think about ideological limits without at the same time thinking of how we should respond when we recognise we have reached them. I do not think ideological limits are fixed, but that they are boundaries created by our habits, experiences, and the thought collectives we belong to. In the situation described in my narrative, I simply could not accept we had reached an impermeable ideological boundary while not also thinking about how we might navigate this new territory together. By ‘together’, I do not mean some sort of idealised harmony, but a collective recognition of the different limitations we were all facing. On reflection, Richard and his colleagues were adept at moving beyond the ideological limits imposed on us — by ourselves, by those we work with, or by the principles of EBM. Here, I am not suggesting that EBM has agency (although in conversations with colleagues it might sound as if we think it has); rather, I am recognising how easy it is to fall into a ‘process reduction’, reified way of thinking. This may be due to our longing for stability, ease, safety, or control. This longing might make it easy for us collude with reified notions, especially those which then marginalise the relational complexity of the situation. In spite of the broadly empirical/positivist methodological foundations of clinical research, including the JOURNEY project, being involved in it has a relational complexity that cannot be dealt with through these simplifications, but requires practical judgement.

This raises a question about what I mean by ‘practical judgement’. According to Elias, social life is both ‘firm’ and ‘elastic’. He writes: *“Crossroads appear at which people* *must choose, and on their choices, depending on their social position, may depend either their immediate personal fate or that of a whole family, or, in certain circumstances, of entire nations or groups within them"* (1991:49). This choosing at a 'crossroads' captures the complexity of practical judgement: we are faced with decisions arising from the interwoven and unpredictable nature of our relationship. Power, opportunity, ambition, and limitations emerge in an uncontrollable way in the complex responsive processes of relating that we experience every day. At a decisional crossroads, we have to not only decide what *end* we want to achieve but also reflect on and determine whether this particular *end* is consistent with our overall *end*, our values, or our ideologies.

One way of looking at my narrative is as an account of a process of bringing an EBM approach — a conscientious, explicit, and judicious use of current best evidence — to our management decisions. This, along with a challenge from my community of inquiry, prompted me to look at some literature from organisational management studies (OMS) where practical judgement (*phronesis),* with its roots in Aristotelian dialogue, and the associated concepts of praxis and poiesis, have been taken up.

John Shotter, a psychologist, and Tsoukas, have written several papers (both together and separately with other colleagues) on 'practical judgement'. In their paper "Performing Phronesis: On the Way to Engaged Judgment" (Shotter and Tsoukas, 2014b), they argue that practical judgement, rather than being hidden inside the mind, is best talked of as something that emerges in the flow of activity that people who are doing things are immersed in. When practitioners (in the context of the paper, this means managers) face a bewildering situation in which they are unclear about how to proceed (at least initially), the judgement they exercise emerges from efforts to establish a new orientation to the situation they find themselves in. They explain (Shotter and Tsoukas, 2014b:377) that this process of orientating their response involves practitioners *"actively trying to be in touch with their felt emotions and moral sensibilities, while attempting to articulate linguistically the feelings experienced in order to get a clearer view of relevant aspects of the situation at hand"*. They describe the type of fluidity involved in coming to a judgement as *"moving around within a landscape of possibilities",* with a spontaneous responsiveness to the consequences of each move and assessing the best way to proceed.

I am intrigued by this paper, especially the authors' description of 'judgement' as a concept that primarily reflects individual mental states or psychological traits. It is as if judgement is reified in both the way Honneth uses the term — we are forgetful of its intricate, dynamic, and relational nature — and in the more traditional sense of the term, where qualities become concrete things that one can acquire and use in a controlled way.

Shotter and Tsoukas conclude this paper by writing:

> *"as we hope we have made clear, the process involved as to how to act in an otherwise bewildering circumstance is not a simple matter of*

> *decision-making or problem-solving, but of resolving on, or focusing on, a best line of action as the result of an inner process of imaginative exploration of the possibilities available within whatever particular situation the actor, at any one time, happens to be in. Such possibilities come to light only in that exploration, they are not available prior to it.” (Shotter and Tsoukas, 2014b:392)*

As is evident in my narrative, my colleagues and I learnt about our ‘life’ together by exploring it — not through rushing to a simplistic or narrow response, but through attempting to notice or anticipate what was happening. However, one thing that stands out for me is the potential for conflict to arise between using practical judgement as described above, and the principles and practice of making clinical decisions led by an attempt to rigidly adhere to the principles of EBM. This was never the intention of the EBM movement, and the need to use proficiency and judgement, is described by Sackett et al. (1996) in their seminal publication on EBM. However, there is some consensus that EBM is sometimes used in rigid ways — especially for non-pharmacological interventions, as Greenhalgh and colleges describe: *“EBM’s experimental, intervention-focused, checklist-driven, effect-size-oriented and deductive approach has sometimes confused rather than informed debate”* (Greenhalgh et al., 2022).

In an earlier paper, Tsoukas, along with Jorgen Sandberg, a professor of management and organisation, (Sandberg and Tsoukas, 2011) describe a tension in applying scientific rationality to management decisions in organisations. They argue that the scientific rationality that underpins many management theories is radically different from the way organisations run. For me, this has a strong resonance with the way my colleagues and I initially took an EBM, scientifically rational approach of objectivity and deductive logic in our management decision-making.

Sandberg and Tsoukas’ (2011:339) main claim is that ‘scientific rationality’ actually prevents researchers from developing theories that capture the ‘logic of practice’ and, as a result, these theories do not connect. While Sandberg and Tsoukas are writing in response to management and organisational theories, what they describe clearly resonates with my experiences of interacting with EBM in the NHS. This gap between theory and practice is, as I described earlier, the second translational gap.

Summary: Part 1

Something I have previously noted, and that Sandberg and Tsoukas (2011) draw attention to, is that research conceptualises as atemporal. It abstracts away from the temporal flow of what happens day to day, diminishing the practical necessities, uncertainties, and urgencies that emerge daily in order to find timeless or placeless truths. The result of this, the authors claim, is that the organisation management’s research process artificialises the subject through abstraction and process reduction; all that matters is stripped away. Again, this resonates strongly with my experiences at work, which are reflected in this narrative and my P2 narrative.

Sandberg and Tsoukas (2011) alternative to scientific rationality is a methodological approach that consists of searching for entwinement is a way that reveals the relational whole of the situation. From this, practitioners are able to go through a process of thematic deliberation and reflection on their experiences. This methodological approach is not significantly different from the methodological approach I am taking on the DMan programme.

Although the work of Tsoukas, Sandberg and Shotter resonates with me, I feel that a little caution is required. It would be all too easy to idealise an alternative to scientific rationality. Yet in my organisation (and perhaps the wider NHS), we cannot escape the historical and current place that EBM and its underpinning scientific rationality have in health services across the world; indeed, it has provided major breakthroughs in treatments for many diseases. As such, we have both a scientific rationality *and* a practical rationality.

When I think about the design of the JOURNEY project, scientific and practical rationalities seem to be interwoven: attempting to use methods from deep within the scientifically rational world of health research to prove a treatment that relies on practical judgement may be an act of genius, an unintended consequence, or destined for failure — or all of these. The risk here is that purists from each side (scientific rationality / practical judgement) might argue that this approach is theoretically inconsistent and therefore problematic. This perhaps mirrors the breakdown in my practice that I describe in my narrative.

Ann Cunliffe, in her provocatively titled paper “Must I Grow a Pair of Balls to Theorize about Theory in Organization and Management Studies?” (2022), begins with a critique on the “*ontological blindness*”, epistemological defensiveness, hegemonic masculinity, and myopic self-referentiality that are present in so much of the research that takes place in OMS[3]. Cunliffe (2022) goes on to argue that within OMS there needs to be more recognition of the importance of a plurality of ontologies and epistemologies. She then advocates for what she calls ‘subjective and intersubjective ontologies and epistemologies’, arguing that it is possible to theorise ‘humanly’ by developing sensibility (knowing from a human point of view), sensitivity (responsiveness to unique, living moments where new possibilities arise), reflexivity, and imagination (Cunliffe, 2022:11-12).

Cunliffe touches on something important here, which is consistent with my reflections on the work of Shotter and Sandberg: participating in a plurality of ontologies and epistemologies in our ‘everyday’ is inescapable. In the context of this project, I mean that we should somehow simultaneously hold scientific and practical rationalities in mind. The danger here is that our conversations and decision-making might become opaque, as demonstrated in my narrative when the issue we were responding to was pushed through multiple committee meetings, papers, and reports. What is important then, is that I keep trying to create an environment where we can have a plurality of

---

[3] Although I did not articulate it in this way, this was a clear finding that emerged from my MSc research in relation to suicide prevention research.)

views, while also reflecting on the impact of this together. In addition, it is worth noting that plurality may also manifest as a split between certainty and uncertainty. When a conversation becomes oversimplified, it becomes a choice between doing the 'right' thing (following the evidence) and staying open to new, potentially better, ways of doing things.

In this project I have touched on how my colleagues and I attempted to navigate ideological differences. While at times this felt like an instrumental process that I and others attempted to control, I (and, perhaps some of my colleagues) had to face uncertainty, feelings of loss of control, and conflict. Allowing the situation we were in to complexify enabled us to move away from our initial attempts to pursue a more simplistic understanding of our situation. I found that in paying attention to the relational, holding a simplistic understanding became untenable after a while, because it was not possible to dismiss the competing 'goods' of following the evidence and of doing what was right for individual patients needing our care.

We should consider our thinking when we are caught up in decisions that seem to be poorly served by the accepted evidence, and this is apparent in my narrative. On reflection, my attempts to enable reflexive thinking to deal with the situation we were immersed in could be seen as attempts to instrumentalise and control the situation. However, by trying to use political skill, employ ethical judgement, and consider a plurality of views (the differing truths from different thought collectives), we established a more processual space to enable our decision-making — despite the difficulties and emotions involved. The outcomes of all the conversations and meetings we had about Creative Dialogue would have been very different had we pursued a purist EBM ideology; Richard might have left and the JOURNEY trial might have collapsed as a result. Yet, with Richard's tenacious and persistent drive, and despite the ideological differences and the seemingly high stakes, we had a collective interest in being fully present in the challenge and in our efforts to find common ground.

It sometimes seems that the dominant and public discourse of EBM in the NHS marginalises or diminishes the acceptability of using practical judgement — or, at least, using it publicly or transparently. I also experienced how following the evidence felt totalising. Perhaps EBM appeals to us in these uncertain times precisely because it locates judgement informing decisions about health rationing in the 'evidence' and in bodies such as NICE, rather than in individuals. This may ameliorate the anxiety that managers and politicians feel when they have to account for the allocation of treatment and the associated risks of public shaming: *"I'm just following the rules/orders/evidence"*.

I also think that an idealised use of EBM may make it difficult to include practical judgement, because doing so may erode the belief in the 'objective' nature of the work. Yet practical judgement can include the products and processes of EBM where it is felt to be appropriate. In the conversations where practical judgement appears to be more prominent, it seems possible to discuss multiple and conflicting accounts of knowledge and experience. Conversely, the bureaucratic nature of EBM means that once a problem has been clearly articulated, the primary course of action is to prove or disprove a particular response through scientific or empirical methods. In practice it is undoubtedly more complex than this; EBM is open to contestation — indeed, a frequent lament is that despite ‘best evidence’ existing, it is not always easily adopted and decisions are made based on individual cases of patient benefit, clinical preferences, or both.

Summary: Part 2

Explanatory hypothesis emerging from my reflexive and abductive inquiry

EBM is social, political, and ideological, and this is something I have not paid sufficient attention to so far in my work. In the way Fleck describes, to which I have drawn attention in this and my previous projects, I am fully immersed in a particular thought collective; I have thought of the EBM process as something that is objective, is beyond doubt, and gives results that are truthful. I also recognise that I tend to think in this way, and my research has enabled me to see this. EBM is political and ideological; therefore, taking the ideas of plurality and perspective seriously is important. EBM is also a structural part of the NHS, governed by legislative and policy statements, so the struggle in my narrative about whether we can be certain that what we are doing is for the good of our patients becomes our everyday work.

In my research I found it hard to challenge the ideological basis for EBM. I found that in doing research we need both the *wriggle room* and the *bureaucracy* to be successful in our work; we cannot ignore the place that EBM has in running NHS services. The ever-increasing costs and demands placed on the NHS require those who are managing and leading within it to plan, procure, and run services that provide the highest quality for the best value. They must do this while avoiding duplication, inefficiency, and waste. The expectation is that decision-making is based on evidence; indeed, the duty to use evidence from research has been enshrined in UK healthcare legislation for many years.

However, it is not enough to only work in the EBM paradigm; we have to recognise that we are both constrained and enabled by it. The EBM paradigm is a simplifying discourse. Although research that takes place within the paradigm is far from simple, the ultimate aim of clinical trials is to prove or disprove that a particular treatment or treatment approach is efficacious and efficient. Nevertheless, clinical service planning and decision-making are complex tasks, as my narrative shows. People (in this case, Richard, Susan, and Clive) can be fully engaged and immersed in delivering a clinical trial while simultaneously having powerful experiences of an intervention working (as a placebo or otherwise). This both expedites the aims of research, while at the same time negating the need for it.

Based on my narrative and my exploration of it, we could broaden our understanding of what 'working within the EBM paradigm' means. I believe we should pay far more attention to the processual and social nature of research when it comes to deciding how to proceed with a trial or the implementation of research evidence. We also need to consider the role that doubt plays when creating or using research evidence; while one aspect of this is equipoise, When working with EBM, we need to find ways to accommodate a plurality of views, paying sufficient attention to the relational nature of these.

The processual nature of research includes recognising the loyalties, roles, and obligations within the workplace that affect our decision-making. Engage fully and with reflexivity can allows us to think "without a banister" (Arendt and Kohn, 2021). By drawing attention to the relational dynamics of the inclusion in and exclusion from different thought collectives, we are more able to navigate what emerges (conflict, recognition/misrecognition, violence) when we work. As I think about my themes of ideology, recognition, and violence across my first three projects, I can see their relevance in this project and in the context of the day-to-day activities involved in EBM.

EBM is clearly political; nevertheless, my experiences and my previous narratives show how readily my colleagues and I attempt to treat it in an apolitical way. The idea that 'good science' is not political (but is just good science) is an ideological position that has emerged from a particular thought style. It is important to consider, then, that doing research and using research are both political. However, even after taking this into consideration, we need to remember that this view might not be helpful if we, as Nicolini says, forget that evidence is not a thing, but a process through which we make decisions.

Guided by my animating question from my narrative and sense-making, and as a result of my theoretical work, I have described and explored the ideological limits of EBM in my organisation. In terms of what happens when we reach these limits, I have found that my colleagues had the capacity to sit with discomfort and challenge, and were willing to explore the implications of such ideological limits.

Postscript to Project 4

I had a conversation with Richard after he and his team had read this project. He described feeling incredibly honoured to have been recognised in this way and impressed by how I had turned his *'sometimes incoherent rambling'* into an account of events in which he felt seen, listened to, and understood. I mentioned that I thought that my committee colleagues and I had done a good job at creating an environment where the intervention could continue outside the trial itself. Richard pointed out that although on paper that was indeed what it looked like, little progress had been made due to an unwillingness to release any funding to do more. He said that he and his colleagues still felt sad and angry about how such an opportunity was being squandered by the organisation — not because of the evidence issues, but, he assumed, because people in positions of power liked neither him nor the intervention.

Synopsis

Introduction to the synopsis

The format of this synopsis is straightforward. First, I will introduce the theory of complex responsive processes of relating and its relevance to my work in the UK's National Health Service (the NHS). Following this, I will set out my method and my deliberations on the ethics of my work. I will then present reflexive summaries of my four projects from the vantage point of being at the end of my participation on the DMan programme. My arguments will follow this. I will finish by setting out what I see as my contribution to theory and practice, and some areas for further research.

Complex responsive processes of relating

My research draws on the ontological, epistemological, and methodological positions of ‘complex responsive processes of relating’*.* This radical manifestation of the complexity sciences emerged in response to a growing dissatisfaction with systems thinking, instrumental management tools and models, and change management programmes.

The theory of complex responsive processes of relating is concerned with phenomena that are in a state of flux and change over time. It is focused on how global patterns arise from micro-interactions, and how micro-interactions form global patterns. It challenges the idea of the rational, autonomous individual which dominates much of the management and systems theory that impacts how the NHS runs (Mowles et al., 2010).

Developed by Ralph Stacey and colleagues over 20 years ago (Stacey et al., 2000) complex responsive processes of relating is a perspective that provides an understanding of what happens in organisations by drawing together four theoretical traditions: (1) the complexity sciences, (2) Norbert Elias’ process sociology, (3) pragmatic philosophy, in particular that of Peirce, Mead, and Dewey, and (4) the group analytic tradition set out by SH Foulkes.

Complexity

Complex responsive processes of relating builds on an understanding of evolutionary complex adaptive systems (CAS) models. CAS models are theoretical frameworks that are used to understand and analyse complex systems (Stacey and Mowles, 2016:319-320). These models emphasise that complex systems are dynamic and adaptive, with multiple agents or actors interacting and influencing each other. They are characterised by emergent behaviour, where patterns and structures arise from the interactions of individual agents. In addition, CAS models emphasise that complex systems are constantly evolving and changing, and that the behaviour of a system as a whole cannot be predicted from the behaviour of individual agents (Mowles, 2021:18-30).

Complex responsive processes of relating takes CAS models and builds on them by analogy, recognising that the ‘agents’ involved are humans, who have different life histories, who have dynamic desires and hopes for the future, and who are involved in power dynamics that shape them, their social relations, and situations. As such, any patterns are unpredictable over the long term (Stacey and Mowles, 2016:331-323).

Similar to CAS models, in complex responsive processes of relating there is no one locus of control; whatever happens does so because of the activity of humans interacting with each other locally. This local activity creates global patterns; meanwhile, the quality of interactions is constrained by the global patterns they produce. Therefore, these patterns have the quality of a paradox: humans form and are formed by population-wide patterns at the same time (Mowles, 2021:18-37).

The management of the NHS that I have described in my projects tends to be dominated by ‘systems theory’ (Mowles et al., 2010, Clarkson et al., 2018, Chada, 2022). A ‘system’ in systems theory is a collection of parts or processes organised around a specific purpose and function. Systems have clear boundaries and operate within and next to other systems (NHS England, 2017). Examples of systems include the cardiovascular system, a political system, a GP practice, or a mental health trust. Within each of these ‘systems’ there are other systems operating; in the context of an NHS trust, this could include, a finance team, an HR team, an IG team, a research team, and so on. In recent years, there has been a growing recognition that the NHS is a complex system, and it is frequently referred to as a ‘complex adaptive system’ (Pype et al., 2018, NHS England, 2023), especially in relation to transformation and change management activities; for example, when implementing the new Integrated Care Systems for commissioning and provider organisations.

In the twenty-first century, healthcare has become more complex. This complexity has moved beyond the mathematical descriptions of complexity theory in health services of the early 2000s. As Greenhalgh et al (2023) describe *“real-world complexity is not only (or even primarily) a mathematical phenomenon; it is a human, social, and political one characterised by strongly held values, contested meanings, and stakeholder conflicts”*. Despite this increasing complexity, there is a desire among healthcare managers to find tools that make it possible to manage and control the complex and unpredictable systems. One such tool is the Cynefin framework designed by David Snowden (Kurtz and Snowden, 2003). This sense-making framework enables the user to decide whether the issues they are facing are obvious, complicated, complex, or chaotic (Van Beurden et al., 2011, Elford, 2012, Gray, 2017). The claim is that by understanding levels of complexity, practitioners can effectively manage the situations they are in.

This claim reminds me of Dewey’s ‘Quest for certainty’ (Dewey et al., 2008) and raises many questions, concerning the nature of what *truth* is and including those that emerged in my four projects. Such tools are seductive, especially given the current workforce and financial constraints in the NHS, in their claim to provide controllability, predictability, and certainty. For me, two specific concerns arise: (1) by indicating that managers and leaders can decide whether something is simple, complicated, or complex, tools such as the Cynefin framework assume that managers and leaders are in control, and (2) there is an assumption that as managers we can somehow detach ourselves from the work we are immersed in and make choices about what we are doing. As I have drawn attention to in my projects and in this brief introduction to complex responsive processes of relating, I argue that all human interactions are complex, even the things we think we do routinely; in every encounter we have to improvise, adapt, and respond to the people we are dealing with, while somehow accommodating our histories, language, culture, and power dynamics, and our individual, mutual, and global constraints.

Paradox is an inherent feature of complex systems, and any attempts to resolve or eliminate it can lead to oversimplification and a distorted understanding (Stacey and

Mowles, 2016:502-504). Paradox is a particular type of contradiction: one in which we have the ability to think the opposite of what we are currently thinking, due to two self-referencing ideas that simultaneously define and negate each other (Mowles, 2015:13).

Process sociology

Rather than thinking about society as comprising entities, systems, and organisations, and instead of assuming that society is stable as a starting point for my research, I adopted an Eliasian perspective. This meant thinking about all aspects of life as continually shaped by and adapting to social processes and relationships.

Elias' ideas on the unpredictability and uncontrollability of social life describe how the plans, actions, emotional impulses, and rational impulses of individuals constantly interweave in a cooperative or conflictual way. The results of many single plans and actions of people can give rise to changes and patterns that no individual person has planned or created (Elias, 2000:366). In my practice as a research manager, and as I have described in my projects, I regularly encounter unpredictability and uncontrollability. I remain struck by the contrast between my everyday experiences and the rational ideas of control, order, and detached objectivity, which are present in most healthcare research.

Elias describes society as a 'web of interdependencies', in which power is a functional characteristic of all our relationships because while we are interdependent, our need for others both enables and constrains. The interweaving of our intentions and the melee of society, is mediated by fluctuating power relationships (Elias, 1978). Elsewhere, individuals and groups are connected and interdependent, and the actions of one person or group can have far-reaching consequences for others (Mennell, 1977, Quintaneiro, 2006). These chains of interdependence become longer and longer; and as one person moves, others in the vicinity are affected. How this ripples out across the broader network is unpredictable (Elias, 1978:131,137).

Pragmatism

Pragmatism is an American philosophical movement developed in the nineteenth century by a group of thinkers who included Charles Sanders Peirce, William James, George Herbert Mead, and John Dewey. I have often found pragmatism to be a helpful way to make sense of my experiences; I have drawn heavily on it during my DMan studies, and it has continued to shape the way I think and work.

Central to the utility I have found in pragmatism is the 'pragmatic maxim'(Peirce, 1994). This is a 'rule' for clarifying the meaning of a hypothesis by tracing its 'practical consequences'; that is, its implications for experience in specific situations. This maxim is then applied to a process of clarifying the concept of 'truth' (Misak, 2013:29-32). This has resulted in pragmatism adopting the distinctive epistemological outlook of being fallibilist, anti-foundational, and anti-Cartesian. My interpretation is that pragmatism is an idea about ideas. Ideas are not 'out there' waiting to be discovered; they are not representations or copies of how the world is. Instead, ideas are tools with which *“we transform, engage, and cope with the world as we go about living our lives”* (Brinkmann, 2012:38).

The early psychologists and philosophers within pragmatism were preoccupied with understanding the self. Turning to Mead’s conceptualisation of the self, he argues that selves, the seats of human agency, are inherently social. Selves are not born but arise though social interaction (Mead, 1934:140). The self is a ‘reflexive social structure’ that is both subject and object to itself. Mead’s formulation of the social object is methodologically helpful in my research because it enables me to think more carefully about, and respond to, how social interactions shape the way I go about my research. From Mead’s perspective, the social world is composed of objects that are created and sustained through social interaction. He defines social objects as shared meanings, values, and norms that guide social interaction and shape individual and collective identities. Social objects are created through communication and interaction between individuals, and they constantly evolve as social relations shift over time. In my practice, Mead’s ideas on the ‘self’ have become increasingly important; they emphasise that identities are dynamic and deeply intertwined with the social world, and this is visible in my P1 in particular, where I have described shared experiences that have shaped my views of the world.

Mead’s description of how shared meanings change over time links closely to Dewey’s doubts about the quest for certainty. Dewey argues that knowledge is an ongoing and dynamic process of inquiry that is constantly being revised and refined. Therefore, the pursuit of absolute certainty is misguided because it implies that knowledge is fixed and unchanging (Dewey et al., 2008:16). Dewey also criticises traditional epistemological inquiry for being overly concerned with abstract and theoretical questions. He argues that the most important questions in philosophy are practical ones and that because we are social beings, it is only by combining our knowledge about the world with our experience of the world that we become wiser.

Group analytic theory

Foulkes’ (1983) group analytic theories further emphasise that individuals are deeply influenced by the social and cultural contexts in which they live. Much of life (and indeed, most of the activity I am involved in every day) takes place in groups, and Foulkes claims that the best place to find out about groups is in a group. Noticing and paying attention to issues that inevitably arise when in groups is a powerful means of understanding and working through those issues.

Contrasting with the ideas I have encountered in systems theories, I have taken three key insights from Foulkes:

1. Whatever we take to be the ‘whole’, it cannot be reduced to studying the parts in isolation: interactions are dynamic, and life is never in equilibrium (Foulkes, 1983:1)
2. The influence of psychoanalysis, including the workings of the unconscious, and the conflict which takes place in groups. These manifest as repetitive

patterns in individual and group behaviour and often prevent people from understanding one another and themselves (Mowles, 2018)

3. Humans are first and foremost members of groups; therefore, groups provide explanations of human interaction that resonate strongly with the notions of self-organisation and emergence that are found in the complexity sciences (Mowles, 2017b). In taking this perspective, we move from speaking about adaptive systems to discussing responsive processes of relating between human bodies (Stacey, 2001:195).

This thesis is informed by these theoretical traditions; I make no objective truth claims in my work, and it is incomplete and provisional (Martela, 2015), rather it is an invitation for readers to engage with what I have written. This thesis also reflects the evolution of my thinking, and is tied to the contributions I makes to theory and practice; It represents a journey from ‘Truth’ to ‘truths’, in which pluralism extends to both the subject and object of the research; to both the assumptions and values of EBM and the assumptions and values of a critical Pragmatic philosophy and the knowledge that emerges from our ‘actual living’ (Martela, 2015:538, 542).

Research methodology

Method in context

The research methodology I have followed involves writing narratives about experience at work and taking those experiences seriously (Stacey and Griffin, 2005:9) in order to explore my research question: w*hat makes doing mental health research difficult*? The emphasis of this thesis is an inquiry into my practice and the relationships with those I work with. I recognise that my research method rests on the theory of complex responsive processes of relating; as such, I can only really understand my narratives, and their organisational context, from within the local interaction in which global tendencies to act are taken up. This means that as a researcher, there is no split between me (the individual) and the social; I am not an external, objective observer of my research object. The stance I have taken in writing my narratives is one of detached involvement, as described by Elias (2001:47). Elias gives the analogy of the ‘airman’ and the ‘swimmer’, which I understand as the process of recognising how immersed I am in the details of an experience, while at the same time thinking about the context, the bigger picture, and long-term trends (Elias, 2000, Mowles, 2015:52). Therefore, to understand my narratives I need to understand my own experiences of participating and co-creating such accounts — both while they are being created and within their historical context.

In the NHS, research tends to fall into one of two broad categories: quantitative or qualitative. This thesis falls into the latter. There is no single agreed definition of qualitative research; however, Denzin and Lincoln (2005) describe it as ‘naturalistic’ (it takes place in ‘real-world’ settings and tries to avoid any interference or influence) and interpretative of its subject matter. Qualitative methods are also described as an ongoing critique of the politics and methods of post-positivism, wherein a plurality of epistemological stances is possible but efforts are made to avoid epistemological anarchy (that is, ‘anything-goes’ relativism) (Denzin and Lincoln, 2005:10, Hicks, 2018).

My methods share commonalities with qualitative methods such as action research (Jupp, 2006:2), participative or collaborative inquiry (Jupp, 2006:216), case study methods (Denzin and Lincoln, 2005:443), ethnographic research (Taylor, 2002b:1-2), and narrative inquiry (Andrews et al., 2008:4). However, there are some notable differences. Two such differences are:

1. I have not set out to purposefully research something, to improve my workplace or practice, or to generate and test solutions to a problem.
2. I hold that I cannot be an objective external observer of my own experiences.

To explore this second point in more depth, qualitative researchers claim that although creating completely objective accounts is likely to be impossible, it is possible to create *“accounts [that] can approximate, or at least attempt to approximate, an objective truth”* (Guest et al., 2013:7). This reflects the arguments of Denzin and Lincoln, who assert that *“only partially objective accounts of the world* *can be produced"* and that *"all methods examining such accounts are flawed" (2005:27).*

In much qualitative research, and specifically that which is conducted in the NHS, the aim is to generate a reasonable approximation of reality that is tied closely to what is observed, while attempting to preserve the idealised *"stance of an objective observer"* through a process of recognising the interconnectedness between the observer and the observed (Stacey and Griffin, 2005:2). Taking this into account in my research and within my community of inquiry (which I describe on p115), I have written about the micro-details of my own experiences of interactions with others in a subjective way, or rather, one of paradoxically 'detached involvement'. *Involvement* means I recognise the inevitable affective nature of doing things with other people. As I cannot avoid full involvement, it follows that I cannot achieve full detachment and rational thinking. Therefore, in my research I have tried to hold a stance which is both *detached* and *involved* at the same time (Stacey and Griffin, 2005:9).

Method in theory

To set out my method in more detail, I will introduce some key theoretical points before describing how these translate into practice.

Abductive reasoning

Abduction is a form of reasoning that is prevalent in everyday life (Brinkmann, 2012:44-46). It is distinguished from other forms of reasoning (deduction and induction) that date back to Aristotle and dominate much of the health research (Cartwright, 2010, Deaton and Cartwright, 2018). Abductive reasoning is employed in situations of uncertainty when we need to understand or explain what might be happening (Brinkmann, 2012:46). Abduction describes the process of taking observed facts and formulating a reasonable explanation of what could have caused the observed event (Misak, 2013:48-49, Beckwith, 2019). Used as a method in my research, it involved applying a process of interpretation (or sense-making) to a narrative account of a surprising event or breakdown in my practice, and then testing this against hypothetical overarching patterns to develop an explanation that would resolve or explain the surprise.

In the context of a widely promulgated narrative that health research is a 'good thing' (e.g.Boaz et al., 2015), in P2 (p41) I suggested the following explanatory hypothesis for the breakdown I experienced: *"Perhaps the experience of scrutiny [of research] has a profound potential for alienation; we struggle to recognise or be recognised, and, as such, the space for the human, rather than dehumanised, engagement is diminished."* This forms an abductive statement, although my use of the word *perhaps* underscores my uncertainty about making a truth claim. This claim came from the overarching pattern of recognition and misrecognition that emerged through my efforts to develop an explanatory hypothesis. In discussion and in comments, this claim was tested by my supervisor and my student peers; we discussed how the experience of being scrutinised led to profound engagement, which, at the time, I described as dehumanising. In discussion, I came to the (provisional) conclusion that rather than the experience of scrutiny not being human,

‘human engagement’ could be seen as opposite to ‘dehumanised practices’ that appeared to have no regard for people. This led to a conversation about the work of Hartmut Rosa, who describes resonance as the alternative to alienation (Rosa and Wagner, 2019). I was able to explore something about the quality of the relationships through this process, where it became possible or impossible to listen and engage with others with a degree of openness, curiosity, and imagination without losing sight of my own position or view (P2, p43).

Points of breakdown

My narratives began from points of ‘naturalistic breakdown’. In other words, I did not seek to engineer them; instead, through my participation in the DMan programme, I paid particular attention to points of trouble, conflict, or mystery. This is in contrast to other qualitative research methods; for example, action research, which seeks to improve social situations through a change intervention involving a collaboration between researchers and participants (Jupp, 2006:2). By focusing my inquiry on naturally occurring breakdowns and by (1) making the familiar strange, (2) searching for underlying patterns, and (3) challenging taken-for-granted assumptions, I was able to minimise the risk of writing narratives that uncritically reproduce established wisdoms. Through framing and exploring breakdowns as a mystery and not as something already partly solved (Brinkmann, 2012:44), and through abductive reasoning, I was able to open up empirical impressions for novel thinking (Alvesson and Kärreman, 2011, Misak, 2013:44).

Much of the clinical research that my team and I are involved in draws on inductive reasoning; indeed, my narrative descriptions of my management practice imply my desire to improve situations collaboratively through change interventions (see p27, p58, p86). However, in P2 I described a clear breakdown in my practice when the objectivity of the audit I was working on was called into question; this challenged my theoretical assumptions about how things were supposed to work. In P4 I described a slowly unfolding breakdown in my practice as I came to the realisation that I needed to think about research evidence differently. These examples illustrate some of the limitations of inductive and deductive approaches to deepening my understanding of my practice, and shows that these approaches were insufficient for the purpose of my inquiry.

Epistemology

The epistemology of complex responsive processes of relating is twofold:

1. Knowledge and understanding of the world, our experiences, and breakdowns are situated in specific social and cultural contexts, and our understanding of the world is constantly evolving through our interactions with others.
2. Knowledge is not something that exists in isolation from our experience and interaction with the world, but is a product of these interactions; we learn through doing, and our understanding of the world is shaped by our practical experience.

Martela (2015) argues that pragmatism holds an ‘ontological experimentalism’, meaning that experience is taken as primary and we can never escape being embedded in social and temporal relationships. Drawing on the work of Dewey, Martela states that the *“inquiry itself is primary and any ontological and epistemological commitments are entangled within and arise from this inquiry rather than standing outside it as independent presuppositions”* (Martela, 2015:539). This leads to an epistemology of ‘engaged fallibilistic pluralism’ (Bernstein, 2014), which holds that our beliefs can never be anything but fallible and that knowledge is most helpfully thought about as ‘warranted assertions’ (Dewey, 1941). Of course, this does not mean that we can simply start believing in anything we find suitable at any given moment; rather, we require a ‘community of inquiry’ to make judgements about the status of knowledge claims.

Of the theoretical traditions that underpin complex responsive processes of relating, pragmatism is the most preoccupied with questions of method. My aim is for a methodological coherence that brings together the complexity sciences, Elias’ thinking, pragmatist philosophy, and the relationship between the individual and the social. Therefore, my methodology is one of pragmatic pluralism, but it also takes inspiration from Foulkes and Elias in that my research is collaborative and autoethnographic in nature, relying on narrative inquiry to describe my experiences at work.

Community of inquiry

The DMan community formed my ‘community of inquiry’ as described by the early pragmatist philosopher Peirce (1992:52), According to Peirce, a community of inquiry is a group of individuals who come together to engage in a process of shared inquiry, seeking to develop a collective understanding of a particular problem or question, is central to abductive inquiry. Peirce believed that this collaborative approach to inquiry is essential for the development of scientific knowledge because it allows for the testing and refinement of ideas through dialogue and cooperation, critical reflection, and a willingness to challenge one’s own assumptions and beliefs (Misak, 2013:32-37).

Autoethnography

Autoethnography is an approach to qualitative inquiry in which a researcher recounts a story of their own experience, coupled with a reflexive analysis of the context and implications of that experience (Lapadat, 2017) within the broader cultural context of those experiences (Ellis, 2004:31-45). The narratives of autoethnographic work are an important way for the author to make sense of their world(s) (Dashper, 2015). The *auto* part of the autoethnography inquiry means that I have the best access to my own practice, and I am therefore best placed to inquire into my role (thinking, feeling, and history) in the experiences. *Auto* also requires me to be reflexive (a process which I describe in more detail on p116), especially with regard to the impossibility of standing outside my own experiences as an objective researcher, while adopting a form of detached involvement to allow for both an evocative and an analytical approach to autoethnography (Elias, 1956, Dewey, 1958, Elias, 1991, Anderson, 2006, Denzin, 2014)..

Autoethnography has been described by some critics as self-indulgent, narcissistic, introspective, and individualised (Stahlke Wall, 2016), often lacking any analysis of the sociocultural meaning of the author's personal experiences (Chang, 2016). These criticisms are helpfully addressed by the epistemological and ontological position of pragmatism that underpins my methods; experience and knowledge are social, emerging through our interactions with others, as well as through the process of reflexivity, including analytic reflexivity (Anderson, 2006) and recognising the place of 'the other' in the narrative account (Roth, 2008, Denzin, 2014). There are important ethical considerations involved in autoethnographic work, and, as my projects demonstrate, it is impossible not to implicate others in my narratives (Dashper, 2015). I have described my response to this ethical dilemma in the introduction to my P2 (p34-35), and I will discuss it in more general terms in my ethics section (p123).

Narrative inquiry

Narrative inquiry is *"a way of understanding one's own and others' actions, of organising events and objects into a meaningful whole, and of connecting and seeing the consequences of actions and events over time"* (Chase, 2005:656). Narratives are analytic tools for retrospective meaning-making from the way the narrated experiences are shaped and ordered, which is not necessarily chronological. Narratives are the foundation of my DMan research: these accounts of my experiences as an NHS manager form my empirical data (Chase, 2005:652). More specifically, the narrative accounts I have written about my practice emerged through a process of problematising unanticipated breakdowns that I experienced (Alvesson and Sandberg, 2011). This is in contrast to narrative research that involves collecting narratives to answer pre-determined and specific research questions; for example, Mishler's work on adult identity formation in craft artists' work histories (Mishler, 1999:22-52, as cited by, Chase, 2005:659). My narratives form a distinct type of discourse; they focus on me doing or accomplishing something; and they are both enabled and constrained by a range of social resources and circumstances, including history, culture, assumptions, and context (Chase, 2005:656-657).

Reflexivity

Reflexivity and reflexive writing are central to my narratives. They are a particular form of response to experiences and involve exposing or questioning habitual ways of doing. Reflexivity, as described by Mowles et al. (2010), *"takes into view both subject and object of study, and understands them to be in paradoxical relation."* Reflexivity has a recursive nature, which suggests a circularity of gesture and response as a way of overcoming the dualisms of subjective/objective and linear intentionality (Mowles et al., 2010). As both the *subject* and the *object* of the research, reflexivity enables me to explore my practice in a detached yet involved way, recognising that I am already embedded in particular patterns of thinking and acting. In P4, I reflected on how the loyalties, roles, and obligations within the bureaucracies of the workplace affect our decision-making and essentially 'banister' our thinking (Arendt and Kohn, 2021). By this, I mean that thinking can be hemmed in, structured in ways that might not be immediately clear. Through the reflexive process, thinking without these handrails became possible. This opened up opportunities to think more about the ideologies and assumptions that were maintaining and sustaining the power relations that dominated the decision-making I was trying to understand.

The atemporal nature of research

In P4 I reflected briefly on Sandberg and Tsoukas' (2011) assertion that research conceptualises as atemporal. That is, research abstracts away from the temporal flow of what happens day to day, diminishing the practical necessities, uncertainties, and urgencies that emerge each day, in order to find timeless or placeless truths. The result of this, the authors claim, is that the research process artificialises the subject through abstraction and process reduction; all that really matters is stripped away (Sandberg and Tsoukas, 2011:339). The narrative writing method in this thesis allows my empirical material to reflect the processual nature of life in organisations and is an attempt to limit this type of abstraction.

Method in practice

Stacey and Griffin (2005) argue that organisations are not systems, but ongoing patterns of interaction between people. As such, I have sought to understand breakdowns and events in my practice where I noticed the *"ongoing, iterated processes of cooperative and competitive relating between people"* (Stacey and Griffin, 2005:1). Furthermore, just as thinking is a social process, my research was also a social process, because it involved navigating the tensions between the abstract and generalised ways in which I often talk about my embodied, uncertain, and unpredictable experiences.

I recognise that I cannot have a 'God's eye view' and that instead my view is *"local, situated, embodied, relative, intersubjective, relational, discursive, gendered and many other things"* (Brinkmann, 2012:33). My second, third, and fourth projects start with an iteratively written narrative that includes, from my perspective, the cultural characteristics (such as language, ceremonies, texts, imagery, and symbols) that constitute a 'thick description' of events (Geertz, 1973). In those projects I take an analytical approach to ethnography, where the narrative becomes the starting point for theorising (Anderson, 2006).

The DMan programme formed my 'community of inquiry' (Peirce, 1992:52) where, through a process of empirical or conceptual inquiry into problematic situations, truthful accounts of our experiences might arise. In this context, the time spent in my research community comprised the following:

Residential weekends. The DMan programme is organised as a research community comprising students and faculty staff, given that it conceives research as a group activity (Mowles, 2015:3). Residential weekends involve working collaboratively, being reflexive about one's prejudices, taking part in learning sets, and engaging in reflection as a social process. The community meets for a four-day residential weekend four times each year. A typical residential weekend consists of faculty presentations and discussion, student presentations and discussion, community meetings, and learning set meetings. Between residential weekends, learning sets meet online to discuss their work. I attended 12 residential weekends, four of which were online due to COVID-19.

Community meetings. On residential weekends, each morning I attended a 90-minute community meeting inspired by group analytic theory, where conversations are associative, free-ranging, and improvisational (Foulkes, 1983). The community meetings relied on the contributions participants made, paying attention to themselves and their reaction to the contributions of others. Over the past 18 months, the conversations often focused on the struggles that members experienced, and the joining and leaving of students. The community meeting ran without an agenda, and with members sitting in a circle where *"everyone is visible to everyone else so that there is nothing to screen off or distract one another"* (Mowles, 2017a). The associative nature of the meeting often brought the unnoticed aspects of organisational life into the open. As Mowles goes on to explain, *"the most potent place for learning about groups, where we spend most of our lives, is in a group"* (Mowles, 2017a).

Thinking about my contribution to the community meetings, I noticed that the way I act sometimes mirrors the way I am at work, in that I am thinking politically and diplomatically. However, within the community meeting, it was a case of not just speaking but also being reflexive about what was said. Being reflexive is similar to, yet different from, being reflective. Reflective practice in research is often taken to mean an in-depth consideration of a specific situation. However, I have come to understand reflexivity as "finding strategies to question our own attitudes, thought processes, values, assumptions, prejudices and habitual actions, to strive to understand our complex roles in relation to others" (Bolton and Russell, 2018:14). Reflexivity allows me "to draw attention to the complex relationship between processes of knowledge production and the various contexts of such processes, as well as the involvement of the knowledge producer" (Alvesson and Sköldberg, 2009:8), and, as such, it is a process of interpreting the interpretations. As an example of reflexivity in practice, during a community meeting I spoke forthrightly to a student in my learning set about the impact their lack of contribution to my project was having, and how this could call into question my methodological approach. As the conversation continued, I was able to share how uncomfortable I felt about speaking in the way I did; nevertheless the residential weekend theme of 'the performance of politics' enabled me to try out performing my emerging role as a senior student in a more experimental way while being open to a range of responses to this. Within the network of interrelationships in the group, changes in the patterns of relationships between individual group members and their struggles can be caused by "to acceptance and rejection, inclusion and exclusion, recognition and misrecognition" (Mowles, 2017a, citing Foulkes, 1975). In saying what I thought to be unsayable, the emotional turmoil bubbled up; thinking about this now, I can see this reflects the ebb and flow of anxiety that I described in my projects (e.g. p37).

Learning sets. On the DMan programme, a learning set comprises a supervisor and a smaller group of student researchers. After writing each project (a narrative followed by a reflexive and theoretical response), I shared it with my colleagues in my learning set. We responded reciprocally by making comments on each other's submitted work, followed by discussions on the work on Zoom calls and at meetings during residential weekends.

I drew provisional and emerging conclusions from this iterative process, and these were subject to challenge, notably evoking both resonance and dissonance. This approach provided a range of views, which enabled a variety of interpretations of my work. This in itself did not produce work that is generalisable, but it enabled me, as a member of a community of inquiry working within a pragmatic tradition, to consider the practical effects of my ideas. I am clear that my projects reflect the social world as I see it; the social process of inquiry raises other viewpoints. Through listening to the responses that my projects elicited from others, I was able to notice more of what was going on in my involved participation – including my own subjectivity – which allowed me to offer a more detached description of my experiences in order to complete my work. As a learning set member, I also commented on other people's work; the process of reading, reflecting, and commenting was an important part of how my understanding of concepts, ideas, and theories related to everyday experiences. My commenting on my peers' work became fuller, especially as my confidence grew. This was not easy; sitting in the shadows, as I have described in my projects (e.g. p30, p93), feels far safer than commenting and those comments being rejected or ignored.

My choice of literature

During my participation in the DMan programme I have attempted to accommodate the voices of foundational academics and scholars from the programme (such as Elias, Mead, Dewey, Peirce, Stacey, and Mowles), those from a wider process-sociological and critical theory perspective, and those from contemporary health services research.

One afternoon during a period of writing my first project, my eldest child (16 at the time) looked at the pile of books on my desk and observed that many (probably most) of the authors I was referencing were old, white, dead men. I could not ignore this casual observation, especially in a society where patriarchal views still dominate and given that cultural movements such as MeToo and Black Lives Matter have shaped how I and my family members think. Within my team of 30 people, there are only a few men, and across other research-active organisations in my region the ratio is similar. I have therefore been troubled by the issue of relevance and resonance in my work to my wider community, and how my choice of literature might further reinforce any structural misogyny or everyday sexism present in research in this area. In response to this, I purposefully worked to include the voices and perspectives of female academics. This undoubtedly introduced different biases into my work, as did the unplanned process of connecting different theorists together. As such, there is not a rational or typical literature review in this thesis. Rather than working within an established body of literature to formulate my research questions with the aim of 'filling in gaps' (Alvesson and Sandberg, 2011), I have chosen literature from project to project that aided my understanding and response to the questions emerging from the breakdowns in my practice. Coupled with the reflexive methodological approach I took and the community of inquiry I was a part of, this abductive approach to seeking explanatory theories meant I was less constrained by the boundaries of any one particular body of literature.

Generalisability of my research

Through the reflexive methodological process outlined above, I drafted several iterations of each of my projects as my understanding of my experiences was challenged and shaped by the alternative perspectives of those in my community of inquiry.

Commonly, and especially in EBM, generalisability is the degree to which the results of a research study reflect what the results would be ‘in the real world’ (Frey, 2018). In other words, research results are generalisable when the findings are true in most contexts, with most people, most of the time. The degree of generalisability is often argued on the basis of statistical controls, probabilities, and repeatability (Kukull and Ganguli, 2012). Generalisability is equally important within the DMan method; however, rather than relying on statistical methods, the concept of resonance is more useful as a tool for generalisability. Resonance is coherent with the pragmatic notion of ontological experimentalism, which acknowledges the social and temporal embedded nature of the work.

The judgement of at what point a project is ‘good enough’ depended on the resonance that the work and the critical reflexive engagement raised with other students and my supervisors. The progress of my research inquiry involved broadening the view of experience. Foulkes (1990:297-305) described resonance as how we decide what is relevant to us, and this relevance also played a role in determining the value and potential generalisability of my research. Rosa (2019:195) describes resonance as a specific way in which the subject and the world relate to each other. Resonance in the context of generalisability is what it means to experience relevance and recognition, and in this context I am arguing that resonance is a way of relating to the ideas I have written about, which my readers might judge as useful or reasonable (or not) on the basis of recognising, in their own practice, the breakdowns I have described and the provisional conclusions I have made. This approach is consistent with the concept of usefulness in pragmatism that I have followed throughout my work.

As such, generalisability in this thesis has emerged from the things I have done, observed, and written about. It is *“framed not in the diluted constructs of generalising natural science but rather in questioning and surprise, heuristic, particularity, analogy, consonance or dissonance with my own situation”* (Thomas, 2011). To test the generalisability of my research, I have shared it with colleagues outside the programme, both informally and formally. For example, I have shared it in a presentation on an MSc programme on research delivery at my local university, at a mental health research community of practice meeting, a team away day, and at an academic research collaboration board meeting — an example I will return to in ‘Contribution to practice’.

Thematic generalisability has arisen through my projects in relation to my practice, including (1) moving from the shadow to light, (2) moving from ‘Truth’ to truths, (3) the place of hierarchy in the workplace, (4) from accepting EBM to developing a critical awareness of EBM, (5) substituting reliance on one ideological position (e.g. EBM) with an uncritical acceptance of another (e.g. complex responsive processes of relating) but developing critical awareness, and (6) thinking that people in power positions *have* power to think that power is always negotiated.

Having considered the points made above, I am arguing that my research is generalisable; others who have read my work have described how it does or does not resonate with them. I recognise that in their current state, my projects and this thesis are also provisional and fallible. They are provisional because when my work reached a good enough state, I moved on; and they are fallible in that, in the words of Peirce *“We cannot be absolutely certain that our conclusions are even approximately true; for the sample may be utterly unlike the unsampled part of the collection”* (Peirce, 1994:1.141).

Throughout my participation on the DMan programme, I submitted my work for further critique in the wider research community (my community of inquiry) and in the progression viva. By way of example, I submitted the third iteration of my P3 to a wider group of students than those in my learning set. One of them was at a similar stage in their writing, and the other was starting their fourth project. Their comments, along with those of my supervisors and my learning set, deepened my thinking in a particular area. The comments reflected how my work resonated, but I also received them as a criticism of my shallow understanding of a theorist (Arendt) I was using and the disconnect between the theory and my narrative. I sat with these comments for a while, trying to decide how much more I needed (or wanted) to read and write. Over the weeks that followed, I was able to respond to these and other comments and submitted my fourth iteration. Following this, my work was seen as ‘good enough’ and I moved on to my next project.

Limitations of the method

Firstly, as I have already described, when writing narratives I faced the methodological challenge of being sufficiently detached, including from the emotional experience I was analysing, while simultaneously being sufficiently involved and open to exploring, revealing, and responding to the areas of weakness in my narratives and analysis. On the one hand, the input from my community of inquiry and the iterative nature of my projects helped me achieve the necessary detachment; on the other hand, being reflexive helped to ensure I remained sufficiently involved in the experiences I was exploring.

Secondly, the limitations of my research method stem from its basis on my own perspective of the experiences I have had. Although these are my perspectives, my appeal to the reader is for them to find resonance, plausibility, and utility in the context of their own experiences at work through the detailed, nuanced, context-based descriptions of my practice. The abductive nature of my research does not result in universal truth claims, but aims to arrive at what Dewey (1941:176) refers to as ‘warranted assertions’. Here, rather than proving truth or falsity, it is the *“relevancy and efficacy of [the] subject matter with respect to the problem in hand”* that is important.

Thirdly, exploring a specific breakdown while simultaneously connecting it to general experiences is not without difficulty, especially when compared with other methods, such as action research. A limitation is how easy it is to get caught up in the potentially individualised and indulgent nature of autoethnography. This seems especially pertinent in the NHS, which is at a point of crisis: I feel obliged to not only study the past and the present but also actively try to shape the future from within my research.

The warranted assertions that come from my research are the *“outcomes of inquiry that are so settled that we are ready to act upon them, yet remain always open to be changed in the future”* (Martela, 2015:540). Therefore, my research conclusions may be limited in terms of their generalisability; they are temporary, provisional, and open to further inquiry in the future.

Ethics

My research was conducted in line with the ethics approval granted by the University of Hertfordshire. Referring to the HRA's Decision Tools website (HRA, 2017), the executive director for research in my organisation clarified that my research did not meet the HRA's conditions for requiring HRA or Research Ethics Committee (REC) approval to be conducted in the NHS, and that it was more akin to an evaluation or an improvement project. In NHS and healthcare terms, my narratives are best described as case studies.

Through my research I have been careful in how I write about people. Given that my writing took place retrospectively, I was rarely able to seek consent in advance from the people who featured in my narratives. Therefore, I carefully anonymised those who that appeared in my narratives, making sure to change identifying features and anonymise organisational details. In some cases (for example, P2), this involved significant editing of some narrative details. In my first project, I wrote from my perspective about my childhood and family life, and this was much harder to anonymise. Although I have anonymised family details, I imagine that searching online would reveal them with relative ease. As such, I shared my thesis with my family members, sought their feedback and asked their agreement to include them in my P1.

Central to the ethics of my research is that my inquiry is not focused on other people in detail, but aims to provide a generalisable reflection of events that focuses on my own reactions and emotional responses to the situations in which I found myself or co-created. While autoethnographic methods are focused on the 'self', 'the other' is implicated in the narrative. The self exists in relation to the world, in and through participation in everyday events (Roth, 2008). Autoethnographic work can privilege the monologic voice of the author, but a better solution is for autoethnography to comprise a more collective or cogeneration dialogue (Roth, 2008). In my work, I have written collaborative narratives in two principle ways. (1) Through the reflexive methodology I describe above (p112-122) including the role of my learning set and my wider community of inquiry, and (2) by inviting those who featured in my narratives to respond to them.

Further, I have anonymised and generalised quotations to retain the meaning and plausibility; there are no direct quotations in my narratives. In line with my ethics approval, there were no participants and therefore no consents were required.

Throughout my research, I have discussed my narratives and any ethical implications of them with my learning set and my wider research community to ensure that any real or perceived ethical issues were reviewed and addressed as necessary. I was granted ethics approval by the University Ethics Committee to use this approach.

Introduction to reflexive summaries

In this section, I reflexively summarise my four DMan projects to show how my thinking has developed through my participation in the DMan programme.

As I have previously described, my first project presents a narrative autoethnographic account of the experiences and assumptions that have influenced the way I think. Its purposes were to identify patterns and themes for further research, and to situate me as a writer and researcher.

My second, third, and fourth projects started with a narrative account of a breakdown in my practice, and continued with a process of sense-making and theorising.

Together, these reflexive summaries sequentially reveal wider patterns or themes in which my thinking is embedded. They also provide the opportunity to think critically and reflexively about these patterns and my interpretations of them, which have emerged across my projects and over time.

These reflexive summaries form the basis of my arguments.

Project 1: reflexive summary

This project formed the foundations of my research. Taking an autoethnographic approach to writing this reflexive narrative of my past experiences, including my professional life, I focused on the patterns, assumptions, and ways of thinking that have informed who I am today. As such, it is a reflection on how I have become who I am. The autoethnographic approach enabled me to question the role of subjectivity, prejudice, and patterns of thinking/practice that cannot be erased (Lapadat, 2017). In making these patterns, prejudices, and habits visible by describing some of the formative events in my life that have influenced how I think, I hoped to enable the reader to judge the utility and reliability of what I had to say.

It is clear that different ideologies have shaped who I am and dominated the work I do. I grew up in a very religious community where there was certainty about its beliefs being the truth. This had many constraints, which I found myself exploring in my twenties. This deconstruction of my beliefs was grounded in new ways of thinking that I developed when I began reading a wide range of books, started my job as a researcher, and studied for my MSc. All through my life, certainty of belief (‘there is a God’, ‘I will always have a dad’, ‘there are absolute truths’, ‘medical treatments work’) has been a central factor, and when these beliefs were shaken, challenged, or disrupted, my sense of fear, anger, doubt, and confusion became very powerful; this also played out across my subsequent projects.

Through a combination of events and the passage of time, I have come to a broader understanding of what truth might be; nevertheless, I still find myself being drawn to certainty of beliefs, and working in a research environment amplifies this. Although there are significant differences between the empirical ‘quantitative research’, and the ‘qualitative research’ camps, I have found myself immersed in methodologically diverse ways of working — often in research teams who were also trying to straddle these differences. This is exhilarating, especially considering that a theme throughout my life has been a search for certainty: firm ground to stand on when faced with the uncertainty of life.

I have come to see that the political and power struggles of my work reflected much bigger global patterns. I have noticed that I took (and still take) advantage of the ambiguity of situations I find myself in, even though at times this provoked anxiety. This sometimes meant that I hid in the shadows, although — with reflexive hindsight — on occasion this proved to be a disadvantage in terms of power and politics. One pattern that emerged during this project, and became clearer in later projects, was that sometimes I relied on a more empirical stance while at other times I took a more pragmatic position, especially if I thought it sensible to do so. Thinking about this now, it feels even more important that I recognise how inconsistent I might be with this methodological flexibility, and that I do not make methodological decisions impartially or from a position of neutrality.

At the start of my participation in the DMan programme, diplomacy and compromise stood out as important. They are still reflected in my management style today, but I have come to a much more nuanced view of what they mean. From my present-day vantage point, diplomacy also involves practical judgement and political action. When working in different ‘research camps’ or with colleagues whose ideas were cooperative and conflicting, each colleague trying to gain territory from another, I could see how engaged I was in a complex political practice of keeping conversations, ideas, and my department alive — or not. As my project narratives have shown (for example, in P2), I did not know how others would respond to the things I was doing. I have become much more aware of the political games that are played, including by me. These political games have sometimes felt like turning the generation of research evidence into a competition, where winning means being able to hold the reified results of our work aloft like a trophy I might have won at a cycling race.

In what I described as my quest for truth, I have come to understand that I cannot ignore the importance of context, perspective, dependencies, and, importantly, ‘me’, when it comes to doing research. In this project, I described my journey of questioning ‘truth’. Looking back over my experiences, I notice that my thinking shifted from the positivist paradigm to align more with a constructionist or pragmatist paradigm; yet I am still drawn to certainty. I described how this has affected my day-to-day work and my life more generally. In making sense of truth, the following two authors were influential:

1. Thomas Kuhn (1962) and his concept of incommensurability. What struck me most about Kuhn’s work was his insight that if one is to understand a particular approach to science, one must know about the intellectual tradition within which that approach to science sits. I took this to heart, and subsequently I have always tried to make sure I understand the intellectual traditions of those I am working with.
2. Joshua Meyrowitz (1985, 2008) and his ideas about how we approach dominant ideological beliefs with negotiated understanding based on the research camp we feel most at home in.

As I gained a deeper understanding of complex responsive processes of relating, the contestation between EBM and a messier reality became more apparent; the way in which understanding is negotiated is always in a state of flux. An emerging theme from P1 that resurfaced in P4 was the question: ‘If something makes sense and probably should be done, does it really need an evidence base?’ Here my thinking has developed over time: I would now claim that the answer is ‘Yes, but the evidence base should not be limited to a scientifically rational body of evidence’. Our practical experiences also form an evidence base — one that sometimes makes more sense than the science.

The work of Fleck (principally, 1935) in describing thought collectives has become important in my thinking about how to hold a plurality of views. My historical certainty of beliefs blinkered my ability to see things differently. Fleck, whose work I introduced in P1 and discussed in more detail in P3 and P4, describes how truth emerges within thought collectives; his description is based on insights that emerged during a historical review of the evolution of an understanding of syphilis. I also recalled that truth claims cannot be separated from the social and historical context in which they emerge (Derrida, 1967:28). While some thinking might be universal, often it is not. Indeed, the truth emerging from one thought collective might be at odds with the truth emerging from another. In my projects, I have come back to thought collectives as a theoretical framing narrative to make sense of my experiences; however, this in itself might be part of my desire for certainty and it reflects the often instrumental and reified nature of research activity. In addition, my participation in the DMan programme could be seen as joining a new thought collective, the thought style of which may be at odds with other thought styles I have been a part of. I work within a thought collective where RCTs are seen as a definitive way of proving that something works. Their aim, as I described in P1, is to provide context-free, universally applicable truths about how to treat illness, through a process of distilling complex, messy, ordinary experiences into idealised statements. Through my time on the DMan programme, the difficulties I have with this, and which emerge with this thought style, have become quite apparent.

With regard to my management style and the work I do, I described how I am often caught up in a desire for simplicity and certainty; yet I can also see that sometimes I attempt to respond in much more nuanced ways. I still feel cornered by the ideas and dominance of rational, scientific, empirical findings, which makes it harder to accommodate a plurality of views when working in a healthcare setting. I recognise my dilemma: however frustrating EBM might be in its narrow and dominant view (at least, publicly) of how care should be provided, it is not an unreasonable view to have, especially with COVID-19 conspiracy theories and other healthcare conspiracies still widely circulating.

Over the course of my participation in the DMan programme, I have become more aware of how my propensity to work behind the scenes (out of the spotlight) suits me; after all, research is meant to be objective, so the ideas and results should speak for themselves, irrespective of who is presenting them. Working in a research environment where one must ‘follow the science’ also feeds my deep desire for simplicity, certainty, and objective truth. In addition, the process of becoming a senior student on the DMan programme, which involves contributing more to community meetings and the taught sessions, has helped me to move from feeling like an observer in the shadows to being able to immerse myself and take a step back to think out loud about the impact of these moments of deep immersion. This is demonstrated in chapter 4 of my P4 narrative.

Living in the shadows is a pattern of behaviour that I have followed for at least the last 35 years. As a teenager, I existed in the shadows of my siblings. At work, I have been in the shadow of my director. I am comfortable behind the scenes, and my role in research management suits this disposition. However, I have also noticed how I have emerged from and retreated to the shadows during my participation on the DMan programme.

In summary, my P1 formed the basis of my research inquiry. By exploring the relational dynamics within my practice, where I am caught up in political manoeuvring that involves practical judgement, I have recognised that my own desire for certainty and truth is also informed by global patterns within health research activity.

Project 2: reflexive summary

This project focused on a clinical service audit-research project I co-led with a colleague. We were commissioned by a clinical director to describe patient access to care and patterns of service use. The method we used was deemed rigorous, objective, and likely to result in incontestable truthful statements about the service. Having completed the work, we had it signed off by the clinical director and sent it to the clinical team with a request to present our findings. Although colleagues in the service initially engaged with the idea of seeing the results presented, several months later I and the audit co-lead received a long letter from the service that made accusations of improbity, threatened to take legal action, made an extensive rebuttal of our work, and ultimately, dismissed it altogether.

This response filled me with fear and anger, and I asked another colleague to help me come up with a course of action. The outcome was a long call with the lead author of the letter. During this call, we tried to maintain our relationship but also became further and further entrenched in our respective ideological positions. We argued about the language, but my offer to change this was rejected because the issues ran deeper: the work was flawed, biased, and did not reflect what went on in the service according to clinicians' experiences. I asked to meet again, but the response was a resolute refusal, with my colleague saying no further time could be given to this work, nothing would change what was thought of it. We were unable to resolve our differences; in the end, I was asked me to drown the report.

I think the project report provoked the responses it did (from the clinicians and from me) because of how much was at stake. Effectively, the professional reputations of both sides were at risk, and we both had a lot to lose. Recognising that the report represented far more than the authors' views or the clinicians' experiences was also important; there were patients, carers, families, and friends involved by extension, all with expectations about what they, the clinical director, colleagues, and others might have thought.

When writing this project, I was struck that at the same time we were being robustly criticised for our bureaucratically rational methods, we were being called upon to use them to shut the report down. To conclude the audit, I enlisted the clinical director as an enforcer who could ensure that the clinical team accepted the report and acted on the recommendations to improve the way the service was run. Although my board deemed the audit successful, I was left with a nagging sense of doubt about whether I had acted well or if I had behaved selfishly by protecting my own self-interests.

Marginalisation

In P2 I argued that when research findings ('the truth') are at odds with what people think to be true, it can create conflict. This is especially the case when these differences disrupt how individuals and groups think, undermine identities, and threaten things that are known to be important. I found exploring these differences through the concept of 'thought collectives' helped to broaden my understanding of what concepts of truth there might be in the workplace; a truth for one thought collective might not be a truth for another. While writing P2, I became more aware of how my ‘ideology of certainty’ was driven by the political landscape I was working in, along with my personal beliefs and values.

By drawing on Norbert Elias’ theories on power in P1 and P2, I came to understand power as a structural characteristic of relationships — fluctuating, tilting, and flowing (Elias, 1978:131) — rather than something that could be possessed. I described how in my work I get caught up in different thought collectives, each trying to gain power over another. Yet, in my practice I think I was striving for differences to coexist in an accepted state of flux and uncertainty, rather than for one position to dominate by forcing a compromise. What Fleck terms ‘thought collectives’ links with what Elias refers to as ‘power figurations’. Power figurations are networks of interdependent human beings, with shifting asymmetrical power balances. Elias argues that power is not an attribute of individuals or institutions, but a complex and dynamic process that emerges from the interactions between individuals and groups. *Figurations* are patterns of social interaction and power relations that emerge in different contexts. For Elias, interdependent individuals, with their own interests, goals, and perspectives, are not only bound together in ideological groups by shared beliefs and values; they are also caught up in mutual enabling and constraining shaped by power dynamics. In my practice, and as I have described in all my projects, these were the power and political struggles I found myself navigating, as I tried to focus on the quality of the relationship to avoid escalating the conflict and to prevent ideological polarisation. Thinking reflexively about this, I am now happier to sit and engage with conflict and ideological polarisation, and I feel less compelled to attempt to manage and control it.

In this project, I claimed that the audit-research was objective and that its results were believable and representative of how the service was running, even if the results had limitations. However, I came to recognise that these beliefs marginalised the possibility of others engaging with the work more fully, other than to discount it completely. This marginalisation resulted in harm; my colleague and I both felt hurt and damaged by our encounters, and these feelings of being wronged have remained long after the project closed.

Ideology

My inquiry in this project led to the insight that the work I do is driven by my ideological beliefs, and I have found it useful to think about how this might be the case for people I work with. This became more important during my projects, as ideology, or alternatively ‘knowledge in the service of interests’, appears to be neglected in management literature, and conflict is often thought of as something to be solved through using the right tools and techniques (Stacey, 2012b:122-123, Mowles, 2015:120). Conflict arises between our individualistic pursuits and our interdependence, and I am struck by the way in which external constraints on how my colleagues and I thought could be embraced or dismissed. In the politics of corporate life, a sense of safety and certainty can be found in following methodological or bureaucratic rules, and this too can form ideological beliefs. I think that sometimes, ‘just following the rules’ is an attempt to avoid conflict.

Arendt's work on acting politically was important in my theorising in this project, particularly in how selves are revealed in speech and action. Building on this now, I cannot help but think of Arendt's most controversial work, *Eichmann in Jerusalem* (Arendt, 1963), where she analyses Eichmann's defence that he was merely following orders when he facilitated the transportation of Jews to concentration camps during the Holocaust. Arendt's term 'banality of evil' came from her observation that Eichmann appeared to have lost the capacity to think (Arendt, 1963:49, 135-137, 287-288). She notes that Eichmann's actions resulted from not only blind obedience but also his own ideological beliefs and his desire for personal advancement. My inquiry in this project demonstrated that this was the first time I had genuinely paid attention to the bureaucratic nature of the work I do (over and above research being one of the most regulated areas of work in the NHS). It showed how bureaucracy was tied to my work — scientific scrutiny was also bureaucratic scrutiny — and that the dominance of this ideological position was oppressive for me and for the clinical team.

Power and political action

When the balance of power tilts in one's own or another's favour (Elias, 1978:131) it is easier to make, change, and use rules in support of one's own beliefs. Of course, others can take up rules and use them as a form of attack or to advance their own ideologies. In the politics of this project, I did just this: followed rules, ignored them, flexed them when needed, and used power tilted in my favour to advance my work. This still troubles me, especially the ease with which I was caught up in this without noticing the detriment to someone else. However, at the same time, I tried to find ways to stay in relation with the clinicians who felt strongly aggrieved by the work. These relationships were (and are) important to me, and I hoped to arrive at a shared understanding of the constraints of the situation we were in. While I was advancing my own work, I was also working to the orders of the clinical director, and this feels especially uncomfortable given the discussion about Eichmann in the previous section. The clinical director had called for a clear and unambiguous statement of truth about the clinical service, such were the concerns about its performance and outcomes; because I shared these concerns, it was easy for me to follow these orders.

The thought collectives we belong to, the situational context, and the political pressures, motives, values, norms, and ideologies we hold, all affect our actions. Our responses to each other reflected the many ongoing conversations we were part of; when the conversation ended, I found it hard to accept that it was actually finished. As I tried to understand and respond to what I interpreted as an aggressive reaction to my work, another colleague reminded me that research is political. This gave me the biggest cause to pause and reflect. Prior to that, I had been attempting to ignore this aspect of the research. I sought refuge in a simplistic view that method, rigour, and bureaucratic management of the work would render it meaningful and believable, and that this would diminish any threat the work might pose to the clinical team.

In exploring the relational dynamics of this situation and the implications for EBM, my research showed that belonging to thought collectives shapes our response to the things being done with, for, and to us. Having recognised my political manoeuvring, I drew on Arendt's book *The Human Condition* (1958) and looked at what she meant by political action as the active engagement of citizens in the public realm. I understand this to mean that 'politics' can be described as the public debate by a group of people about meaningful aspects of their shared life together. For Arendt, speaking is a form of political action, and although she focuses on it in the context of democracy, it also relates to my everyday life. By speaking, I was engaging in political action, and this challenged my idealised notions of objectivity, evidence, safety, kindness, and goodness, as well as the need to pay more attention to the link between politics and violence (Arendt, 1969).

Truth and certainty

My first reflections on my narrative were of the impact of scrutiny when research takes place. I started with a narrow view that scrutiny applies to that which is being researched. As I think about this now, I recognise that this reflects the EBM paradigm. I was caught up in my (and the clinical director's) view that there were concerns about the services and we had a duty of care towards those receiving treatment; from this position, I was claiming empirical methodological rigour, with researchers as objective and invisible in the research process. Through the reflexive process, I recognised that I had overlooked the personal scrutiny that I was subjected to as a researcher by the researched, and this realisation came as a shock. I had thought I was being objective by using a methodological approach that claimed objectivity, unencumbered by personal views and prejudices. As events unfolded, I claimed that I knew this project was not a definitive statement about the service, but I did not make this clear, choosing instead to take advantage of the ambiguity that it might be seen as such. Looking back, I still wonder about my hypocrisy: not just faking my virtue, but believing what I faked to be true (Runciman, 2008). I was positioning myself politically without realising I was doing so, believing and thinking that I was doing good.

Project 3: reflexive summary

The narrative in my P3 is based on a meeting I attended with a colleague, Melissa, in a similar organisation elsewhere in the country. The meeting was also attended by Mike and Lucy from Melissa's Information Governance (IG) team. Melissa was struggling to progress a research project due to, in her opinion, her colleagues' overzealous application of data protection law. I had been working with Melissa as her mentor for some time, so I agreed to help. Despite the meeting being held on Teams, when I joined I immediately noticed hostile body language from Melissa's IG colleagues, who were using a PowerPoint as a weapon of truth. There was talk of worst-case scenarios, fines, and lack of trust in academic partners. During the meeting, and in response to Melissa's request, I commented on how I managed such challenges in my own organisation. I was trying to find some common ground and wriggle room in which we could meet the governance obligations without causing significant delays. These comments were not well received by the IG colleagues; their response was a direct challenge to any authority I might have had: *'Who are you?'* was asked with a type of scorn that triggered a 'fight or flight' response in me. I realised I might have had another role in the meeting: to bolster my colleague's side in the battle of governance opinions. Also at the meeting was Jon, who was Melissa's manager and had been a clinical-academic colleague of mine for many years. Jon appeared to go out of his way to push or goad the IG colleagues to proceed with approving the project. This irritated them, and I was left feeling quite uncomfortable about such a blunt, non-diplomatic way of dealing with the bureaucratic impasse. I noticed that it became increasingly difficult for each side to see the other's point of view.

After the call, I began to think in more depth about why Melissa's IG colleagues had acted as they did, and I spoke to the head of IG in my own organisation. He suggested that Melissa's colleagues might not be well supported by their executive directors. This prompted me to think about how, if recognition from our managers is lacking, we might work in ways that force recognition through other mechanisms; in this case, through heavily controlling the bureaucratic processes we are responsible for. In the end, Jon wrote to the research regulator to explain their predicament, and the reply was unequivocal and brutal: the IG managers were acting outside any recognised process and should not continue in that way.

Throughout my P3, I sought to understand what else might have been happening alongside this approach to ensuring compliance with IG law. Looking back at these events and the comments made by other DMan students, there was a lot of resonance with my idea that bureaucracy can lead us to being caught up in institutionalised patterns of interaction that can sometimes be conflictual and may turn out to be violent. As I think about it at the time of writing this reflexive summary, I can see that my P3 is a reversal of my P2. In this project, I was caught in a type of bureaucratic violence that was hard to escape from; in my P2, I was the perpetrator of a kind of bureaucratic violence that my colleague became caught up in and found it difficult to escape from.

Certainty through bureaucratic rationality

Through the academic reading involved in this project, I came to an understanding that the ideas and beliefs we have about the way ‘the world’ must function, and of how we function within it, can become a bureaucratic ideology. In other words, the way in which we think organisations should function is driven by our idealised values; this is well described by Stacey and Mowles (2016:393-399), Townley (2008:22-26), and Stivers (2008). Reflecting on my narrative, I think that we were each attempting to control what was happening. Althusser’s (1970) work on ideological control became a helpful frame of reference when looking at how control is both repressive and ideological, and how conformity through complex political-legal governing bodies (police, educational institutions, organisations, religions, and families) enables us to hold onto control. Althusser makes the point that control is both ideological and violent, but I think it can also be generative and prevent violence. In my inquiry I claimed that an ideology of certainty might have come from the interweaving of scientific (EBM) and bureaucratic rationality; these work together to constrain and enable, to dictate and monitor, the work that is done in organisations.

Bureaucratic structures and associated belief systems help to alleviate the anxiety that comes from complete freedom (Vine, 2020:28); bureaucratic and scientific rationality provide a sense of stability and security, and they are seen as essential when faced with uncertainty (Vine, 2020:63). I found that when I (and sometimes my colleagues) faced such ambiguities it sometimes felt easy to resort to the well-known, familiar, and legitimate research practices — despite the reason for doing research often being clinical uncertainty about the best course of action. This paradox of using bureaucratic and scientific rationality to create certainty and mitigate the disorientating challenges of not knowing what to do through a process of clinical research, can also sustain the uncertainty which is being addressed. That is, the knowledge that arises from clinical research in response to uncertainty can create more uncertainty.

I have found that working within and with bureaucratic processes creates an environment dominated by an absence of a recognition. This, along with the individualised nature of management — where the underlying assumption is that organisations perform well when individuals are motivated to perform as individuals (Stacey and Mowles, 2016:85) — can lead to dynamics between people that are characterised by a sense of conflict and violence. In my narrative, this violence comprised threats, silencing, and escalation of conflict. This often seems to be how difference at work is dealt with. From my experience, I have noticed that the dominant pattern of solving conflicts that arise as a consequence of competing but legitimate thought styles is the brutal enforcement of a solution by those with power tilted in their favour. Further, this can lead to escalations in conflict due to one party feeling marginalised, silenced, or misrecognised. I have also recognised that this is a pattern I have found myself following, either facilitating the brutal enforcing actions of others or being the recipient of such enforcement. One observation I have returned to, especially when thinking about this project for this synopsis, is how I am sometimes caught up my own ongoing struggle with an ideology of certainty.

From my present-day vantage point, I realise the word *brutal* is very strong. Re-reading my narratives, I noted that my use of this word came from my reading of Arendt (Arendt, 1958) and the central link between action and speech in her description of power. Arendt argues that when people act together, the potential of what they can achieve can only be realised *“where word and deed have not parted company, where words are not empty and deeds not brutal”*, and *“where words are not used to veil intentions but to disclose realities, and deeds are not used to violate and destroy but to establish relations and create new realities”* (Arendt, 1958:200). I described how words and deeds ‘parted company’ in P2 and P3, where, despite ‘talk’ of fair or transparent motive, ‘deeds’ happened through deception (self or otherwise), hypocrisy, and conflicting motivations, sometimes my own, and sometimes those of others. This emphasises how thinking should take place public allowing for ethical judgement to be made (Geertz, 1968).

Recognition, misrecognition, and alienation

What we do at work cannot be separated from who we are; we construct our own and others’ identities as we interact with each other, and our struggle for recognition is a key dynamic in all human relating (e.g. P3, p69-72, and P4, 82). I have explored what meaning recognition and misrecognition might have in my narrative (Taylor, 1994, Honneth, 2005b). Taylor’s position is that our identity is formed in part by our belonging to a particular cultural group, and our sense of self-worth is tied to the value that others attach to that group; if the group is demeaned or held in contempt, its members may suffer harm as a consequence (Taylor, 1994:25). In my P1 I gave an account of the process I went through leaving the religious community I grew up in and belonged to for 30 years. This draws attention to how differences of values can sometimes become so irreconcilable, one might feel compelled to break the ties with those in ‘our’ thought collective. (or could leave them feeling compelled to leave) Furthermore, Honneth (2005b) argues that to be misrecognised is to be violated, such is the damage it can cause to one’s relation-to-self. This process can further entrench people within their thought collectives, sparking an ongoing cycle of conflict. I think that over time, this cycle has become part of the beliefs I hold about particular roles in the NHS, which have led me to expect people in particular groups to behave in predictable ways. This resonated with members of my learning set and with my supervisor, who recalled those times when she had worked with a ‘Lucy’.

Taylor’s work on the relationship between identity and recognition has been important in developing my understanding. Taylor argues that identity-formation is a dialogical process; that is, identity is formed socially and in dialogue with others, long after those people have disappeared (Taylor, 1994:33). This interdependent (rather than independent) process means that when one experiences misrecognition, one’s identity is threatened; this in turn can cause feelings of being estranged or at odds with others one has an affinity with, or with oneself. My inquiry in this project demonstrated how differing ideological positions can drive cooperation or competition, and based on my research I found that this can lead to events that may be harmful or violent.

Reification

A key idea at the heart of complex responsive processes of relating is that everything is relational and temporal; therefore, organisations are patterns of conversations, relational constraints, and power figurations (Stacey and Mowles, 2016:392, 421). By this, I mean that nothing exists outside human relating: organisational patterns emerge from how people talk and how their talking configures power relations. These social processes of relating unfold over time (Elias, 1978).

Stacey and Mowles (2016:437) go on to discuss 'second-order abstraction', which they describe as a form of reification. Here, in addition to the generalising that takes place through identifying categories of experience, a second order of abstraction takes place when we look at the patterns of relationships between the first-order categories of experience. Simplifying, categorising, objectifying, measuring, averaging, modelling, and forecasting are all examples of processes of second-order abstraction or reification. I find myself doing many of these things without consciously noticing. These reifications *"can cover over our preoccupations with the details"* of our everyday work. I find this position helpful because it challenges my tendency to reify the systems and structures around me, particularly those associated with research governance. Focusing on the problems associated with reification, Honneth describes reification as a type of human behaviour that *"violates moral or ethical principles by not treating other subjects in accordance with their characteristics as human beings, but instead as numb and lifeless objects — as 'things' or 'commodities'"* (Honneth, 2005a:94). Since writing my projects, I have returned to Elias' work on time and temporality, which I have found helpful; Mennell (1992:179, 211-217) sets out how Elias argued that it is a mistake to reduce complex social processes to a single moment in time, because in doing so the process becomes a discrete event, disconnected from its broader historical and social context. Illustratively, focusing on a meeting with colleagues challenging an IG decision as a discreet event was to ignore any historical decisions that may have led to colleagues acting as they did (e.g. P3, p57)

The trust, *the organisation*, *the Department of Health*, and *the university* are all terms I use and hear regularly; however, they may inadvertently be dehumanising. Stacey and Mowles (2016:437) make the point that we are largely unconscious of how we rely on abstractions, so we find it difficult to notice just how readily we reify things. Doing so covers over our preoccupation with the things we are involved in. I think my narratives suggest that sometimes it is as if 'the trust' and 'the regulators' have moral agency, or are committing acts of violence towards us. It raises concerns about the disappearance of moral agency; when colleagues become 'the institution', I found it easier to marginalise or neglect the attention I needed to give the situation I was in. I found that efforts to recognise that all human relating involves power relationships allowed me to engage with the complexity of what we were trying to do together. Reification sits alongside the term *instrumentalise* in my work, although it is not synonymous. I use the concept of 'instrumentalisation' in relation to how processes are used as tools or means to achieve a particular goal or end, as opposed to valuing processes for their inherent qualities or properties. In P2, I was using research in an instrumental and reified way to achieve a specific goal, and in this project Melissa's colleagues were using regulations and laws in a similar way. It would be easy to be critical of this, but that would be to misrecognise the ease with which I, and my colleagues, reify and instrumentalise many of the things we do.

Therefore, despite the administration systems, tools, and instruments we use, the way we are at work also depends on our relationships and our experience. As I consider this further at the time of writing this summary, to assert that how I am is either about relational dynamics or about instrumental or bureaucratic tools seems oversimplified; I realise that if I take the tools at face value and assume that they correspond to something objective in the world, I am being naïve. The use of tools or rules is also a complex relational practice that involves power relationships and negotiations. Stacey (2012b:51-52) argues this point well by stating that to follow rules in ways that are helpful or effective requires background knowledge, context, and practical judgement. Therefore, I argue that following rules is a social practice that is given to variation depending on the situation at the time and the particular goals an individual might have.

Wriggle room

I explored the idea that while governance practices in the NHS are complex, legalistic, enforcing, repressive, and controlling (aimed at keeping people and data safe), there often appears to be ‘wriggle room’ to accommodate nuance in decision-making. In other words, while ‘following rules’ looks straightforward and binary on a superficial level, it is actually a complex relational process. Within this complexity, there is a flexibility to respond pragmatically, depending on power, politics, relationships, and ideologies. As I have argued in the methodology section, I cannot stand outside the struggles I experience, so I have to find ways to create and pay attention to harmony and divergence of thought. Paying attention to conflicting or paradoxical states of uncertainty/certainty is, I think, central to how practical judgement emerges. In the midst of bruising encounters, by slowing conversations down and creating a ‘public realm’ in the way Arendt describes (Arendt, 1958), I was ableto create the space to re-evaluate the meaning that was being made.

Project 4: reflexive summary

I enjoyed writing P4 the most because it brought together the different strands of my previous projects. Ahead of this project, at a residential weekend and after a presentation of my research, I was challenged by my second supervisor to think about 'lifting the lid' on research in my organisation. As a research team, we have been successful, and to an outsider we look like a highly effective outfit. For some clinical trials we have been the highest-recruiting organisation in the country, outperforming far bigger and more established research centres; and we have been a leading research-active NHS organisation in the field of mental health for several years. Therefore, it would have been relatively easy to sit back in a detached way and enjoy continued success. Yet, lifting the lid, on the JOURNEY study (a large scale RCT I was involved with) presented an opportunity to look closer at what might have been going on during the research process. The everyday drama of frustration, negotiation, delay, and anger, and the 'hard graft' of doing research, are effectively hidden from sight by the time the research is published. For example, the public account of research that my team was involved in, and that necessitated hours of toil, simply states: *"Between 10 March 2015 and 31 March 2016, we recruited 414 people (intervention 208, usual care 206) with 341 (84.4%) participants completing the trial"* (Holt et al., 2019). Journals must impose word limits on authors, but it still struck me that so little attention is paid to how research recruitment and intervention delivery actually happens, both in my organisation and more widely, and how disconnected the research process is from 'real-world' implementations of evidence.

Unlike the narratives about my work in P1, P2, and P3, the narrative in P4 unfolded over a longer period of time and centred on a large-scale randomised trial of a non-pharmacological intervention for people with mental illness. At the centre of the narrative was the struggle and desire of the clinical team (Richard, Susan, and Clive, who were involved in delivering the trial intervention to patients) to implement the intervention ahead of any results being published. From my perspective, this ambition to roll out the intervention early was strongly rooted in their belief that the intervention worked even though the consensus among academics, research funders, and national leaders from across mental health services was that the 'evidence' was inconclusive and of 'low quality'. A simple statement such as this appears to ignore that creating evidence (in the traditional positivist-empirical way) for this type of intervention would have been difficult. The intervention itself also involved a critique of the reifying tendencies of treatments in the NHS. By the end of my project, I was able to see that despite attempting to be impartial, I was much more empathetic to this critique.

Considerable tension surrounded the delivery of the trial due to the initial position that some of my colleagues and I were holding to: that is, the intervention should not be rolled out until the study results were available. Richard and his colleagues continued to push against this, expressing dissatisfaction that the benefits they could see from the intervention were being denied to other patients. At the request of our chief medical officer, I set about trying to find a way to move forwards. Several fraught months followed, which included threats from Richard to derail things by leaving, disengagement, tearfully impassioned pleas from clinicians, and negotiations with managers. Finally, and with some input from Richard and his colleagues, I drafted a position paper, which I presented and discussed at various advisory groups and to our Clinical Effectiveness Committee. During this time, passions, expectations, and hopes were raised. It constantly felt as if decisions rested on a knife edge, with the opposing voices and those with power weighted in their favour trying to use that to their advantage. Over the course of several years, the intervention developed a reputation for being quite disruptive to various ‘transformational change’ programmes in the trust; indeed, my postscript to the project and one of my conversations with Richard left me wondering about ongoing animosity towards the clinicians and the JOURNEY trial.

Through the process of looking at the JOURNEY project in relation to my practice, I found my own position shifting considerably, and it became ever more apparent to me that our arguments were based on ideologies. I was struck by the passionate first-hand accounts from patients and carers about how transformative the intervention was, despite the lack of acceptable evidence that the intervention was a suitable alternative to existing care. I found it hard to reconcile these accounts within the EBM way of doing things.

The question that arose from my narrative and sense-making process had two parts to it: (1) understanding what are the ideological limits I and my colleagues imposed on EBM, and (2) understanding what my colleagues and I do when we reach these limits.

Ideology

In examining my P4 in the light of my overarching theme of an ideology of certainty, I was thoughtful of the role that values and competing goods seemed to play throughout this project (and in P2 and P3) and how the idealisation of certain values affects the emergence of ideologies. EBM could be seen as a social object, as described by Mead (1934), wherein it is understood as a unified experience. Mead argues that individuals tend to idealise the collective (experience) and treat it as if it has an overriding value or motive, free from conflict and constraint; he refers to this as ‘cult values’. As Stacey and Mowles (2016:390) point out, these social objects can emerge as precious parts of our history, and while ‘cult values’ attached to social objects can be good, bad, or both, the idealisations that lead to them emerging are problematic. When people’s views fall outside these idealisations, they can be considered to be bad ; or, in the context of my narrative, Richard felt as if he and his team would simply disappear, their voices becoming less and less powerful. I think that some of the people included in my narrative took up research (and ‘the evidence’) uncritically; for example, during one meeting to discuss the JOURNEY project a colleague questioned whether we were an organisation that ‘followed the science’ or not, and I found that this question quickly closed down opportunities for debate and for engaging in a plurality of views. As I began to look more critically, particularly at conversations about what practical action to take next, the competing goods became more visible and our struggle for mutual recognition became more obvious.

Reification

At the end of my project, I claimed that I easily fall into a reductive and reified way of thinking, and that this might be due to my longing for stability, ease, safety, and/or control. Nicolini et al. (2021) describe this as the common treatment of evidence as an ‘entity-like’ substance, which can go on to create divergent understandings of the same truth.

I also found that this desire for certainty might make it easier to collude with the reification of evidence, especially when certainty marginalises or covers up the relational complexity of the situation and appears to make things easier to deal with. This is consistent with findings reported by Court et al (2017); they argued that NICE guidelines can create an unhelpful illusion of neatness. Accepting the apparent certainty of EBM, I exercised practical judgement. According to Shotter and Tsoukas (2014b), there are dangers in exercising practical judgement as if it is something that is ‘hidden inside the mind’. Rather, it should be openly talked about as emerging in the flow of activity that people doing things are immersed in. In this project, I was drawing attention to the problems that arise as a consequence of the dominance of the reification of research and research evidence. Here, reification is both ensuring that we do not forget the intricate, dynamic, and relational nature of judgement (Honneth, 2005a) and assuming that research evidence can become something that is concrete, certain, and possible to use in a controlled way. Across my projects, there are examples of EBM being reified and simplified in ways that made it easier to do something with it. These judgements of how to respond to research or evidence emerged in concert with others and thought of as ‘good enough’ at the time however, in retrospect some decisions — that turned out to be useful as well as harmful.

Political action

Doing clinical trials and implementing the findings are activities that are far from neutral and objective; rather, they are highly social, political, and ideological. I have recognised that many of the decisions I made during P4 involved trying to understand the political landscape and its relevance within which I am operating. Drawing on Arendt (1967), I have explored how political action is tied to ‘truth-telling’. Arendt makes it clear that ‘truth’ is an abstract concept that can be transformed into something that shapes political action. She explains that ‘truth-telling’, in particular the telling of ‘factual truths’ is related to our understanding of the common realm of human existence and our visibility in the ‘world’ as we share our thinking and experiences with each other (Arendt, 1967). Arendt’s position here is consistent with Fleck’s description of how truth or facts emerge in thought collectives. I found that my (and others’) tendency to reify and instrumentalise research made it easier to consider research as something that is not formed by people, but is factual, objective and historical, while at the same time having contemporary relevance (Fleck, 1935).

Across all my projects I have recognised the ebb and flow of anxiety that comes from the politics of the everyday action I am caught up in. Arendt’s description of the public realm, a place common to everyone where action and speech take place (Canovan, 1985:110-116), helped me frame my acute sense of wanting to withdraw into the shadows. Sacrificing engagement with a project by withdrawing leads to a sense of meaningless and political powerlessness back in the shadows. Yet, the shadows was a place where I knew how to operate. I am able to recognise a shift in my practice in my P4, especially in my greater willingness to engage in the public realm I was working in.

Research is relational

Re-reading my project, it was noticeable how much relational activity goes on when doing research; I recently mentioned this to a retiring professorial colleague during a conversation about another trial we were having difficulty recruiting to. This had a strong resonance with him, and he used the term ‘soft activity’ to describe the pragmatic, responsive, adaptive, and political efforts that are needed to ensure clinical trials run well and meet the recruitment targets set. I cannot help but wonder what impact these ‘soft’ factors might have on the effectiveness of an intervention, especially considering that these factors do not seem to be often spoken or written about. It also brings into sharp relief the ineffectiveness of the idea of ‘equipoise’; that is, the assumption that there is not one ‘better’ intervention during the design of a randomised controlled trial. In this project, prioritising reflexivity over equipoise was more helpful. Of course, turning reflexivity into a research management or methodological tool might have only a minimal effect, especially as it becomes reified and bureaucratised. In this project I have recognised that even though we could not do without EBM, we also needed something more: something that recognises the ‘non-protocol’ work undertaken when doing research, and acknowledges the conflict that emerges between research and everyday clinical practice.

This project has provided an important account of how clinical research is far more than objective, positivist, empiricist action; it is also steeped in subjective and messy uncertainty, broken relationships, and misrecognition, pain, and suffering. These things still trouble me: after all, the aim of research is to make a positive difference to people’s health. I am still sitting with the question: ‘What if, in order to make health improvements for patients, the mental wellbeing of clinical staff and managers is made worse?’

This project, along with my further reflections on my first three projects, has revealed that there are clear themes running through my practice. I have had, been influenced by, and been caught up in conversations where differing ideologies of certainty dominate. The need for EBM and bureaucratic rationality feels like both an oppressive tyranny and a permissive necessity. Whether it is permissive or oppressive, I (and, I think, my colleagues) have felt marginalised and misrecognised, and have experienced conflict and harm arising from competing means and ends when doing research. Far from predictability and control, there is constant flux with the never-ending negotiation between generalised intentions and the need to be recognised as an individual (Mowles, 2012).

Wriggle room

Wriggle room, that is, the opportunity to understand something differently, was a theme that emerged in an obvious way during P3 and continued to be useful in my practice as I responded to the breakdown(s) narrated in P4, where I described noticing that among my colleagues with management responsibilities (clinicians and non-clinicians), there was a tendency to use research and research evidence as if it were concrete, neutral, and objective. This had clear consequences, as describedI describe in my narrative. Nicolini et al (2021) argue that people *“talk as if evidence were a sort of substance — a body of facts or information with immutable properties or attributes that can be stored and deployed at will”*.

Re-reading P4, I am reminded that although rational ways of thinking makes it easier to understand, plan, control, and deliver our services, it also marginalises different experiences, meaning that *“what counts as evidence is disputed and subject to debate, conflict, and controversy” (Nicolini et al., 2021)*. I attempted to create some wriggle room to help resolve our collective breakdown; meanwhile, I wondered if, along with some of my colleagues, I was hiding behind ‘the evidence’ or ‘following the science’ to make decisions seem easier to make and to avoid confronting my ideological differences with other colleagues. Wriggle room is connected to phronesis, or practical judgement, and I cannot help but visually connect Elias’ description of life as both *“firm”* and *“elastic”* (Elias, 1991:49) with the act of wriggling into an opportunity that does not seem to exist, in order to think differently.

I claim that creating wriggle room, or exercising practical judgement, is a way of establishing a new orientation to a situation; and it emphasises that a type of fluidity or *“moving around within a landscape of possibilities”* (Shotter and Tsoukas, 2014b) is involved in coming to a judgement. With some consensus that EBM can be used in very rigid ways (Greenhalgh et al., 2022), the potential for conflict to arise when exercising practical judgement exists. Responding to conflict requires creating or enlarging the time and space within which to respond more relationally. Looking back across my projects, I think the potential for conflict when doing research is somehow structural: the scientific and bureaucratic rationality that I have described is, as Sandberg and Tsoukas (2011) argue, radically different from the way organisations run. Sandberg and Tsoukas’ claim that scientific rationality prevents researchers from developing theories that capture the ‘logic of practice’ is, in my view, implicated in the difficulties experienced in doing research. As I discovered in P4, the gap between theory and practice is hard to bridge when rational systems and processes dominate.

Introduction to arguments

In re-reading and reflexively summarising my projects, I have been thinking about the kinds of issues I have found myself responding to.

Following my first project (on the foundations of my research), P2 started with an account of a breakdown in my practice where my legitimacy to undertake a research-audit project was questioned. In P3, my offer to help colleagues resulted in a harmful escalation as those they were in opposition to fought to defend their approach to an IG issue. Finally, the breakdown in P4 centred on how I supported clinical colleagues to 'follow the science' while doing what they thought was best clinically.

While research is one of the most heavily regulated areas of activity in the NHS, there are opportunities to create some wriggle room. I recognise that we have to stick with the tools and techniques of EBM while at the same time also attending to the political, relational, and processual nature of the work. In addition, I found I can no longer stay in the shadows. Strong feelings often emerged in my work and in paying attention to these (often complex) situations. Making sense of these situations and the rules of research had to be done with others and was the politics of work; it needed to be done openly and transparently to reduce the likelihood of any harm arising.

Broadly, my argument is that in a healthcare environment such as the NHS, it is often assumed that producing high-quality evidence puts an end to politics and dispute; research is done, favourable results are published, clinical guidelines are written, and organisations are instructed to implement the guidance. My research shows that although evidence may be relatively clear about an area of practice, producing research and deciding what to do with it inevitably involves politics and practical judgement. As a patient, I find guidelines reassuring; I want to know the treatment I consent to has a fair chance of being effective and that what clinicians are doing is not going to make me worse or harm me, although ideologies of certainty may create environments characterised by an absence of recognition, which can lead to escalation of conflict and violence. The production and use of research in mental healthcare is dominated by an ideology of certainty; that is, it closes down discussion in favour of bureaucratic ends, and this may lead to conflict and the breakdown of working relationships. By improving our understanding of the challenges that arise from clinical research through exercising practical judgement, it may be possible to help to sustain research activity, reduce the potential for conflict and harm, and, ultimately, make the research more useful.

From my experiences, and with insights from the work of Elias (1978), Fleck (1935), Taylor (1994), Stacey and Mowles (2016), Nicolini (2021), Butler (2020), Arendt (i.e., 1967), Tsoukas (1997), Honneth (2005b), and others, I have described how the clinical research in an NHS mental health trust I have been involved in has many benefits, but is also complex; it is full of power struggles and imbalances, recognition and misrecognition, marginalisation and conflict; and, despite those doing research appearing to have the best intentions, it is sometimes harmful to those involved. This can damage individuals and relationships. Strict adherence to highly rational, bureaucratic approaches to research leaves little wriggle room for negotiating the ambiguities and uncertainties that arise. Health research can improve quality of life and reduce suffering while also having the potential to cause harm, conflict, and suffering. This happens not because the interventions are inherently harmful (although historically some have been), but because sometimes the rational nature of EBM can marginalise opportunities engage relationally with colleagues. However, in my research I have found that engaging more fully with my colleagues is necessary if we are to make sense of EBM in its everyday use.

Practical judgement is essential in management, research delivery, and research implementation., enabling the navigation of uncertainty, maintain relationships and incorporate EBM practices into healthcare while allowing for the inclusion of other valuable perspectives.

Argument 1

Research and development in the NHS is permeated and dominated by an ideology of certainty that comes from bureaucratic and scientific rationality.

The dominant discourse of my healthcare organisation

As highlighted in my projects, EBM is both pervasive and dominant in healthcare settings, including the NHS. The history of inquiry in medicine goes back millennia; upon reading the *Hippocratic Writings* (460BC, 1978) in my early twenties, I marvelled at the diagnostic descriptions, systematic observations, and application of treatments detailed in the book. I now see this as a type of 'rational medicine', where decisions are made on the basis of reason or logic and the best available scientific evidence. In the late twentieth century, EBM, which grew out of critical appraisal methods, became established as a pillar of modern healthcare (Sackett et al., 1996, Smith and Rennie, 2014, Thoma and Eaves, 2015) through the work of such people as David Sackett, Tom Chalmers, William Rosenberg, Muir Gray, Archie Cochrane, and Iain Chalmers. EBM is now firmly established as the dominant discourse in medicine and healthcare, and my projects have clearly demonstrated that this is the case in my mental health organisation.

In its most idealised form, EBM *"integrates clinical experience and patient values with the best available research information"* (Sackett et al., 1996), and this is at the heart of the implementation science I describe in P4. However, in the experiences I describe in my projects, my colleagues (clinical and managerial) and I sometimes have little time to read and evaluate a range of literature and apply it to the patient before them, a clinical pathway, or management decisions. This is exacerbated in clinical trials; we expect model fidelity, consistency, and control of the 'dose' in order to identify a measurable 'response'.

Due to the highly prescribed way in which I have seen services designed and planned in the modern health service, I found that it was not often possible to routinely have clinicians integrate clinical experience with the best evidence in the way described by Sackett et al. (1996) and other proponents of EBM. This is exemplified in the meetings I described attending in P4, during which we had to justify (evidentially) any deviation in clinical provision from the existing service design. To complicate matters further, the evidence base for mental healthcare is often contested. For example, Kirmayer (2012) argues that research is done in ways that are biased by specific disciplinary, economic, or political interests and by cultural assumptions; Slade and Longden (2015) argue that the causes and diagnostic categorisations of SMI (Severe Mental Illness i.e. schizophrenia) are contested; McCabe et al. (2018) argue that patients, clinicians, and services have differing opinions about what recovery means; and Katakis et al. (2023) argue that treatment duration and intensity does not moderate the effectiveness of the interventions for any outcome in patients with a personality disorder, each patient should be treated according to availability of specialists and the patient's preference. However, despite the evidence base for mental health being contested, and as P4 demonstrates, my colleagues and I often embrace EBM. In P2, using quantitative methods to create better outcomes for patients also became disruptive and political, and this caused some of those involved to want to disengage. Although I claimed that I was serving the greater good, I was also serving my own interests (Fleck, 1935:41, Runciman, 2008:50). In P3, the link between bureaucratic and scientific rationality became clearer, and in P4 I described how important *thinking* is when caught up in decisions that seem poorly served by the accepted evidence.

Bureaucratic rationality and the management of healthcare

Healthcare organisations have a reputation for being rigid and difficult to manage, and this is sometimes attributed to conflicting interests of clinicians and managers (Oliveira et al., 2020). As such, the rise of bureaucracy and neo-bureaucracy in healthcare management is well documented (Wears et al., 2019) and often combines the ideas of Taylor and Fayol (as I described in P3) with the need to rationalise medicine and healthcare. The bureaucratic concepts of systematisation, rationality, authority, jurisdiction, professional qualification, knowledge, discipline, transparency, and accountability (Oliveira et al., 2020) remain part of everyday work; however, in healthcare there is a form of bureaucracy that is paradoxically both centralised and decentralised (Farrell and Morris, 2003). Here, and in attempts to move beyond or eliminate bureaucracy by delegating tasks away from the centre to smaller networks of people with specific responsibilities, the result is often more bureaucracy, even if it looks slightly different (Harrison and Smith, 2003, Vine, 2020). As I found in P3, and as I describe in the ‘contribution to practice’ section, in an NHS setting such as the one I work in, relying on ‘bureaucratic rationality’, which focuses on accurate and efficient implementation, can lead to junior officials making decisions poorly without sufficient quality controls (Thomas and Tomlinson, 2017).

Vine (2020:5) claims that *“we are all bureaucrats”* and that once we have risen above the “*populist damnation*“ of bureaucracy, the vast majority of us seek refuge in bureaucracies of one type or another. Vine’s (2020:5) point that *“Bureaucracy and its counterpoint [adhocracy] represent the parameters within which organisational life unfolds”* is clearly illustrated in P2, where I narrated that I was asked to stop my bureaucratic interfering by using the bureaucracy I had at my disposal. Vine also makes the important point that organisations are social entities, and therefore bureaucracy is socially embedded (Vine, 2020:122). Meanwhile, Townley (2008) argues that it is a rationality, or ‘domination through knowledge’, that allows bureaucratic structures (for example, those described in my projects) to function in the way they do. However, these structures can become a disembodied form of rationality that has no regard for the person and appears to be a view from nowhere.

From my inquiry into my practice, it has become clear where health research (qualitative and quantitative) sits in this bureaucratic rational context. My research has demonstrated that an ideology of certainty dominates in a bureaucratically and scientifically rational setting. Further, as other researchers have described, in this context, clinicians are likely to move from clinical problem-solving (which enables the integration of the best available research evidence with clinical expertise and patient values) towards a type of ‘cook-book’ medicine that tries to ensure standardisation (Freddi and Romàn-Pumar, 2011, Knaapen, 2014, Weaver, 2015). Here, pathways, guidelines, clinical effectiveness audits, and instrumentalised tools (such as NICE guideline compliance statements) are used to ensure that care can be effectively controlled and performance managed. In P4, this approach limited the opportunity (and crushed the ambition) my colleagues and I had to safely enable an experimental treatment to thrive. The treatment itself, which was deemed safe by my colleagues, was less constrained by scientific rationality than by the established use of alternative treatments. However, it was hemmed in and subjected to ongoing bureaucratic processes. To be less bureaucratically constrained and to pursue a solution that satisfied more needs, I had to use my expertise, act politically, and exercise practical judgement to take advantage of bureaucratic and administrative processes

P2, P3, and P4 show clearly that in different ways, I was immersed in a desire for certainty; although through the reflexive methodology I have used in my research, I have come to a more nuanced understanding of this and its implications for my practice. At the same time as wanting certainty, I also wanted to enable research to take place that might fundamentally challenge this certainty. In P2 this certainty manifested in my ambition to prove whether care was ‘good enough’ or not, while in P3 it was manifested by others in their strict interpretation of the rules. In P4 I described how, through discussions on the certainty of whether there was sufficient evidence to use an intervention outside the research process, what I thought to be certainty was actually both certainty and uncertainty at the same time. My projects illustrate how through bureaucratically rational ways of thinking it became possible to present issues as simplistic, binary questions, where the outcomes could be recorded, monitored, and reported. This domination of scientific and bureaucratic rationality in healthcare research activity creates what I have termed ‘an ideology of certainty’.

An ideology of certainty and a quest for truth

Throughout my projects, and in the context of the NHS research activity I have been involved in, I have described a collective desire for certainty. This is especially strong when it comes to doing the right thing for patients; for example, the quest for simple abstract truths described in P2. In healthcare settings, the desire for certainty can drive an ongoing quest for truth — often pursued by employing scientifically rational methods, such as RCTs, meta-analyses, and systematic reviews — so we know what treatments will work. The industrialisation of healthcare has led to a hybrid role of physician-managers in alliance with healthcare regulators, where bureaucratic controls such as practice guidelines and utilisation management feature prominently in organisational forms (Wears et al., 2019:36). My research shows that bureaucratic and scientific rationality are entwined, and, because of this, it is important to understand the bureaucratic rationality that drives a desire for definitive answers about what works in healthcare.

In applying Arendt’s work to twenty-first century issues, Stivers, in her book *Governance in Dark Times* (2008), argues that from Arendt’s perspective, the ‘light of the public realm’ is extinguished by the highly efficient double-talk of officials, who explain away unpleasant facts and justified concerns (Stivers, 2008:53). As a result, truth becomes degraded by moral exhortations and meaningless triviality. Stivers argues that among public administrators, the search for effective management continues and is centred on tools grounded in ‘practical science’ (for example, performance management, contract management, and outcome assessments); in a complex and unstable world, these tools provide objective information, truth, and certainty (Stivers, 2008:55). I have found this position compellingly resonant with how EBM is used in mental healthcare. Stivers goes on to argue that in public life, truth and lies become tools to facilitate the political nature of our work and are intricately bound to how power ebbs and flows in the relationships we have (Stivers, 2008:56). As such, I argue that the very objectivity and stability we seek through the use of research and management tools — or in relation to my practice, an ‘evidence base’ — only creates a delicate veneer of order and control. However, while using claims of ‘truth’ based on evidence is one way to champion a position, it can silence alternative positions, which can create conflict and tension (Mowles, 2015:121). The truth based on objective evidence is a product of the dominant discourse of the scientific rationality that shapes working lives. What happens when two opposing statements are both truthful, but those who make them are unable to navigate this apparent conflict and tension? In the context of P2 and P4, it resulted in conflict and relational breakdown, where dominant truth claims marginalised alternative accounts of what might have been happening or what required attention.

Reification of research activity

A theme of reification emerged in my projects, and I claimed that in the healthcare context, reification is driven by the rational ideologies of EBM. In my research I found that EBM was reified, abstracted, idealised, and, in Townley’s (2008) terms, disembodied. Reification has different meanings. These include: (1) *“forgetfulness of recognition”* (Honneth, 2005a), (2) turning the things we do into objects, which is tied to commodity exchange (Jütten, 2010, citing Lukas 1923), (3) devoid of social-historical context (Jütten, 2010), (4) where abstract concepts (in my case, research results) are treated as if they were an objective reality, and (4) follows alienation (Berger and Pullberg, 1965).

My research has shown that an idealised, instrumentalised, reified way of thinking and working makes managing healthcare resources more straightforward; patients can be counted, interventions delivered, and financial returns made in a way that is objective, fair, and equitable. The downside is that this approach can (at least administratively) have little regard for people (and the individual). This echoes the points I have made about Eichmann: the bureaucratically rational way in which work is done sometimes leaves little room to think. I am not saying that my colleagues do not think or that they have little regard for patients; indeed, my project narratives show the opposite. Richard (P4) was passionate about providing the best care possible, and My clinical colleague (P2) cared deeply about the clinical outcomes for the patients under their care. However, the rational, objective, unprejudiced, and performance-managed environment of mental health services became a ‘system’ that made them feel ‘disembodied’ and ‘disembedded’ (Townley, 2008:24).

Across all my projects I have noticed how easily the process of reification takes place, both in my practice and in my thesis-writing. In clinical trials of healthcare interventions — especially those on treatments for mental illness — complex, dynamic, and interactional events are often, out of necessity, subjected to a type of reductionist process in order to study them. Complex and ambiguous concepts and activities are turned into manageable projects that can be scrutinised, costed, implemented, and measured. As evident in P2 and P4, when I focused on this process, I became forgetful of the recognition needed for those involved in running clinical services and those who are cared for; this reification of the social and processual nature of research made it easier to perceive individuals merely as objects or define them by their ideological beliefs (Honneth, 2005a:58-62). As the research-audit activity described in P2 became reified (in this case, by a report that could be used to manage the service), I found it easy to forget the political and relational nature of what we were doing. This had consequences, which I will explore in my second argument. In P4 I described a dissonance between the evidence for an intervention and the everyday common-sense experiences of my clinical colleagues. I argued that it was plausible that we had forgotten to recognise the differing historical and social contexts of what we were trying to do. To counter this, we made a collective attempt to resist the simplification of the decision-making process. As was the case in P2, and at times in P4, it seemed easy to become forgetful of the intricate, dynamic, and relational nature of research activity.

My research has shown that EBM can become alienating, which in turn can lead to reification. This reification of research contributes to an ideology of certainty; I found that it was easy to be certain about ‘cold hard facts’ written in black and white. However, the moment these were discussed (such as with My clinical colleague in P2 or Richard in P4) and I remembered the people, context, and emotion, the certainty unravelled. Rather than abstract reified products of research, we were once again deep in the realm of human relating and making sense of how to manage our common interests.

Argument 2

An ideology of certainty marginalises the relational, political, and processual nature of research. As a consequence, this can harm individuals and relationships.

Research is relational, political, and processual as well as rational

Research and EBM create better outcomes for patients; this is a central tenet of modern healthcare (Arasaradnam et al., 2023). Research is also powerful, disruptive, and political. In my practice I have encountered claims that definitive scientific knowledge exists or can be found; however, in my projects, and most obviously in P4, I found myself asking whether this was possible. Perhaps a more nuanced question would be, 'How can scientific knowledge exist except within the social and practical world in which it is created?'

Rather than supporting the (often unquestionable) view that EBM is objective, certain, and stable, my empirical material reveals that the practical activities that make up EBM are far from these things — or, rather, they are so much more. Starting with my claims that we may belong to different thought collectives (Fleck, 1935) and that the truth which emerges from research is not 'the' truth (Arendt, 1967), my argument is that health research is an activity that is permeated by scientific and bureaucratic rationality and achieved through relational, political, and processual interactions between people.

Although in P4 there was deemed to be insufficient evidence that the intervention worked, there was a belief that it did. Furthermore, various other 'lower quality' research findings reported the intervention as being successful. These aligned with the experiences of the intervention working by those who were using it every day, including patients and carers. This meant that I (and, I think, my colleagues) had to consider a plurality of perspectives; that is, depending on one's perspective and experiences, there might be multiple versions of the truth. However, to guard against relativism, we needed to reflexively and critically engage with these different perspectives. The desire for a definitive position was balanced with a growing understanding of the relational and political process we were in, negotiating meaning, and reaching agreement on how to proceed. It was relational because the dynamic between the individual and the group was co-constructed: as individuals and as a group we formed the patterns that shaped the research, while at the same time these patterns were formed by previous research in this area.

I found that claims about the need for 'objective science' were sometimes used to shut down further conversations, marginalising the potential for broader and more public engagement. As a consequence, I and my colleagues seemed to be more likely to apply science in rigid ways, which perpetuated a discontent with this responses. Decisions were not always made in the open and transparent ways as claimed: self-interest, beliefs, values, and ideologies were hidden behind such statements as *'we need to follow the science'*, which were made during meetings aimed at creating a definitive organisational position on using the intervention outside the research context. The complex and negotiated social processes involved in translating abstract and theoretical knowledge into practical daily activities ended up marginalising people. Although there did not seem to be a ‘public realm’ (Arendt, 1958) in which we could address the political nature of our research, there was some wriggle room. I took advantage of this, purposefully using administrative and governance processes that were available to create space to discuss the issues in more detail.

To understand for whom and how the intervention might work was, I argued, as much a political activity as it was a scientific activity. It involved the recognition of hypocrisy, competitive and cooperative interests, and the overall uncertainty about whether the methods chosen really would answer the questions we had. The political nature of research meant that despite the certainty/uncertainty about the work (for example, the audit in P2, the JOURNEY project in P4), it was necessary to find ways to accommodate, negotiate, and/or resist differing means and differing ends. As a participant-observer in my research, I was caught up in this; I was constrained and enabled by the local and the global (Mowles, 2021:18-30).

In my view, there was a significant risk of colluding with each other to neglect uncertainty. Due to this lack of recognition of the paradoxical nature of what was happening, the everyday uncertainty or instability was replaced by a delicate veneer of order and calm. Scientific uncertainty (that is, accepting that research methods might result in fallible conclusions) sits uncomfortably in a rational world, where stability and generalisability are assumed and the ascertainable truths of scientific knowledge progress onwards. In my projects I described how hard (impossible, perhaps) I found it to escape from using terms like *certainty*, *confidence*, *precision*, *data-driven*, and *evidence-based*. The purpose of the research in the NHS that I was involved in contributed to filling the gaps in knowledge, and this allowed the illusion of certainty to prevail.

In P4, this certainty/uncertainty dilemma was laid bare at points of crisis when precise, abstract truths were elusive. Even though some of the time, my colleagues and I tried to claim that the truth was known or knowable and easy to follow, on the whole our responses were improvised, muddled, and grounded in deliberations that involved weighing up competing and conflicting stories to aid our decision-making. In Arendtian terms, research is political in that it requires active public engagement, needs to recognise a plurality and diversity of opinions, perspectives, and experiences, and involves power dynamics between those involved (Arendt, 1958).

Bourdieu (1977), Tsoukas (1997), Sandberg (2011), Shotter (2014a), and others make it clear that knowledge is embodied in practical experiences. Knowledge is processual; it is not static or fixed, but it emerges and evolves through ongoing interactions, interpretations, and conversations, and the sharing of practical experiences. However, within EBM (and probably more generally), knowledge becomes abstracted and decontextualised, is usually numerical, and is easy to manage, store, and retrieve, but is less useful for everyday needs (Tsoukas, 1997, Greenhalgh, 2021). When knowledge is abstracted, we risk ending up not knowing where the knowledge came from, how or why it emerged, or what its intended use was. Lacking this practical knowledge about research increases the chances of not knowing what it really means, which in turn makes it hard to trust, follow, or implement. As I described in P2 and P4, I worked with (and sometimes against) different communities of individuals who appeared to share a common framework of thought, concepts, and beliefs. I paid attention to how this shaped their (and my) perception of reality and appeared to influence how they understood the world. This led to multiple versions of reified truth emerging, our views polarising, and my colleagues and I becoming entrenched in a particular thought style (Fleck, 1935). When such deep divisions manifested, our proposed solution was to wait for definitive scientific evidence or more research; but waiting risked a decision never being made, losing all support for the work we were trying to do, or a paralysis in decision-making. Although compromise positions were aimed for, my postscript to P4 shows how easy the compromise was to ignore, simply by not releasing any funding, which appeared to perpetuate the harm that was being caused.

As I have described in my projects, clinical research in the NHS context is (mostly) designed to give certainty about whether a treatment should or should not be used. (e.g., the JOURNEY study was described as a definitive trial aiming to give unequivocal evidence) I have also noticed that my team and I then attempt to deliver the research in this way. This can lead to the political nature of research being neglected through not paying attention to how things get done. Furthermore, my research shows that efforts to suppress or manage the conflicts that emerge in research delivery can marginalise awareness of how important the relational and processual nature of the work is. The relational, political, and processual often sit in oppositional conflict with the scientific and bureaucratic rationality that underpins the methods. What I mean here, as manifested clearly in P2, is that my colleagues and I can only achieve what we achieve through relational, political, and processual work, but we do this in an environment that ignores or neglects the importance of these processes. As a result of this marginalisation of the complexity of experience, conflict emerges. This conflict can go on to cause harm through misrecognition, with the disappearance of moral agency that comes from having to ‘follow the rules’, where differing thought styles clash, and where conversations become polarised.

As I have already drawn attention to by discussing the relationally simplified accounts of research documented in peer-reviewed journals, it is as if these published accounts become a performance of unbiased, rational research and associated truth claims. It is known that research is a messy, complex activity – indeed, this is true of the origins of EBM, whereby clinicians weighed up the advantages and disadvantages of evidence in light of the patient before them. However, my research shows that the performance of science being ‘objective and pure’ is carried through into how research evidence is subsequently used.

Conflict and harm can emerge through misrecognition

A key point made by Arendt, which I drew attention to in P2, is that speaking is a form of political action (1958:3). Through speaking, we make ourselves visible; speaking can make the plurality of positions and identities more visible, rendering others’ positions plausible or implausible. Arendt also claims that politics and violence are opposites (Arendt, 1969:56). When I look at this in light of my claims that the ideological certainty of scientific empirical research marginalises the political nature of research, the violence that I inadvertently perpetrated and others experienced (and vice versa) seems inevitable.

In P2, hearing that research is political was a stark reminder of the nature of what I was involved in. Searching for a common purpose was not straightforward, and the political nature of research emphasised both the importance of recognising a plurality of beliefs and the ease with which we can become increasingly polarised. Arendt argues that plurality is the basis for all human activity, including political action, and that it is only through recognising and respecting, rather than eliminating difference that political action becomes possible (Arendt, 1958, Arendt and Kohn, 2005).

In the context of research, my empirical material has demonstrated that research can benefit some (for example, patients or the chief investigator) while it harms others (for example, research delivery staff, managers, or clinicians). I have found that this harm often emerged when a belief in the certainty of the research activity suppressed the views of others involved. This suppression became a type of tyranny, where some of my colleagues felt misrecognised, felt powerless, lacked agency, and experienced a loss of identity. Subsequently, this caused them to rise up and fight for the things they believed to be true.

An emergent theme in my projects is hypocrisy, specifically the hypocrisy that arises from the combination of taking political action and attempting to hold a plurality of views. Canovan (1992:192-193) describes this as a type of political evil, especially where moral and political goodness are conflated. At the same time as having to guard against ‘political evil’, we have to take responsibility and do good in the public world; although I recognise that at times, my desire to do good might have been a way to mask how I was working to benefit my own interests. Runciman (2008:52-53) describes hypocrisy as playing with truth; not only making claims about oneself that are not true, but also concealing the truth about oneself by sticking to a type of truth in public. Speaking only the bare minimum that allows one to ‘get by’ contributes to clashes between those with differing thought styles, misrecognition, and the further polarisation of beliefs.

My research has demonstrated that EBM involves the politics of recognition (whether it is acknowledged or not). Therefore, there is the potential for those involved to experience misrecognition, which can escalate into conflict, violence, and harm. As I made clear in P3, this is not physical violence — although I recognise that in some cases, such as the anti-mask and anti-vax movements associated with the COVID-19 pandemic, it might be (e.g.Pascual-Ferrá et al., 2021). Rather, it is a type of methodological and ideological sparring that plays out across multiple arenas and can sometimes leave those involved feeling bruised and at other times can be generative.

In my research I claimed that belonging to a particular thought collective contributed to conversations becoming polarised. For example, polarisation could occur in conversations between qualitative and quantitative researchers, trialists and process researchers, ethnographers and grounded theorists, or managers and clinicians. Regardless of who the polarisation is between, differing research methodologies produce results that give different answers, which sometimes leads to multiple but conflicting truths emerging from (or in relation to) research. This is most obvious when the overall results of an RCT do not return positive findings about clinical effectiveness or cost-effectiveness, but a *process evaluation* might describe in rich detail how an intervention is experienced and how well it is working for some of the participants.

Mowles (2012:551), drawing on Dewey, Arendt, and Taylor, describes how the objectification that arises from more detached ways of understanding the world, along with the domination of instrumental, technical, and rationalist ways of knowing and understanding the social world, can potentially impoverish social relations. In my projects, this impoverishment was caused by an absence of recognition that came from the rigid adherence to organisational bureaucracy, research regulations, and empirical research methods; in this way, research can both alienate and resonate (Rosa and Wagner, 2019).

When I think about misrecognition in relation to EBM, I have experienced it happening at multiple points across a research project, including through funding rejections, aggressive peer review, collaborative compromises, patients not feeling the perceived benefits, patients being randomised to the control arm, and results not being published. Conflicting methods, values, ideologies, and beliefs mean that the portrayal of research is anything but sanitised; the dominance of EBM creates an environment where finding a position of stability or control becomes more difficult, despite research results sometimes claiming to be definitive. This can contribute to a type of structural violence becoming inherent in research and EBM. In my projects, the belief in the objectivity of EBM meant that research results were understood and applied in rigid ways, which led to coercion, oppression, frustration, and moral injury.

Argument 3

Research management involves exercising practical judgement, being engaged more fully in political action, and being immersed in the social melee of human relating.

Political action and phronesis as resources in research management

The clinical research methods addressing various aspects of mental illness, and that I have been involved in using, rarely pay attention to the processual nature of creating and using research evidence. However, I have found that doing research involves acknowledging the fundamental idea that the human condition is one of plurality (Arendt, 1958:7). This may undermine the belief in the existence of 'the' truth (for example, 'this treatment does / does not work' or 'this service is / is not safe'). However, at the same time, research can be a mechanism for reaching an *agreed* truth (for example, 'this treatment works for us'), particularly when taking into account the theories of Popper (1963), Kuhn (1962), and Fleck (1935). Based on my research, I concluded that while we neither want to nor will reject EBM, being more fully involved in the processual and relational nature of research activities might improve the quality of the work, rendering it more useful in the long run.

I have argued that to *engage more fully* included recognising that:

1. the process of being in dialogue is identity-forming (Taylor, 1994:33);
2. mutual esteem is essential to avoid misrecognition (Honneth, 2005b:123-124), but competing self-interests are a threat to this;
3. the use and misuse of administrative powers in a corporate setting can be a form of symbolic and structural violence (Bourgois, 2001:8, Vince and Mazen, 2014);
4. reactions and perspectives are based on what is experienced, and being honest about what one has at stake (Mowles, 2015:139);
5. our selves are implicated in each other's lives, bound by a set of social relations that can be as destructive as they are sustaining (Butler, 2020:9); and
6. to *engage more fully* may not always be generative, especially given the unpredictable nature of human relating (Canovan, 1992:133, Mowles, 2015:134):
7. creating wriggle room, or the time and space to see things differently is an important way to manage difference.

In my projects, I described how conflict and breakdowns might have emerged due to a gap between the simplicity and certainty of positivist and technocratic views on the one hand, and the complexity and uncertainty of the lived experience of decision-making on the other hand. Within the empirical-scientific landscape of EBM, finding ways to cope with uncertainty is crucial. It is claimed that objective knowledge produced by rational research is essential to how the NHS functions. However, acknowledging the roles of practical judgement (phronesis) and political action allows another way to engage more fully with questions about the theoretical and social conditions in which such objective knowledge is produced, and reflects an ongoing struggle to recognise the plurality of voices. Following on from Bourdieu, I argue that the gains from objective knowledge are conserved and transcended by *“integrating the truth of practical experience, and the practical mode of knowledge which this learned knowledge had to be constructed against”* (Bourdieu et al., 1977:4). Therefore, acknowledging that rational science is produced in a social world is a way to navigate the certainty and uncertainty which stems from it.

Some critics of the way EBM is used in both policy-making and clinical practice have argued that (especially in a ‘post-pandemic’ world) more pluralistic methods need to be used in clinical research (Greenhalgh et al., 2022). My research has demonstrated that methodological pluralism might need to go beyond much needed changes to the evidence hierarchy, as described by Greenhalgh et al. (2022), by also reflecting what it means to be more fully engaged in the political, processual, and relational nature of research management and delivery. This may help research activity to accommodate the dynamic, unpredictable, and adaptive nature of human relating. While an increasing number of RCTs include a ‘process evaluation’ (French et al., 2020), this is often an inconsistent inclusion, which could be ignored at a later stage. An important part of the JOURNEY project was being able to secure additional funding for an extended anthropological study of how both the intervention and the RCT more generally were working in an everyday way. This in-depth exploration of the intervention in practice, which will consider the human, social, and relational, may well become a more important project than the RCT.

In my P3 and P4 I took the phrase *finding wriggle room* as a vernacular term for phronesis by drawing on the Eliasian description of life being both firm and elastic (Elias, 1991:49) and as a way to describe how I might establish a new orientation to a situation. *Finding wriggle room* also emphasises that a type of fluidity is involved in coming to a judgement. The idea of phronesis (practical judgement or wisdom, prudence, or common sense) comes from Aristotle; it is described as the most important of the intellectual virtues, due to its relevance to what is good and bad for ‘men’ (Aristotle, 1953:176 - book 6, chapter 5). In other words, it is the intellectual virtue that deals with questions of ethics, which in turn speak to the violence and harm I have described in my work (e.g. P3, p75-79, where I describe dismissal and blocking progress as acts of violence). A person with practical wisdom has knowledge of how to act in any circumstance that cannot be derived solely from a knowledge of generalised truths (Flyvbjerg, 2001:57). Therefore, phronesis is rooted in understanding, judgement, and the application of knowledge gathered over time by navigating complex situations. Phronesis builds a person’s capacity to act in moral and ethical ways (Kraut, 2022). Given that we move around within *“a landscape of possibilities”*, phronesis, rather than being hidden inside the mind, is best described as something that emerges from the flow of activity that people are immersed in when doing things (Shotter and Tsoukas, 2014b). Arendt’s concept of judgement draws on Kant and Aristotle (Passerin D’entrèves, 2000:253, Taylor, 2002a:153). Judgement requires engaging in critical thinking in the public realm. Arendt argues that political judgements require an understanding of the unique circumstances and perspectives (emphasising phronesis) and the importance of the public realm for deliberation and collective decision-making (Steinberger, 1990:809, Canovan, 1992:229, Passerin D'entrèves, 2000:250). This resonates with Shotter and Tsoukas' (2014b) claims that exercising phronesis is not a private individualised activity.

Arendt (1958) makes distinctions between 'labour' as the necessary activities to sustain life, such as securing food; 'work', which involves the production of lasting artefacts; and 'action', which represents human interaction, speech, and political engagement and is essential for the formation of identity and the pursuit of freedom. It is through action that lasting meaning in public life is found (Arendt, 1958:179). Arendt's writing is concerned with modernity and the rise of scientific and bureaucratic rationality, which she thought would marginalise political action in favour of work. The unique capacity of humans to engage in collective deliberation, judgement, and public discourse, shaping the world through shared decision-making, risks being eroded or collapsed into the realm of work, and reduced to instrumental means for achieving personal or economic goals (Arendt, 1958:180, 220, 230). I have drawn on these concepts across my projects (for example, P2 p37, P3 p66), and in those projects the political nature of research activity is clear. Arendt distinguishes political action from violence; she argues that violence is a destructive force that disrupts political action, because it seeks to dominate and destroy rather than to engage in meaningful dialogue (Canovan, 1992:186); our ability to think politically and ethically risks becoming an instrumental and rational production of 'artefacts' or research results. Arendt's descriptions of action resonated with me; I felt able to relate them to my everyday practice, even though Arendt was writing in response to the rise in totalitarianism and about how this denied the central characteristic of humans: their plurality (Canovan, 1992:130).

Arendt's concept of political action is distinct from Aristotle's concept of phronesis, although both concepts involve the exercising of human agency and the pursuit of good. While political action is characterised by the plurality of perspectives, the exercising of freedoms, and the possibility of creating new beginnings through collective action, phronesis is far more extensive. It guides an individual's action in a broader sense, bringing one's past experience and ethics to determine the best course of action. I found exercising phronesis alongside political action means taking a perspective that is both taking involved and detached in order to use reflection[4] and reflexivity[5]. Reflexive engagement is a way for us to become more aware of our actions that arise from taken-for-granted assumptions, and it helps us to become more immersed in the thinking, feeling, and forming of our intentions; this keeps us alive to the unique circumstances we may be facing. As Mowles (2015:71) writes, using phronesis means *"talking and experimenting together, and by taking risks in*

---

[4] the in-depth consideration of a specific situation to develop perception. BOLTON, G. & RUSSELL, D. 2018. *Reflective practice : writing and professional development,* London, Sage.

[5] taking into view both the subject and the object of study, and understanding them in paradoxical relation. MOWLES, C., VAN DER GAAG, A. & FOX, J. 2010. The practice of complexity: Review, change and service improvement in an NHS department. *Journal of Health Organization and Management,* 24**,** 127-144.

uncovering some of the assumptions that [managers] are making in undertaking the work. In doing so they find themselves engaging in the messy uncertainties of the here and now of their work situation, and the contradictions and paradoxes that are inherent in it".

In the context of the research activity that I am involved in, phronesis and political action are resources for use in managing research. However, exercising phronesis involves being open to a plurality of views, which may undermine beliefs in the idea there are definitive research results while simultaneously enabling action based on an agreed set of research results. Arendt argues that plurality is the basis for all human activity, including political action, and that it is only through recognising and respecting difference (rather than seeking to eliminate it) that political action becomes possible (Arendt and Kohn, 2006:60-61).This recognition of plurality allows individuals to engage in dialogue and debate, which can lead to the formation of new ideas and perspectives.

My research shows that there are possibilities for engaging with EBM in a mental health context in ways that are much more sensitive to relationships and to individuals involved. Recognising the boundaries that EBM imposes may make it possible to engage with it in ways that do not marginalise the qualities of the work that involve uncertainty that permit fuller engagement with the inevitable tensions and conflicts (as I wrote about in P3).

Phronesis: taking experience seriously, and being reflexive

Phronetic knowledge can only be developed through experience and through exercising *"a wide range of practical skills in adapting to changing circumstances"* (Stacey, 2012b:56) and because experiences are social, *"phronesis is essentially a social way of knowing"* (Stacey, 2012b:56). Therefore, and as I have demonstrated in my research, 'taking experience seriously' is important: reflective and reflexive engagement with these experiences creates the possibility for developing phronesis. Furthermore, Stacey argues that management practice is more helpfully located in the realm of phronesis than those of 'episteme' or 'techne' because among these three intellectual virtues, phronesis is the one that focuses on *"what is good and bad for man"* (Stacey, 2012b). In other words, phronesis is knowledge that does not reduce everything to instrumental rationality but holds on to a notion of 'value rationality' (Flyvbjerg, 2001:53, 62, 130), where decision-making and actions are reflexively guided by an agreed set of values, norms, or principles. Various other management scholars have incorporated the concept of phronesis into the contexts of management, knowledge creation, and innovation in a business setting. The literature on phronesis in management highlights its relevance for ethical decision-making, ways to create new meaning, the political nature of people coming together, reflection, and the sharing of experiences (e.g. Gosling and Mintzberg, 2004, Nonaka, 2008, Nonaka and Takeuchi, 2011). In the context of my organisational experiences, taking experiences seriously and exercising phronesis also means acknowledging the ethical qualities of interactions and the ever-present risk of harm and violence.

Based on my research I found that practical judgement (phronesis) a resource to be used in delivering clinical research, enabling those involved to respond effectively to the uncertainty experienced. Though reflection and reflexivity It enable me and those I was working with to engage in the instability of the work we were doing which in turn helped to stabilise, even if temporarily, the fragility within pervasive management practice. Further, I argue that it temporarily stabilised the fragility of human relationships in humane and ethical ways though interrupting our responses to unexpected contingencies (Stacey, 2012b:56). This may have subsequently reduce the likelihood of harm arising from the work we do together, while recognising that conflict and disagreement are unavoidable (Bernstein, 2013:337).

As my narratives have shown I have found it easy to claim objective, rational, and scientific impartiality when running mental health research projects or clinical trials that seek to produce definitive answers about what works for patients. However, I now assert that achieving objectivity and impartiality in healthcare research is implausible — or, rather, my research has demonstrated that it is rendered plausible only by paying attention to the complex, messy, and unpredictable human relating that takes place alongside the research activity.

In my projects, I found it impossible to undertake clinical research (that is, RCTs) without exercising practical judgement (phronesis), being engaged in political action, and being immersed in the social melee of human relating. The claims that objective, unbiased, statistically robust results are derived from RCTs would probably be easier to challenge if the results accommodated the social, political, and relational nature of the work done in running the research; yet running an RCT without being immersed in the social-political-relational would be hard, if not impossible.

Contribution to theory

This research described in my thesis provides a highly contextual understanding of doing research in an NHS mental health setting. It contributes to the existing literature by drawing attention to how research activity can discursively assume an ideology of certainty. At the same time, the activities undertaken by those involved are permeated by uncertainty that arises from the relational, political, and processual qualities of interactions between people.

This thesis makes the following contributions to the current body of knowledge on management (in research activity and generally) in an NHS context.

In the NHS, management tends to be dominated by systems theory (Mowles et al., 2010, Clarkson et al., 2018, Chada, 2022). However, more recently, there has been a growing recognition that the NHS has become increasingly complex (Pype et al., 2018, NHS England, 2023). Despite this, there is a desire among healthcare managers to find tools that enable the complex and unpredictable to be managed and controlled. Examples include the Cynefin framework (Van Beurden et al., 2011, Elford, 2012, Gray, 2017), compassionate leadership (de Zulueta, 2016, West and Chowla, 2017, Benevene et al., 2022), and VUCA (volatile, uncertain, complex, and ambiguous) environments (Baran and Woznyj, 2020, Schulze et al., 2021, Luthans and Broad, 2022). While each of these tools is distinct from the others, they all suggest that by understanding the complexity of work, human interactions, and the environment, it is possible to effectively and instrumentally control and manage situations — whether by assessing the level of complexity, adopting positive behaviours, analysing ambiguity, or following various leadership steps. These claims about the possibility of control rest on the idea of the manager as an autonomous individual; in other words, these management tools and models rarely or insufficiently recognise the relationality of human life. They neglect the idea that managers form the organisation that they are a part of while at the same time being formed by organisational population-wide patterns of activity (Stacey, 2012b:99-100). By assuming that managers are free to do what they consciously and rationally choose to do, these tools and models neglect the relational nature of all social interaction, meaning that they eventually rely on an assumption of individualism and instrumentalism. As my research has demonstrated, this can contribute to a desire, or perhaps even a fundamental expectation among healthcare managers for certainty and control.

Working with conflict, ambiguity, and uncertainty is not easy. However, engaging reflexively in moments of breakdown, particularly with prior assumptions and within a community of inquiry setting, can help to increase confidence in dealing with the complex everyday work that managers and clinicians are involved in (Mowles et al., 2010). Moving from an undifferentiated generalised view to a more particular situational perception of events, being deliberately imaginative, and engaging with emotions responsively are ways to bring phronesis into our practice (Mead, 1934:155-156, Shotter and Tsoukas, 2014a). Recognising the social nature of knowledge and acknowledging the political and institutional conditions are also important ways to engage with EBM (Swan et al., 2016). Collective meaning-making, acknowledging uncertainty, and attending to the relational nature of the work at hand may help managers to find ways of learning through action (Greenhalgh et al., 2023). On the basis of my research, I conclude that management practice (including research management) is about continuous responsiveness in particular uncertain situations. As my research has demonstrated, a defence to the anxiety this can provoke sometimes means avoiding uncertainty – working in the shadows – as I describe in my projects. The possibility of taking responsibility arises from engaging politically through one's speech and actions. In this way, our participation in events around us is a form of phronetic participation.

In this thesis I have described how conflict can manifest when doing research. In my projects conflict was particularly prevalent in discussions about what should be done that revealed the different ways in which knowledge develops: theoretically (episteme), bureaucratically, or experientially (phronesis). The bureaucratic and scientific rationality underpinning management and research contributes to the domination of Aristotle's 'episteme' or theoretical knowledge (Townley, 2008:65), but it negates that new knowledge is also socially derived from historical knowledge (Säljö, 2002:400) and that, more generally, knowledge is an ongoing and dynamic process of inquiry that is constantly being revised and refined (Dewey et al., 2008).

I have argued that navigating this ongoing and dynamic process in a way that might be less harmful requires fully engaging with developing and exercising practical judgement. My research contributes to the ongoing conversation in management research about the idea that selves are social and, therefore, even the most scientifically rational research is also social — constrained and enabled through differing ideologies, thought styles, beliefs, and values. From my research I have concluded that the scientific and bureaucratic tools of EBM can marginalise engagement with the relational nature of research, making research much harder to do, especially when conflict emerges. On the one hand, my research has shown that engaging more fully in conflict or difference that arises when working with others can cause it to escalate. On the other hand, suppressing conflict (or violence) through management or research tools does not resolve the conflict in the longer term and can even create the circumstances for the conflict to continue. I suggest that taking Butler's work on nonviolence (2020) and Mowles' work on the cooperation-competition paradox (2015) may enable managers to respond to the everyday conflict that emerges through research. This could be done by finding different ways to engage with those involved, rather than by relying on the instrumental rationality of management tools to attempt to eliminate the unavoidable uncertainty. My research contributes to this field of management research by describing what those involved in clinical research (managers, clinicians, and research staff) may be doing during the research process, and how this may be woven into situations in which conflict arises.

In my projects I drew attention to the contested nature of mental health research, and how this can stem from the contested nature of existing treatments and diagnosis (e.g. P2, p41). In my thesis I have shown that this means that mental health research activity is especially prone to a certainty/uncertainty paradox. For example, and in my experience, the more detailed a research project recruitment plan is and the more certain we might be about how successful the plan will be, the less likely it is to work. As such, recruitment plans rarely survive contact with actual participants (Richards and Hallberg, 2015:165) and in response to this the focus is often on improving what is in the researchers' control. However, as I have demonstrated in this thesis, although I and my colleagues might have been in charge, we had little by way of control (Mowles, 2015). Despite this challenge, I have found that research can be conducted in ways I suggest above (argument 3, p155) that are less harmful by paying attention to its relational, political, and social nature while also meeting the standards expected by the broader scientific research community.

In a context of historic underfunding of mental health research, I am not arguing that the NHS needs fewer RCTs; rather, we need better RCTs that accommodate the principles of EBM+ (Fuller, 2021, Tresker, 2021, Greenhalgh et al., 2022), accounting for the evidence omitted by EBM and accommodating the view that *"at best … a trial shows what can be accomplished with a medicine under careful observation and certain restricted conditions"* (Horton, 2000). My thesis contributes to the evidence base on how to deliver research in the NHS by deepening the understanding of the complexity involved and the potential for dehumanised and violent practice to arise from the dominance of particular ideologies. This may also be relevant in contexts outside NHS research delivery.

Therefore, my contribution to theory is a more nuanced understanding of: (1) the challenges that arise from the relational nature of research, and (2) how practical judgement and political action may be less conflictual and more useful resources for sustaining clinical research activity. I believe the best way to draw attention to this contribution to theory is to describe how political action and practical judgement were exercised in the delivery of the research I describe in my projects, which can be published in articles resulting from this thesis.

Potential publications where contributions could be made include:

- *BMJ Evidence-Based Medicine*, ISSN:2515-4478
- *The Journal of Mixed Methods Research*, ISSN:1558-6898
- *The Health Services Research Journal*, ISSN:1475-6773
- *BMC Trials*, ISSN: 1745-6215
- *Health and Social Care Delivery Research*, ISSN:2755-0079

These contributions may also be taken up in practice on the Advanced Research Practice Experience module (HPDM158Z) of the Leading Clinical Research Delivery MSc programme at the University of Exeter.

Contribution to practice

Through the projects included in this thesis, I have purposely thought about my practice, and I have adapted my contributions at work in light of what I have learnt from this reflexive process and from the responses from others in my community of inquiry. Prior to my involvement in the DMan programme, it was not a significant part of my practice to think about and describe events in a way that helped me to imagine what might also be going on for others. I am now much more willing to engage with uncomfortable questions, knowing that there might not be a 'good' answer or one that serves my interests well. I think that sitting with such questions opens up the possibility for understanding. I am also much more attentive to my propensity to reification, in particular because reification risks alienation by ascribing agency to things that only exist due to human activities or relationships. However, this does not mean that we should simply abandon the tools and processes of research management in the NHS. There needs to be accountability for the large amounts of public funding spent on research, recognition of some of the life-changing results of research, and protection against the past failures due to poor research governance practice.

Within my practice, I have also explored how willing my colleagues and I are to engage in conversations, especially when we recognise that our positions, values, or beliefs might be in conflict or that in proceeding we will have to sit with a high level of uncertainty.

I have moved away from embracing a more simplistic view of what my colleagues and I do. I recognise that it is possible to only look at how research functions in the NHS in a rational, objective, and controllable way. However, this position can foster an avoidance of discussing how and why some things work and others do not. Discussing these issues can cause friction and conflict. Avoiding conflict can sometimes lead to more conflict; yet engaging with conflict can also lead to more conflict. As I argued in my projects, engaging with conflict may also be a productive way to progress the work at hand, however. Here, phronesis, that is the practical judgement made through paying attention to our experiences involves sensing when conflict would benefit from being dealt with and when it would be better left untended.

In terms of a more general contribution to my practice, I will continue to pay attention to the gap between idealised and generalised (certainty-forming) theories about management and the complex, messy, and uncertain qualities of everyday experiences. This links to how I might notice that people are caught up in processes of recognition/misrecognition, political struggles, alienation, and conflicts that may escalate into violence.

I and my colleagues are now paying more attention to concepts such as conflict and certainty. I describe how previously they were often viewed as an unnecessary hindrance and unscientific. As 'objective' managers or researchers it was easy to claim we were keeping out of the politics. Through paying attention to experience new spaces into which we might wriggle into became possible, and in doing so allowed for different perspectives on the situation we found ourselves in.

By way of example, I recently met with the director of a research collaboration, along with his senior academic and managerial colleagues, to discuss how we might collectively respond to the types of bureaucratic delays they frequently encounter when trying to get low-risk (non-pharmacological) research projects started in the NHS. The conversation began with a discussion about how we could change NHS research approval systems, how those in administrative roles might be enabled to make the relevant decisions, or how this responsibility could be taken from them and decisions could be made by more senior people. Drawing on examples from P3 (and having introduced my DMan research), I spoke about how sometimes people might be following processes or rules for less obvious reasons. I described how my conversation with my colleague Kelvin (the head of IG) revealed that despite the existence of sensible rules and guidelines, sometimes people in administrative positions respond in ways that appear to be at odds with our interpretation of the rules for reasons that are not clear. Using the case of P3 as an example, my warranted assertions were that alienation and misrecognition resulted in working in a way that provoked recognition and an amplification of personal importance from elsewhere. I also shared that although a potentially brutal enforcement by a powerful person (that is, a research director ordering an administrator to do something) might seem effective in dealing with individual delays and issues, it may perpetuate, escalate, or create new issues in the longer term.

Our conversation then turned to the role that senior managers in authoritative positions (directors, medical consultants) can play in co-creating an environment where more junior staff can act with authority in doing the work at hand. I reflected that although I thought this was important, an authoritative permissive statement to act might be helpful to one person but oppressive to another. This prompted another colleague in the meeting to reflect that this reminded her of reading Bakhtin (e.g., Bakhtin, 1984) and that a multitude of fully valid voices are present in conversations. The experiences I shared, along with my theoretical work, strongly resonated with my colleagues, so we moved on to the ‘questions about what should be done now?’ questions.

The director then shared two stories about working in different NHS trusts on implementing new treatments. One project was deemed a failure in that after three years of work the evidence-based intervention had not been implemented; in the other, the intervention was implemented within weeks following a few months of intensive work to understand what was stopping key people from implementing the intervention

My colleagues started the conversation by asking how systems or processes could be changed to reduce delays in starting research, and together we finished by recognising that the relational and political nature of research is just as important, especially when thinking about how to create bureaucratic wriggle room. With this, we agreed to design and facilitate a series of workshops involving staff at all grades in research delivery and management. In these workshops, rather than mapping processes and systems and getting caught up in how to reduce siloed working, we would instead explore one key question: ‘What stops you doing what needs to be done?’ In this way, I believe my research has the potential to make a difference to other people’s practice as well as my own.

Future research

The research I hope to take forward is that of documenting, as a participant-observer, how the everyday exercising of practical judgement alongside RCTs might take place and how this may (or may not) shape the research outcomes. This is likely to mean a partial departure from the problematising methods employed in this thesis, as I would anticipate taking more purposeful steps to intervene or to change something. I would do this by openly bringing a type of pragmatism into clinical trials that more explicitly recognises the social-political-processual-relational nature of research. However, it will be important to remain open to moments of surprise, mystery, and dissonance that.

Bibliography

AL-JUNDI, A. & SAKKA, S. 2017. Critical Appraisal of Clinical Research. *J Clin Diagn Res,* 11**,** JE01-JE05.

ALTHUSSER, L. 1970. Ideology and Ideological State Apparatuses (Notes Towards and Investigation). Available: https://mforbes.sites.gettysburg.edu/cims226/wp-content/uploads/2018/09/Week-3b-Louis-Althusser.pdf.

ALVESSON, M. & KÄRREMAN, D. 2011. Qualitative Research and Theory Development: Mystery as Method. London: SAGE Publications Ltd.

ALVESSON, M. & SANDBERG, J. 2011. Generating Research Questions Through Problematization. *Academy of Management Review,* 36**,** 247-271.

ALVESSON, M. & SKÖLDBERG, K. 2009. *Reflexive Methodology: New Vistas for Qualitative Research*, SAGE Publications.

ANDERSON, L. 2006. Analytic Autoethnography. *Journal of Contemporary Ethnography,* 35**,** 373-395.

ANDREWS, M., SQUIRE, C. & TAMBOUKOU, M. 2008. *Doing Narrative Research*, SAGE Publications.

ARASARADNAM, R., CLARKE, S., VAN'T HOFF, W. & CHAPPELL, L. 2023. Making research everybody's business: a position statement of the Royal College of Physicians and the National Institute of Health and Care Research. *Clinical Medicine,* 23**,** 102-105.

ARENDT, H. 1958. *The Human Condition, Second Edition 2018.* London, University of Chicago Press.

ARENDT, H. 1963. *Eichmann in Jerusalem, Penguin Edition 2006.* USA, Penguin Books.

ARENDT, H. 1967. *Truth and Politics* [Online]. The New Yorker Magazine, February 25,1967: The New Yorker. Available: https://archives.newyorker.com/newyorker/1967-02-25/flipbook/048 [Accessed 08/12/2022 2022].

ARENDT, H. 1969. *On Violence,* USA, Houghton Mifflin Harcourt Publishing Company.

ARENDT, H. & KOHN, J. 2005. *The Promise of Politics*, Schocken Books.

ARENDT, H. & KOHN, J. 2006. *Between Past and Future*, Penguin Publishing Group.

ARENDT, H. & KOHN, J. 2021. *Thinking Without a Banister : Essays in Understanding 1953-1975, First Paperback ed* New York, Schocken Books.

ARISTOTLE 1953. *Ethics, 1970.* Middlesex, Great Britian, Penguin.

BAKHTIN, M. 1984. *Problems of Dostoevsky's Poetics*, University of Minnesota Press.

BALDWIN, A. 2023. The history of industrial action in the NHS. *The Bulletin of the Royal College of Surgeons of England,* 105**,** 158-160.

BARAN, B. E. & WOZNYJ, H. M. 2020. Managing VUCA: The human dynamics of agility. *Organ Dyn***,** 100787.

BARNES, J., STEIN, A. & ROSENBERG, W. 1999. Evidence based medicine and evaluation of mental health services: methodological issues and future directions. *Archives of Disease in Childhood,* 80**,** 280.

BAUCHNER, H. & VINCI, R. 2001. What have we learnt from the Alder Hey affair? That monitoring physicians' performance is necessary to ensure good practice. *Bmj,* 322**,** 309-10.

BBC. 2015-2021. *In Our Time* [Online]. London: BBC Radio 4. Available: https://www.bbc.co.uk/programmes/b006qykl/episodes/downloads [Accessed 15/02/2021 2021].

BECKWITH, A. 2019. C. S. Peirce and Abduction Inference. *JCCC Honors Journal,* 10.

BENEVENE, P., BUONOMO, I. & WEST, M. 2022. Editorial: Compassion and compassionate leadership in the workplace. *Front Psychol,* 13**,** 1074068.

BERGER, P. & PULLBERG, S. 1965. Reification and the Sociological Critique of Consciousness. *History and Theory,* 4**,** 196-211.

BERNSTEIN, R. 1988. *Why Read Hannah Arendt Now, First 2020.* Cambridge UK, Polity Press.

BERNSTEIN, R. J. 1989. Pragmatism, Pluralism and the Healing of Wounds. *Proceedings and Addresses of the American Philosophical Association,* 63**,** 5-18.

BERNSTEIN, R. J. 2014. Engaged Fallibilistic Pluralism. *COLUMBIA PRAGMATISM COLLOQUIUM.* Columbia Pragmatism group: Columbia University, Philosophy Department.

BIRD, A. 2004. *Thomas Kuhn* [Online]. Stanford University. Available: https://plato.stanford.edu/entries/thomas-kuhn/ [Accessed].

BMA. 2022. *NHS Backlog analysis* [Online]. BMA Website: The British Medical Assoication. Available: https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-backlog-data-analysis [Accessed 02/02/2023].

BOAZ, A., HANNEY, S., JONES, T. & SOPER, B. 2015. Does the engagement of clinicians and organisations in research improve healthcare performance: a three-stage review. *BMJ Open,* 5**,** e009415.

BOCCIA, S., LA TORRE, G., PERSIANI, R., D'UGO, D., VAN DUIJN, C. M. & RICCIARDI, G. 2007. A critical appraisal of epidemiological studies comes from basic knowledge: a reader's guide to assess potential for biases. *World J Emerg Surg,* 2**,** 7.

BOLTON, G. & RUSSELL, D. 2018. *Reflective practice : writing and professional development,* London, Sage.

BOURDIEU, P., BOURDIEU, P. P. & NICE, R. 1977. *Outline of a Theory of Practice*, Cambridge University Press.

BOURGOIS, P. 2001. The power of violence in war and peace: Post-Cold War lessons from El Salvador. *Ethnography,* 2**,** 5-34.

BRAGG, M. 2007. Popper. *In:* BRAGG, M. (ed.) *In Our Time.* BBC Radio 4.

BRINKMANN, S. 2012. *Qualitative Inquiry in Everyday Life: Working with Everyday Life Materials*, SAGE Publications.

BRUNER, J. 2004. Life as narrative. *Social Research: An International Quarterly,* 71**,** 691-710.

BUTLER, J. 2020. *The force of nonviolence : an ethico-political bind, Paperback edition* New York, Verso.

CANOVAN, M. 1985. POLITICS AS CULTURE: HANNAH ARENDT AND THE PUBLIC REALM. *History of Political Thought,* 6**,** 617-642.

CANOVAN, M. 1992. *Hannah Arendt, A Reinterpretation of Her Political Thought, First Paperback, 1994 1995.* Cambridge, UK, Cambridge University Press.

CAPUTO, J., D. 2007. *What Would Jesus Deconstruct?: The Good News of Postmodernism for the Church, First* Grand Rapids, USA, Baker Academic.

CARLISLE, J. B. 2021. False individual patient data and zombie randomised controlled trials submitted to Anaesthesia. *Anaesthesia,* 76**,** 472-479.

CARTWRIGHT, N. 2010. What are randomised controlled trials good for? *Philosophical Studies,* 147**,** 59-70.

CHADA, B. V. 2022. The systems engineering approach to quality improvement in the NHS. *Future Healthcare Journal,* 9**,** 330-332.

CHANG, H. 2016. Autoethnography in Health Research:Growing Pains? *Qualitative Health Research,* 26**,** 443-451.

CHASE, S., E. 2005. Narrative Inquiry: Multiple Lenses, Approaches, Voices. *In:* DENZIN, N., K. & LINCOLN, Y., S. (eds.) *The Sage Handbook of Qualitative Research.* Third ed. London: Sage.

CLARKE, A., TAYLOR-PHILLIPS, S., SWAN, J., GKEREDAKIS, E., MILLS, P., POWELL, J., NICOLINI, D., ROGINSKI, C., SCARBROUGH, H. & GROVE, A. 2013. Evidence-based commissioning in the English NHS: who uses which sources of evidence? A survey 2010/2011. *BMJ Open,* 3.

CLARKSON, J., DEAN, J., WARD, J., KOMASHIE, A. & BASHFORD, T. 2018. A systems approach to healthcare: from thinking to -practice. *Future healthcare journal,* 5**,** 151-155.

COGHLAN, D. & BRYDON-MILLER, M. (eds.) 2014. *The SAGE Encyclopedia of Action Research,* London.

COOKSEY, D. 2006. A review of UK health research funding. London: The Stationery Office.

COURT, A. J., COOKE, A. & SCRIVENER, A. 2017. They're NICE and Neat, but Are They Useful? A Grounded Theory of Clinical Psychologists' Beliefs About and Use of NICE Guidelines. *Clinical Psychology & Psychotherapy,* 24**,** 899-910.

CQC. 2022. *Rising demand for mental health care* [Online]. CQC Website: Care Quality Commission. Available: https://www.cqc.org.uk/publications/major-reports/soc202021_01d_mh-care-demand [Accessed 02/02/2023 2023].

CUNLIFFE, A. L. 2022. Must I Grow a Pair of Balls to Theorize about Theory in Organization and Management Studies? *Organization Theory,* 3**,** 26317877221109277.

DARZI, A. 2008. Evidence-based medicine and the NHS: a commentary. *Journal of the Royal Society of Medicine,* 101**,** 342-344.

DASHPER, K. 2015. Revise, resubmit and reveal? An autoethnographer's story of facing the challenges of revealing the self through publication. *Current Sociology,* 63**,** 511-527.

DE ZULUETA, P. C. 2016. Developing compassionate leadership in health care: an integrative review. *J Healthc Leadersh,* 8**,** 1-10.

DEATON, A. & CARTWRIGHT, N. 2018. Understanding and misunderstanding randomized controlled trials. *Soc Sci Med,* 210**,** 2-21.

DENZIN, K. & LINCOLN, Y. 2005. *The Sage Handbook of Qualitative Research, Third Edition* California, USA, Sage Publication Inc.

DENZIN, K. L., Y. 2005. *The Sage Handbook of Qualitative Research, Third* California, USA, SagePublication Inc.

DENZIN, N. K. 2014. Interpretive Autoethnography. Second Edition ed. 55 City Road 55 City Road, London: SAGE Publications, Ltd.

DERRIDA, J. 1967. *Writing and Difference, Routledge Classic 1978.* Abindon, Oxon, Routledge.

DESCARTES 1961. *Essdential Works of Descartes,* New York, United States of America, Bantam Books.

DEWEY, J. 1941. Propositions, warranted assertibility, and truth. *Journal of Philosophy,* 38**,** 169-186.

DEWEY, J. 1958. *Experience and Nature*, Dover Publications.

DEWEY, J., BOYDSTON, J. A. & TOULMIN, S. 2008. *The later works, 1925 - 1953. 4. 1929 : [The quest for certainty]*, Southern Illinois University Press.

DOSTOÏEVSKI, F. M., DOSTOYEVSKY, F., MCDUFF, D. & TODD, W. M. 2004. *The Idiot*, Penguin Publishing Group.

ELFORD, W. 2012. A multi-ontology view of ergonomics: applying the Cynefin Framework to improve theory and practice. *Work,* 41**,** 812-817.

ELIAS, N. 1956. Problems of Involvement and Detachment. *The British Journal of Sociology,* 7**,** 226-252.

ELIAS, N. 1978. *What is Sociology,* Great Britian, Hutchinson Co (Publishers).

ELIAS, N. 1991. *The society of individuals, 2001 reprint* New York, Continuum.

ELIAS, N. 2000. *Civilizing Process, 2000 Edition* Oxford, Blackwell.

ELIAS, N. 2001. *The society of individuals,* New York, Continuum.

ELKINGTON, E. 2022. The Double Bind of Metrics. *In:* MOWLES, C. & NORMAN, K. (eds.) *Complexity and the Public Sector (1st ed.).* Oxon: Routledge.

ELLIS, C. 2004. *The Ethnographic I: A Methodological Novel about Autoethnography*, AltaMira Press.

ENGLAND, N. Last Update Date 2017. Improvement Leaders' Guide. Working in systems. Process and systems thinking of Entry. Improvement Leaders' Guide. Working in systems. Process and systems thinking of WebLog [Online]. Available from: https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/ILG-2.4-Working-in-Systems.pdf [Accessed Date Access 2017].

ENGLAND, N. 2022. NHS Staff Survey 2021 National results briefing. NHS Staff Survey Website: NHS E/I.

FARRELL, C. & MORRIS, J. 2003. The `Neo-Bureaucratic' State: Professionals, Managers and Professional Managers in Schools, General Practices and Social Work. *Organization,* 10**,** 129-156.

FLECK, L. 1935. *Genesis and Development of a Scientific Fact, Paperback edition 1981.* USA, University of Chicago Press.

FLECK, L. 1986. The Problem of Epistemology [1936]. *In:* COHEN, R. S. & SCHNELLE, T. (eds.) *Cognition and Fact: Materials on Ludwik Fleck.* Dordrecht: Springer Netherlands.

FLYVBJERG, B. 2001. *Making Social Science Matter: Why Social Inquiry Fails and How it Can Succeed Again,* Cambridge, Cambridge University Press.

FOLLETT, M. P. 1924/2013. *Creative experience,* Mansfield Centre CT, Martino Publishing.

FOULKES, S. H. 1983. *Introduction to Group-Analytic Psychotherapy,* Oxon, Maresfield Reprints, Routedge.

FOULKES, S. H. 1990. *Selected Papers: Psychoanalysis and Group Analysis,* London, Karnac Books.

FRASER, N., HONNETH, A. & GOLB, J. 2003. *Redistribution or recognition?: a political-philosophical exchange*, Verso.

FREDDI, G. & ROMÀN-PUMAR, J. L. 2011. Evidence-based medicine: what it can and cannot do. *Ann Ist Super Sanita,* 47**,** 22-5.

FRENCH, C., PINNOCK, H., FORBES, G., SKENE, I. & TAYLOR, S. J. C. 2020. Process evaluation within pragmatic randomised controlled trials: what is it, why is it done, and can we find it?—a systematic review. *Trials,* 21**,** 916.

FREY, B. 2018. The SAGE Encyclopedia of Educational Research, Measurement, and Evaluation.

FULLER, J. 2021. The myth and fallacy of simple extrapolation in medicine. *Synthese,* 198**,** 2919-2939.

GEDDES, J., REYNOLDS, S., STREINER, D., SZATMARI, P. & HAYNES, B. 1998. Evidence-based practice in mental health. *Evidence Based Mental Health,* 1**,** 4.

GEERTZ, C. 1968. Thinking as a Moral Act: Ethical Dimensions of Anthropological Fieldwork in the New States. *The Antioch Review,* 28**,** 139-158.

GEERTZ, C. 1973. *The interpretation of cultures : selected essays, 2000 Edition*, New York : Basic Books,.

GOFFMAN, E. 1955. On Face-Work. *Psychiatry,* 18**,** 213-231.

GOFFMAN, E. 1959. *The preseantation of Self in Everyday Life, Penguin Edition 1990* St Ives, England, Penguin Books.

GOFFMAN, E. 1963. *Behavior in Public Places, First Free Press Paperback Edition 1966.* New York, USA, The Free Press.

GOODYEAR, M. 2006. Learning from the TGN1412 trial. *Bmj,* 332**,** 677-8.

GOSLING, J. & MINTZBERG, H. 2004. The Education of Practicing Managers. *MIT Sloan Management Review,* 45.

GRAY, B. 2017. The Cynefin framework: applying an understanding of complexity to medicine. *J Prim Health Care,* 9**,** 258-261.

GREENHALGH, T. 2021. Crisis policymaking: re-learning the lessons of pragmatist philosophy. *The 3rd Peter Sowerby Interdisciplinary Workshop.* YouTube: Philosophy and Medicine at KCL.

GREENHALGH, T., ENGEBRESTEN, E., BAL, R. & KJELLSTRÖM, S. 2023. Toward a Values-Informed Approach to Complexity in Health Care: Hermeneutic Review. *The Milbank Quarterly,* n/a.

GREENHALGH, T., FISMAN, D., CANE, D. J., OLIVER, M. & MACINTYRE, C. R. 2022. Adapt or die: how the pandemic made the shift from EBM to EBM+ more urgent. *BMJ Evidence-Based Medicine,* 27**,** 253-260.

GREENHALGH, T., POTTS, H. W. W., WONG, G., BARK, P. & SWINGLEHURST, D. 2009. Tensions and Paradoxes in Electronic Patient Record Research: A Systematic Literature Review Using the Meta-Narrative Method. *The Milbank Quarterly,* 87**,** 729-788.

GREENHALGH, T., ROBERT, G., MACFARLANE, F., BATE, P., KYRIAKIDOU, O. & PEACOCK, R. 2005. Storylines of research in diffusion of innovation: a meta-narrative approach to systematic review. *Soc Sci Med,* 61**,** 417-30.

GUEST, G., NAMEY, E. E. & MITCHELL, M. L. 2013. Collecting Qualitative Data: A Field Manual for Applied Research. 55 City Road, London.

HARRISON, S. & SMITH, C. 2003. Neo-bureaucracy and public management: The case of medicine in the national health service. *Competition and Change,* 7**,** 243-254.

HESSE, H. 1922. *Siddhartha, 1954 English Edition 1998.* Picador.

HICKS, T. 2018. The SAGE Encyclopedia of Educational Research, Measurement, and Evaluation. *In:* FREY, B. B. (ed.). SAGE Publications, Inc.

HILL, S. R. 2020. Hannah Arendt and the politics of truth. Available: https://www.opendemocracy.net/en/transformation/hannah-arendt-and-politics-truth/.

HIPPOCRATES 1978. *Hippocratic writings / edited with an introduction by G.E.R. Lloyd ; translated [from the Greek] by J. Chadwick and W.N. Mann ... [et al.],* Harmondsworth ; New York, Penguin.

HOLT, R. I. G., GOSSAGE-WORRALL, R., HIND, D., BRADBURN, M. J., MCCRONE, P., MORRIS, T., EDWARDSON, C., BARNARD, K., CAREY, M. E., DAVIES, M. J., DICKENS, C. M., DOHERTY, Y., ETHERINGTON, A., FRENCH, P., GAUGHRAN, F., GREENWOOD, K. E., KALIDINDI, S., KHUNTI, K., LAUGHARNE, R., PENDLEBURY, J., RATHOD, S., SAXON, D., SHIERS, D., SIDDIQI, N., SWABY, E. A., WALLER, G. & WRIGHT, S. 2019. Structured lifestyle education for people with schizophrenia, schizoaffective disorder and first-episode psychosis (STEPWISE): randomised controlled trial. *Br J Psychiatry,* 214**,** 63-73.

HOMER 1946. *The Odyssey,* Middlesex, England, Penguin Books.

HOMER 1950. *The Iliad,* Middlesex, England, Penguin Books.

HONNETH, A. 2005a. Reification: a Recognition-Theoretical View. *The Tanner Lectures on Human Values* [Online]. Available: https://tannerlectures.utah.edu/_resources/documents/a-to-z/h/Honneth_2006.pdf [Accessed 4/5/2022].

HONNETH, A. 2005b. *The struggle for recognition : the moral grammar of social conflicts,* Cambridge, Polity.

HORTON, R. 2000. Common sense and figures: the rhetoric of validity in medicine (Bradford Hill Memorial Lecture 1999). *Statistics in Medicine,* 19**,** 3149-3164.

HORTON, R. 2004. The lessons of MMR. *The Lancet,* 363**,** 747-749.

HRA. 2017. *Defining Research Table Research Ethics Service.* [Online]. HRA website: Health Research Authority, Research Ethics Service. Available: https://www.hra-decisiontools.org.uk/research/docs/DefiningResearchTable_Oct2022.pdf [Accessed 01/02/2023 2023].

JUPP, V. 2006. *The SAGE Dictionary of Social Research Methods*, SAGE Publications.

JUREIDINI, J. & MCHENRY, L. B. 2022. The illusion of evidence based medicine. *BMJ,* 376**,** o702.

JÜTTEN, T. 2010. What is Reification? A Critique of Axel Honneth. *Inquiry,* 53**,** 235-256.

KAFKA, F. 1926. *The Castle,* Middlesex, England, Penguin Books.

KATAKIS, P., SCHLIEF, M., BARNETT, P., RAINS, L. S., ROWE, S., PILLING, S. & JOHNSON, S. 2023. Effectiveness of outpatient and community treatments for people with a diagnosis of 'personality disorder': systematic review and meta-analysis. *BMC Psychiatry,* 23**,** 57.

KIRMAYER, L. J. 2012. Cultural competence and evidence-based practice in mental health: Epistemic communities and the politics of pluralism. *Social Science & Medicine,* 75**,** 249-256.

KLIKAUER, T. 2019. A preliminary theory of managerialism as an ideology. *Journal for the Theory of Social Behaviour,* 49**,** 421-442.

KNAAPEN, L. 2014. Evidence-Based Medicine or Cookbook Medicine? Addressing Concerns over the Standardization of Care. *Sociology Compass,* 8**,** 823-836.

KRAUT, R. 2022. Aristotle's Ethics. *In:* NODELMAN, E. N. Z. A. U. (ed.) *The Stanford Encyclopedia of Philosophy.* https://plato.stanford.edu/archives/fall2022/entries/aristotle-ethics/: Metaphysics Research Lab, Stanford University.

KUHN, S., T. 1962. *The Structure of Scientific Revolutions, Third Edition 1996.* USA, The University of Chicago Press Ltd.

KUKULL, W. A. & GANGULI, M. 2012. Generalizability: the trees, the forest, and the low-hanging fruit. *Neurology,* 78**,** 1886-1891.

KURTZ, C. F. & SNOWDEN, D. J. 2003. The new dynamics of strategy: Sense-making in a complex and complicated world. *IBM Systems Journal,* 42**,** 462-483.

LAPADAT, J. C. 2017. Ethics in Autoethnography and Collaborative Autoethnography. *Qualitative Inquiry,* 23**,** 589-603.

LAU, R., STEVENSON, F., ONG, B. N., DZIEDZIC, K., TREWEEK, S., ELDRIDGE, S., EVERITT, H., KENNEDY, A., QURESHI, N., ROGERS, A., PEACOCK, R. & MURRAY, E. 2016. Achieving change in primary care--causes of the evidence to practice gap: systematic reviews of reviews. *Implement Sci,* 11**,** 40.

LUTHANS, F. & BROAD, J. D. 2022. Positive psychological capital to help combat the mental health fallout from the pandemic and VUCA environment. *Organ Dyn,* 51**,** 100817.

MARTELA, F. 2015. Fallible Inquiry with Ethical Ends-in-View: A Pragmatist Philosophy of Science for Organizational Research. *Organization Studies,* 36**,** 537-563.

MCCABE, R., WHITTINGTON, R., CRAMOND, L. & PERKINS, E. 2018. Contested understandings of recovery in mental health. *Journal of Mental Health,* 27**,** 475-481.

MCILVEEN, P. 2008. Autoethnography as a Method for Reflexive Research and Practice in Vocational Psychology. *Australian Journal of Career Development,* 17**,** 13-20.

MCQUAIL, D. 2005. *McQuails Mass Communication Theory, Fifth Edition* London, Sage Publications Ltd.

MEAD, G. H. 1934. *Mind, self, and society : the definitive edition, 2015 edition* Chiacago, USA, University of Chiacago Press.

MEAD, G. H. 1938. *Moral Behavior and Reflective Thinking* [Online]. reproduced online https://brocku.ca/MeadProject/Mead/pubs2/philact/Mead_1938_24.html: Brock University, Canada. Available: https://brocku.ca/MeadProject/Mead/pubs2/philact/Mead_1938_24.html [Accessed 30/07/2021 2021].

MENNELL, S. 1977. Individual" action and its" social" consequences in the work of Norbert Elias'. *Human Figurations: Essays for Norbert Elias Amsterdam: Amsterdams Sociologisch Tijdschrift***,** 99-109.

MENNELL, S. 1992. *Norbert Elias: An Introduction, second* Oxford, Blackwell.

MENNELL, S. 2009. *Figurational Studies: Some Concepts, Principles and Major Research Areas* [Online]. Norbert Elias Foundation. Available: http://www.norberteliasfoundation.nl/network/concepts.php [Accessed 25/02/2021 2021].

MERRIAM-WEBSTER (n.d.). Diplomacy. *Merriam-Webster.com dictionary.* online.

MEYROWITZ, J. 1985. *No Sense of Place, The Impact of Electronic Media on Social Behaviour,* Oxford, Oxford University Press.

MEYROWITZ, J. 2008. Power, Pleasure, Patterns: Intersecting Narratives of Media Influence. *Journal of Communication,* 58**,** 641-663.

MISAK, C. 2013. *The American Pragmatists*, OUP Oxford.

MISHLER, E. G. 1999. *Storylines Craftartists' Narratives of Identity*, Harvard University Press.

MORRIS, Z. S., WOODING, S. & GRANT, J. 2011. The answer is 17 years, what is the question: understanding time lags in translational research. *J R Soc Med,* 104**,** 510-20.

MOWLES, C. 2012. KEEPING MEANS AND ENDS IN VIEW—LINKING PRACTICAL JUDGEMENT, ETHICS AND EMERGENCE. *Journal of International Development,* 24**,** 544-555.

MOWLES, C. 2015. *Managing Uncertainty, Complexity and the paradoxes of everyday organisational life,* Oxon, UK, Routledge.

MOWLES, C. 2017a. Experiencing uncertainty: On the potential of groups and a group analytic approach for making management education more critical. *Management Learning,* 48(5).

MOWLES, C. 2017b. Group Analytic Methods Beyond the Clinical Setting—Working with Researcher–Managers. *Group Analysis,* 50**,** 217-236.

MOWLES, C. 2018. Complex responsive processes – 4 pillars of thought, 5 key insights. *Complexity & Management Centre* [Online]. Available from: https://complexityandmanagement.com/2018/06/27/complex-responsive-processes-4-pillars-of-thought-5-key-insights/.

MOWLES, C. 2021. *Complexity: A Key Idea for Business and Society*, Taylor & Francis.

MOWLES, C., VAN DER GAAG, A. & FOX, J. 2010. The practice of complexity: Review, change and service improvement in an NHS department. *Journal of Health Organization and Management,* 24**,** 127-144.

MURRAY, E. & ONG, B. N. 2015. From Evidence to Practice: Addressing the Translation Gap for Complex Interventions in Primary Care. London: National Institute of Health and Care Research (NIHR).

NHS ENGLAND. 2023. *Leading the Spread and Adoption of Innovation and Improvement - Complexity* [Online]. NHS England. Available: https://www.england.nhs.uk/spread-and-adoption/seven-interconnected-principles/complexity/ [Accessed 15/03/2023].

NICE. 2012. *Methods for the development of NICE public health guidance* [Online]. https://www.nice.org.uk/. Available: https://www.nice.org.uk/process/pmg4/chapter/determining-the-evidence-for-review-and-consideration [Accessed 12/02/2021 2021].

NICOLINI, D., BHARATAN, I., GKEREDAKIS, E., MANNING, R. & SWAN, J. 2021. From evidence use to evidencing work: towards a processual view of the role of evidence in commissioning policy-making.

NONAKA, I. 2008. *The Knowledge-Creating Company*, Harvard Business Review Press.

NONAKA, I. & TAKEUCHI, H. 2011. The wise leader. *Harv Bus Rev,* 89**,** 58-67, 146.

OLIVEIRA, H. C., RODRIGUES, L. L. & CRAIG, R. 2020. Bureaucracy and the balanced scorecard in health care settings. *International Journal of Health Care Quality Assurance,* 33**,** 247-259.

OVID 1955. *Thje Metamorphoses of OVID,* Middlesex, England, Penguin Books.

PARK, Y. S., KONGE, L. & ARTINO, A. R., JR. 2020. The Positivism Paradigm of Research. *Acad Med,* 95**,** 690-694.

PASCUAL-FERRÁ, P., ALPERSTEIN, N., BARNETT, D. J. & RIMAL, R. N. 2021. Toxicity and verbal aggression on social media: Polarized discourse on wearing face masks during the COVID-19 pandemic. *Big Data & Society,* 8**,** 20539517211023533.

PASSERIN D'ENTRÈVES, M. 2000. Arendt's theory of judgment. *In:* VILLA, D. (ed.) *The Cambridge Companion to Hannah Arendt.* Cambridge: Cambridge University Press.

PEIRCE, C. S. 1992. *The essential Peirce : selected philosophical writings,* Bloomington, Indiana University Press.

PEIRCE, C. S. 1994. *The Collected Papers of Charles Sanders Peirce, Online edition, John Deely 1931-1935.* Cambridge, Mass, Harvard University Press.

PILAPIL, R. D. 2013. Disrespect and political resistance:Honneth and the theory of recognition. *Thesis Eleven,* 114**,** 48-60.

PLATO 1955. *The Republic, 1987.* London, England, Penguin.

POPPER, K. 1963. *Conjectures and Refutations: The Growth of Scientific Knowledge, Routledge Classic Edition 2002.* London, Routledge.

POWLES, J. & HODSON, H. 2017. Google DeepMind and healthcare in an age of algorithms. *Health Technol (Berl),* 7**,** 351-367.

PYPE, P., MERTENS, F., HELEWAUT, F. & KRYSTALLIDOU, D. 2018. Healthcare teams as complex adaptive systems: understanding team behaviour through team members' perception of interpersonal interaction. *BMC Health Services Research,* 18**,** 570.

QUINTANEIRO, T. 2006. The concept of figuration or configuration in Norbert Elias' sociological theory. *Teoria & Sociedade,* 2**,** 0-0.

RABINSTEIN, A. A., BRINJIKJI, W. & KALLMES, D. F. 2016. Equipoise in Clinical Trials. *Circulation Research,* 119**,** 798-800.

RICHARDS, D. A. & HALLBERG, I. R. 2015. *Complex Interventions in Health: An overview of research methods*, Taylor & Francis.

RICHARDSON, J. E. 2007. *Analysing Newspapers, An Approach from Critical Discourse Analysis,* Hampshire, UK, Palgrave MacMillian.

ROSA, H. & WAGNER, J. 2019. *Resonance: A Sociology of Our Relationship to the World*, Polity Press.

ROTH, W.-M. 2008. Auto/Ethnography and the Question of Ethics. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research,* 10.

RUNCIMAN, D. 2008. *Political Hypocrisy, revised 2018.* Princeton, New Jersey, USA, Princeton University Press.

SACKETT, D. L., ROSENBERG, W. M. C., GRAY, J. A. M., HAYNES, R. B. & RICHARDSON, W. S. 1996. Evidence based medicine: what it is and what it isn't. *BMJ,* 312**,** 71-72.

SÄLJÖ, R. 2002. My brain's running slow today – The preference for "things ontologies" in research and everyday discourse on human thinking. *Studies in Philosophy and Education,* 21**,** 389-405.

SANDBERG, J. & TSOUKAS, H. 2011. GRASPING THE LOGIC OF PRACTICE: THEORIZING THROUGH PRACTICAL RATIONALITY. *The Academy of Management Review,* 36**,** 338-360.

SCHULZE, C., WELKER, A., KÜHN, A., SCHWERTZ, R., OTTO, B., MORALDO, L., DENTZ, U., ARENDS, A., WELK, E., WENDORFF, J. J., KOLLER, H., KUSS, D. & RIES, M. 2021. Public Health Leadership in a VUCA World Environment: Lessons Learned during the Regional Emergency Rollout of SARS-CoV-2 Vaccinations in Heidelberg, Germany, during the COVID-19 Pandemic. *Vaccines (Basel),* 9.

SCUDDER, T. 2019. *HISTORY AND DEVELOPMENT OF THE SDI 2.0* [Online]. https://www.corestrengths.com/history-development-of-sdi-2-0/: Core Strengths. Carlsbad, CA. Available: https://www.corestrengths.com/history-development-of-sdi-2-0/ [Accessed 25/02/2022 2022].

SEYHAN, A. A. 2019. Lost in translation: the valley of death across preclinical and clinical divide – identification of problems and overcoming obstacles. *Translational Medicine Communications,* 4**,** 18.

SHAW, S. & BARRETT, G. 2006. Research governance: regulating risk and reducing harm? *Journal of the Royal Society of Medicine,* 99**,** 14-19.

SHAW, S., BOYNTON, P. M. & GREENHALGH, T. 2005. Research governance: where did it come from, what does it mean? *Journal of the Royal Society of Medicine,* 98**,** 496-502.

SHOTTER, J. & TSOUKAS, H. 2014a. In Search of Phronesis: Leadership and the Art of Judgment. *Academy of Management Learning & Education,* 13**,** 224-243.

SHOTTER, J. & TSOUKAS, H. 2014b. Performing phronesis: On the way to engaged judgment. *Management Learning,* 45**,** 377-396.

SIMONS, D. J. & CHABRIS, C. F. 1999. Gorillas in Our Midst: Sustained Inattentional Blindness for Dynamic Events. *Perception,* 28**,** 1059-1074.

SLADE, M. & LONGDEN, E. 2015. Empirical evidence about recovery and mental health. *BMC Psychiatry,* 15**,** 285.

SLOWTHER, A., BOYNTON, P. & SHAW, S. 2006. Research governance: ethical issues. *Journal of the Royal Society of Medicine,* 99**,** 65-72.

SMITH, R. & RENNIE, D. 2014. Evidence based medicine—an oral history. *BMJ : British Medical Journal,* 348**,** g371.

SOLZHENITSYN, A. 1968. *The First Circle, 1971.* London, Harvill Press Ltd. Fontana Books.

STACEY, R. 2001. What Can it Mean to Say that the Individual is Social through and through? *Group Analysis,* 34**,** 457-471.

STACEY, R. 2012a. Repetitive Patterns of Communication: Thought Collectives and Thought Styles. *Complexity & Management Centre* [Online]. Available from: https://complexityandmanagement.com/2012/10/25/repetitive-patterns-of-communication-thought-collectives-and-thought-styles/ [Accessed 12/02/2021 2021].

STACEY, R. 2012b. *Tools and techniques of leadership and management meeting the challenge of complexity,* Oxon UK, Routledge.

STACEY, R., D. & MOWLES, C. 2016. *Strategic Management and Organisational Dynamics, Seventh 2016.* United Kingdom, Pearson Education Limited.

STACEY, R. & GRIFFIN, D. 2005. *A Complexity Perspective on Researching Organizations. Taking Experience Seriously,* Abingdon, Oxon, Routledge.

STACEY, R. D., GRIFFIN, D. & SHAW, P. 2000. *Complexity and Management: Fad Or Radical Challenge to Systems Thinking?*, Routledge.

STACK, S. 2005. Suicide in the media: a quantitative review of studies based on non-fictional stories. *Suicide Life Threat Behav,* 35**,** 121-33.

STAHLKE WALL, S. 2016. Toward a Moderate Autoethnography. *International Journal of Qualitative Methods,* 15**,** 1609406916674966.

STEINBERGER, P. J. 1990. Hannah Arendt on Judgment. *American Journal of Political Science,* 34**,** 803-821.

STIVERS, C. 2008. *Governance in dark times : practical philosophy for public service,* Washington, D.C, Georgetown Univ. Press.

SWAN, J., GKEREDAKIS, E., MANNING, R., M,, NICOLINI, D., SHARP, D. & POWELL, J. 2017. Improving the capabilities of NHS organisations to use evidence: a qualitative study of redesign projects in Clinical Commissioning Groups. *Health Serv Deliv Res,* 5.

SWAN, J., NEWELL, S. & NICOLINI, D. 2016. *Mobilizing Knowledge in Health Care: Challenges for Management and Organization,* Oxford, Oxford University Press.

SYPNOWICH, C. 2019. *Law and Ideology* [Online]. https://plato.stanford.edu/archives/sum2019/entries/law-ideology/. [Accessed 27/10/2022].

TAYLOR, C. 1991. *The Ethics of Authenticity,* USA, Charles Taylor and the Canadian Broadcasting Corporation.

TAYLOR, C. 1994. *Multiculturalism and the politics of recognition : an essay,* Princeton, N.J., Princeton University Press.

TAYLOR, D. 2002a. Hannah Arendt on Judgement: Thinking for Politics. *International Journal of Philosophical Studies,* 10**,** 151-169.

TAYLOR, S. 2002b. *Ethnographic Research: A Reader*, SAGE Publications. Open University.

THOMA, A. & EAVES, F. F., III 2015. A Brief History of Evidence-Based Medicine (EBM) and the Contributions of Dr David Sackett. *Aesthetic Surgery Journal,* 35**,** NP261-NP263.

THOMAS, G. 2011. The case: generalisation, theory and phronesis in case study. *Oxford Review of Education,* 37**,** 21-35.

THOMAS, R. & TOMLINSON, J. 2017. Mapping current issues in administrative justice: austerity and the ‘more bureaucratic rationality’ approach. *Journal of Social Welfare and Family Law,* 39**,** 380-399.

TORJESEN, I. & WATERS, A. 2023. Medical colleges and unions call for inquiry over “shocking” levels of sexual assault in the NHS. *BMJ,* 381**,** p1105.

TOWNLEY, B. 2008. *Reason’s Neglect,* New Yourk, USA, Oxford University Press.

TRESKER, S. 2021. Treatment Effectiveness and the Russo–Williamson Thesis, EBM+, and Bradford Hill's Viewpoints. *International Studies in the Philosophy of Science,* 34**,** 131-158.

TREWEEK, S., PITKETHLY, M., COOK, J., FRASER, C., MITCHELL, E., SULLIVAN, F., JACKSON, C., TASKILA, T. K. & GARDNER, H. 2018. Strategies to improve recruitment to randomised trials. *Cochrane Database Syst Rev,* 2**,** MR000013.

TSOUKAS, H. 1997. The tyranny of light: The temptations and the paradoxes of the information society. *Futures,* 29**,** 827-843.

TSOUKAS, H. 2017. Don't Simplify, Complexify: From Disjunctive to Conjunctive Theorizing in Organization and Management Studies. *Journal of Management Studies,* 54**,** 132-153.

VAN BEURDEN, E. K., KIA, A. M., ZASK, A., DIETRICH, U. & ROSE, L. 2011. Making sense in a complex landscape: how the Cynefin Framework from Complex Adaptive Systems Theory can inform health promotion practice. *Health Promotion International,* 28**,** 73-83.

VINCE, R. & MAZEN, A. 2014. Violent Innocence: A Contradiction at the Heart of Leadership. *Organization Studies,* 35**,** 189-207.

VINE, T. 2020. *Bureaucracy: A Key Idea for Business and Society*, Taylor & Francis.

VIRGIL 1956. *The Aeneid,* Middlesex, England, Penguin Books.

WEARS, R. L., SUTCLIFFE, K. M., WEARS, R. & SUTCLIFFE, K. 2019. 35Rationalizing Healthcare: Scientific-Bureaucratic Medicine. *Still Not Safe: Patient Safety and the Middle-Managing of American Medicine.* Oxford University Press.

WEAVER, R. R. 2015. Reconciling evidence-based medicine and patient-centred care: defining evidence-based inputs to patient-centred decisions. *J Eval Clin Pract,* 21**,** 1076-80.

WEICK, K., E 1995. *Sensemaking in Organizations,* USA, Sage Publications.

WEST, M. A. & CHOWLA, R. 2017. Compassion: Concepts, Research and Applications. *In:* GILBERT, P. (ed.) *Compassion.* Taylor & Francis.

WOJCIECH, S. 2021. Ludwik Fleck. *In:* ZALTA, E. N. (ed.) *The Stanford Encyclopedia of Philosophy.* https://plato.stanford.edu/archives/win2021/entries/fleck: University of Stanford.