Helping social research make a difference

Exploration of a wider repertoire of approaches to communicating and influencing through research

A Discussion Paper by

Huw Davies and Alison Powell

The *Social Dimensions of Health Institute (SDHI)*, Universities of Dundee & St Andrews (www.sdhi.ac.uk), and
The *Research Unit for Research Utilisation* (RURU) at the Universities of St Andrews & Edinburgh (www.ruru.ac.uk).

This Discussion Paper seeks to 'set the scene' and act as a stimulus for debate for the Health Foundation seminar in November 2010.

In Brief

Helping social research make a difference has proved uncommonly challenging, despite the political and professional rhetoric offering overt support. Too often, interactions around research between researchers, policy makers, managers and practitioners can feel both disappointing and frustrating. This paper, and the accompanying seminar, seek to explore why this is so, and what we might do in consequence.

Research-informed knowledge is complex, contested and challenging. It may involve a mix of new theorising alongside the articulation of new conceptual models, as well as the analysis of empirical data. In many cases, the 'findings', in the broadest sense, utilise or play off values, and only begin to make sense when placed in problem-oriented contexts. Engaging with such research is, therefore, as much about changing minds and mental models as about supporting specific decisions.

Many of the practices around the sharing of research seem stuck in 'information telling' mode: emphasising careful, rational argument to communicate a prior analysis. Yet we know from many other fields that 'changing minds' is an infinitely more subtle process of influencing – drawing in experience, emotion, aesthetics and appeals to identity.

This paper seeks to scope out some of these other areas of 'influencing' – such as storytelling, the arts, or immersive learning – as well as drawing attention to the importance of language and metaphor in shaping how ideas are shared and received.

The aim is to begin some creative discussions as to how social research might make a bigger difference through exploration of a wider repertoire of approaches to its creation, communication and application.

Helping social research make a difference

The nature of the challenge

"Only sophisticated narrative powers will lead to the conversations that society needs to have about its medical system" (Charon 2001: 1900)

Using social research to inform policy making, management action and professional practice has been much advocated but often proves difficult to achieve. Simple models of 'dissemination' or 'knowledge transfer' offer poor *descriptions* of the processes by which research influences, and often ineffective *prescription* for how these linkages could be improved (Davies et al. 2008).

Moreover, communicating around research is as often a problem around *content* as it is around process. Too often, when research is summarised by researchers, the conclusions run like this: there were lots of small, rather poor quality studies, carried out in varied but largely less relevant contexts, that do not supply robust and transferable findings – and so researchers conclude that little can be said with certainty and that more research is needed. And too often, policy makers, or organisation leaders, pose seemingly straightforward questions – like, *Does competition improve quality? Do incentives work? What changes will release resource from the bottom line? How can such changes be achieved?* – that leave social researchers struggling to provide insights beyond *'it depends…'*. As a result, opportunities for the direct application of specific findings from social research are often limited, and interactions around broader bodies of research can feel both disappointing and frustrating.

Yet research *does* matter, and application of findings can happen both directly and indirectly. Studies on diagnostics, prognostics and therapeutics can provide detailed understandings about the nature of ill health, its assessment, potential causal pathways, likely trajectory and scope for amelioration. Collation, synthesis and integration of these findings into evidence, when then linked to implementation, can be for the betterment of patient care. Leaving aside the many disputes over the meaning and nature of such beguiling terms as 'evidence' and 'implementation', we simply note that this kind of instrumental application of clinical research has received sustained attention *but that the application of such 'instructional evidence' is not the main focus of our concerns here.*

Instead, our focus is on how, in the longer term, research can influence *indirectly* but in sometimes profound ways (Black 2009). To take just three examples of remarkable conceptual shifts informed, at least in part, by research: we might think of the recognition of the role of informal carers alongside formal health services in the provision of care; or the movement of the patient to centre stage in their care, with notions of the expert patient, enhanced self-care and co-production of care; and the recognition that many hospitals and other health facilities are often seriously unsafe, replete with risk and latent system error sometimes starkly realised. It is these longer-term shifts in understanding, often only readily discernible in retrospect, that offer more profound opportunities for social research to make a difference.

However, in the push to develop effective implementation around 'what works' (Eccles et al. 2009), less attention has been given to these wider, longer-term, slow and percolative uses of social research: using social research to inform *"basic understanding about the structuring of society and the nature of social problems, as well as their sources and interrelationships…the potential use of research that reshapes the ways in which policy problems are conceptualised or framed as a precursor to enabling more novel policy solutions to make their way onto the agenda"* (Nutley et al. 2007: 22).

In tackling these broad and deep agendas, the knowledge requirements for effective social policy and effective service organisation go far wider than just 'what works' (Ekblom, 2002). We need, for example:

> *Know-why:* knowledge about why action is required, e.g. the relationship between basic values, beliefs and assumptions, and future policy directions.
>
> *Know-about (problems):* e.g. the nature, formation, natural history and interrelations of health and social problems in context.
>
> *Know-what (works):* that is, what policies, strategies or specific interventions will bring about desired outcomes, at acceptable costs and with few enough unwanted consequences.
>
> *Know-how (to put into practice):* knowing what should be done is not the same as being able to do it effectively; knowledge about effective programme implementation is also needed.
>
> *Know-who (to involve):* such knowledge covers estimates of client needs as well as information on key stakeholders necessary for potential solutions and mechanisms for building alliances for action.

Knowledge in most of the above categories is complex, contested and challenging. It may involve a mix of new theorising alongside the articulation of new conceptual models, as well as empirical data drawn from diverse methodological study. In many cases, the 'findings', in the broadest sense, utilise or play off values and only begin to make sense when placed in broader contexts. Engaging with such research is as much about changing minds and mental models as about supporting specific decisions.

While Carol Weiss first drew attention to the importance of 'enlightenment' roles of research over thirty years ago (Weiss 1979), we still know relatively little about how to promote such enlightenment shifts through engagement with research. The challenge lies in changing the ways that the questions are framed in policy contexts, and shifting the mental models and frameworks through which social and organisational worlds are understood: *"a key issue is how to ensure room for both the currently much-in-demand instrumentalist research that provides practical solutions to problems, and for research which is critical - and which problematises current ways of thinking and acting"* (Ovretveit 2009: 1782).

Detaching people from current ways of thinking and promoting new ways of seeing the world is unlikely to be straightforward. Novak discussed the ways in which people

understand the world as their 'standpoint', defining this as "*a complex of all those things that compose an inquiring* <u>who</u>. *It is the complex of past experience, a range of sensibility, accumulated images and imaginative patterns, interests, bodies of insights already appropriated, purposes, structured and unstructured passions, criteria of evidence and relevance, the repertoire of already affirmed concrete judgements, values, goals, decisions"* (quoted in Robinson 1995: 199). Such a description draws attention to the complexity of the substrate on which we might want social research to exert influence.

Sustained study of how research contributes to knowledge (Nutley et al. 2007), and how such knowledge influences thinking and behaviour (Ward et al. 2009) provides only some pointers to how such shifts in standpoints might be encouraged. Most importantly, contemporary conceptions of research 'use' see this as an intensely *social* process. This suggests that research findings need to be engaged with as part of active social processes, interpreted in local contexts, and integrated with current knowledge/experience in ongoing processes of *knowing*. Learning takes place through dialogue and interaction; and knowledge is not so much created and validated 'elsewhere' but is created and re-created in specific problem contexts and adapted through *use*. Unlearning too has an important – but under appreciated – role (Rushmer & Davies, 2004). As the old saw has it*: it ain't so much that I don't know, but that I know so much that just ain't so.*

These insights – as well as more detailed study on how influencing happens, drawing on diverse fields of study – have yet to be fully utilised by those seeking to bring together researchers and influential stakeholders. Instead, interactions around research often tend to be structured around researchers summarising the research findings to mixed audiences who then seek to make interpretations. These interactions are invariably dominated by 'information telling' approaches, building on psychological models of learning, rather than 'knowledge construction' approaches, building on sociological models of learning (Levin & Greenwood 2002). Yet moving away from 'information telling' (or 'death by PowerPoint' as it is more tellingly known) is challenging: the overwhelming majority of 'research sharing' events are dominated by this approach.

This Discussion Paper seeks to open out this debate by scoping out some different but relevant areas where influencing is central, the purpose being to explore what we can learn from these other areas and to begin to consider how such learning can be incorporated into practices around sharing research. Its primary purpose is to provide some context and background material for an interactive workshop on these issues hosted by The Health Foundation in November 2010.

The importance of finding out more about how research can influence can hardly be over-stated: *"The 'big-miss' errors that make social scientists feel helpless, and that sometimes underlie massive decision-making errors by governments, firms, and individuals,* ***are usually driven more by misaligned perceptions and obsolete world views than by poor tactics or marginal errors of measurement in variables****. To change tactics is relatively easy; to change perceptions is much harder."* (Weber 1996: 287; our emphasis).

Finding other areas of relevance (approach)

Our aim in preparing this Discussion Paper was that it should open up new avenues for debate by pointing to some of the approaches used by a wide range of 'influencers' in other fields. Our approach was closest to a scoping review (Arksey and O'Malley 2005, Anderson et al 2008, Davis et al 2009): we were aiming at rapid mapping of the field of interest, at breadth rather than depth and at covering a wide range of research and non-research material without assessing the quality of individual studies:

> *"We suggest that the strengths of a scoping study and what makes it successful lie in its ability to be both developmental and intellectually creative… As a preliminary activity, scoping provides a compelling stepping off point into the investigation of a specific field and encourages an element of 'blue sky thinking'."* (Davis et al 2009: 1387, 1397).

In addition to using the traditional approaches to an academic literature review (searching electronic databases, hand-searching of key journals, following up reference lists of retrieved articles etc), the nature of the review meant that we also drew extensively on our contacts with subject area experts (Mays et al 2001): we consulted them early in the review for their suggestions of key fields of literature, relevant authors and initiatives. To supplement this material and deepen our thinking, during the course of the review we attended a range of academic and public events (conferences, public debates etc) that seemed pertinent to the review; paid closer attention than usual to the public material that entered our own lives via the media; and discussed the issues informally with friends and colleagues.

As a result, six key areas have been uncovered and are briefly reviewed. No attempt has been made to develop a taxonomy of approaches, and we would concede that the materials uncovered may themselves prove far from comprehensive. Nonetheless, we hope that the material presented will provide stimulus for engaged discussion and prompts to deeper and more refined work in this area.

The six areas identified and outlined are as follows:

1. Narratives and stories: fiction, faction and persuasion
2. Language shifts and metaphor diversity
3. Advertising, marketing and social marketing
4. Journeying together: co-producing knowledge; co-producing design
5. Immersion and experiential learning
6. Creativity and the arts

Narratives and stories: fiction, faction and persuasion

"The scientific study of persuasion has reflected an unfortunate displacement of poetics by rhetoric…The power of narratives to change beliefs has never been doubted and has always been feared." (Green and Brock 2000: 701)

Stories can be compelling. Many of us read fiction not just for entertainment, but for the sense of engagement with new ideas, new connections and new ways of seeing. Writers of fiction have often had the serious intent of revealing deeper truths in fictional work. Moreover, the power of narratives is beginning to be recognised as a potential tool for sharing knowledge (Connell et al. 2004).

Powerful novels can change the reader's perspective, alerting them to new ways of seeing. *The Curious Incident of the Dog in the Night Time* (Mark Haddon) does a wonderful job not just in showing some of the intricacies of living with autism, but alerting us in a very sympathetic way to the potential for profound *difference* between ourselves and others. *The Reader* (Bernhard Schlink) shows the difficulties of comprehending the larger facts of history, while exploring notions of truth and reconciliation. *So Much for That* (Lionel Shriver) depicts contemporary US health care in all its devastating costs, inadequacies and callousness through the eyes of a family facing terminal cancer. Moreover, it may not be overstating to say that novels can influence the flow of history: for example, *One Day in the Life of Ivan Denisovich* (Solzhenitsyn) forced acknowledgement of human rights abuses in the former USSR and changed the nature of the debate between the Eastern bloc and the West.

Short stories too can leave the reader changed and often have strong communicative intent. The stories of Tolstoy and Chekhov resonate and disturb well over a century after their creation – who can have read *The Death of Ivan Ilyich* (Tolstoy) in their mid-years and not felt deeply discomforted?

These examples (and readers will have their own favourites in this regard) are introduced to show the power of stories – factual, fiction or faction – to reshape our deeper appreciations in sometimes profound and long-lasting ways. This power has only sometimes been harnessed for the communication of research, yet *"...people naturally think narratively rather than argumentatively or paradigmatically"* (Woodside et al 2008: 98) and *"...stories serve as memory devices and facilitate understanding by providing connections to previous experiences and knowledge"* (Hough and White 2001: 596).

What are some of the characteristics of narratives that make them effective at influencing? Some of these are described below (taken from Schwartz 1998, Slater and Rouner 2002, Iedema et al 2009):

- Narratives are deeply rooted in human experience and history: they are familiar and intrinsic to sense-making

- They can permit the exploration of difficult issues in a non-threatening form

- They help individuals and groups to address the *affective* dimensions of being and working

- They open up multiple perspectives: they invite telling and retelling perhaps invoking personal experience

- They are persuasive: the processing of narratives to a large extent attenuates cognitive resistance or counter-arguing.

So where does this power of narratives come from? *Transportation theory* (Green and Brock 2000) suggests that individuals are more likely to be persuaded when they are absorbed in a story ('transported' into a narrative world) than they are by rhetorical communication: *"the attention given to an engaging narrative has… an intensity that most creators of didactic messages could only dream of inducing*" (Slater and Rouner 2002: 187). Thus narrative can marry the affective and cognitive components of attitude formation more effectively and more routinely than rhetoric, and attitudes that have both an affective and a cognitive basis tend to be more persistent (Green and Brock 2000).

Transportation through narrative is powerful because:

- It occurs readily: there is a universal human tendency to use narrative as the preferred organising and retrieving mental structure and people are motivated to accept even a fictional narrative world at least temporarily.

- It may make narrative experience seem like real experience (which is one of the main routes by which attitudes are formed).

- Narrative makes fewer demands on the speaker than rhetoric does: rhetoric is heavily influenced by 'framing', so if the speaker has low credibility or if the audience members hold negative perceptions about the speaker's intent, or strong prior views on the subject, then they are less likely to accept the basis of the argument. In contrast, *"our findings suggested that once a reader is rolling along with a compelling narrative, the source has diminishing influence"* (Green and Brock 2000: 719).

Narrative, then, may be an under-exploited technique as we seek influential power for social research (while also being replete with risks of course). Perhaps in our concern to establish rigour in research, and differentiate it from other forms of account such as journalism, we have stripped out some of the possibilities for persuasive effect. Some examples of narrative in action can help to illustrate the range of possibilities and may stimulate thinking on further applications in knowledge exchange.

Some examples of narrative in action

- Literature is increasingly taught in medical schools as a way of teaching about the patient's experience and the clinician's own internal development; some medical schools and hospitals now encourage narrative writing by medical students and doctors to strengthen reflection, self-awareness and the adoption of patients' perspectives (Charon 2001).

- An imaginative *First Cut* film directed by Toby Paton and written and narrated by poet Luke Wright, *The Bed* (Channel 4, 6 August 2010), reflects on life in a busy accident and emergency department from the perspective of a trolley. The tale is told through the experiences of patients who occupy the trolley at various times, interspersed with impressionistic poetic interludes supplied by Wright.

- Graphic stories (comics) are being used to provide doctors with new insights into patients' experiences of illness. The graphic form enables powerful messages to be conveyed with economy through the use of a range of techniques (e.g. the manipulation of visual imagery, the juxtaposition of text and images, the use of shading, the use of different font sizes to reflect the relative size of patients anxieties and priorities) and the comic form itself prompts reflection as it requires inferences to be made about what happens 'out of sight' and without words (Green and Myers 2010).

- The film of *Charlie and the Chocolate Factory* (Roald Dahl's children's fantasy and morality tale) has been used to teach recruitment and selection to management students (Billsberry and Gilbert 2008) – the students were introduced to three recruitment and selection paradigms before watching the film, and were then asked to find examples of these paradigms (and answer other questions) as they watched the film.

- Clinical nurse specialists (CNSs) on a practice development programme narrated their own stories of providing care and analysed them as a way of exploring and building on craft knowledge. Using 'critical companionship' facilitation strategies, the process of story telling was followed by critical dialogue and (subsequently) narrative analysis of the taped sessions. These helped the CNSs to have an increased awareness of their own contribution to patient care and the quality of service and of the possibilities for change (McCormack and Henderson 2006).

- A senior healthcare manager who had worked in the NHS for 20 years gained new insights from his own experience as both inpatient and outpatient in several hospitals where he was receiving care. A personal account of his experience circulated to selected policy makers, clinician and managers elicited a wide range of reactions – some welcomed and championed it, using it for briefings at board level and in training clinicians, others used it to stimulate discussion among policy makers, while others were less welcoming (Prosser 2010).

- Providing opportunities for health professionals to share narratives (e.g. to elaborate on the emotional impact of incidents) in a context of psychological safety could enable health professionals and health care organisations to learn from adverse events and near misses more effectively (Iedema et al 2009): *"…narrative constitutes a modality of social interaction that is crucial to how we deal with adverse events and to how we work to enhance patients' safety: it ensures entry into the affective dimensions of failure; it does not prematurely reduce personal and processual complexities to abstract rules and categories,*

and it nurtures people's confidence in being able to confront, explore and learn from incidents and accidents." (Iedema et al 2009: 1755).

- Patients' narratives are used to help other patients make sense of their own experience of living with or being treated for a condition (e.g. healthtalkonline and youthhealthtalk.org). Moreover, in pre-registration and post-registration education and development for health professionals, these same narratives have been used to provide deeper understanding of and insight into patients' experiences.

- Frank argues that research reports need to grab the reader's attention in the same way that good novels do (Frank 2004): *"A good scholarly article should begin like a detective story. The author should allow the readers to* discover the body*, just as a murder mystery is set in motion when the characters on the Orient Express or in the English country house discover a murdered body"* (Frank 2004: 431).

Using evidence to influence health care may, to date, have relied too heavily on one aspect of persuasion – the rational and carefully argued use of logic, data and evidence – to the relative neglect of pathos *"…the power to stir the emotions, beliefs, values and imagination of the audience and [so] generate empathy"* (Dopson et al 2005: 37). Narratives, stories and other such devices – factual, fictional or hybrid – have the potential to redress this imbalance.

Language shifts and metaphor diversity

"To the extent that our constructions are founded upon language… then language underpins the forms of action that it is possible for us to take" (Burr 2003: 61).

Language matters. A substantial body of theory (see for example Burr 2003) supports the idea that language both *reflects* and *influences* perceptions. The categories and concepts that provide a framework of meaning are provided by language, and are shaped by the norms, values and expectations of the prevailing culture. For example, numerous emotional states recognised in non-western cultures do not have straightforward linguistic equivalents in western terms: *"…we can only represent our experiences to ourselves and to others by using the concepts embedded in our language"* (Burr 2003: 53).

The social environment, and the language that is used within it (e.g. in hospitals, or in policy circles), are shaped in part by local structures and power relations, and in part by history. Debates abound about the extent to which it is possible to shift social relationships through changing the language used, and also about the relationships between language and action. Few would argue however that language is unimportant: *"…different constructions of the world sustain different kinds of social action"* (Burr 2003: 61). Indeed, some authors argue that in promoting change, communication is not merely a tool to be used, but instead change is itself a phenomenon that occurs within communication: *"producing intentional change in organizations now becomes a matter of creating and shifting conversations… we propose that communication is the generative mechanism of change that gives people the reality in which they live"* (Ford and Ford, 1995: 560).

The language we use does and has changed and this has influenced how we see the world. The change of language around patients and their drug regimens from *compliance* through *adherence* to *concordance* suggests a discomfort with the communicative power of certain words and a yearning to express things differently. Of course, different language then enables and/or disables certain readings, perhaps opening up or closing down avenues of thought and action. Many language shifts are evident in the health care sector: private hospital or independent provider? patient or service user? drug addiction or substance misuse? quality or safety? Each of these terms carries different connotations and emotional weight, and so has different communicative power. Going further, the emergence of such terms as *informal carer*, *self-care*, *expert patient*, *person-centred care*, *continuity of care*, *integrated care* and many others speaks volumes for the power of language to shape and influence our mental models, and the interests and preoccupations that flow from these.

A key component of language is the use of metaphor. Research in a wide range of fields demonstrates that metaphor exerts a formative influence on science, language, and on how individuals and groups think (Morgan 1997). Changes in the conceptual system (including metaphors) used by individuals and groups and societies change what is 'real' for them, and affect how the world is perceived and how individuals and groups act on those perceptions (Lakoff and Johnson 1980):

> *"Metaphors may create realities for us, especially social realities. A metaphor may thus be a guide for future action. Such actions will, of course, fit the metaphor. This will, in turn, reinforce the power of the metaphor to make*

experience coherent. In this sense metaphors can be self-fulfilling prophecies" (Lakoff and Johnson 1980: 156)

As Gareth Morgan's influential book *Images of Organization* (Morgan 1997) powerfully demonstrates, different metaphors of organisations (e.g. machine, organism, brain, culture, psychic prison etc) can generate very different ways of seeing and acting. All of these images or metaphors are of course partial ways of seeing: certain metaphors draw attention to specific aspects of the subject, while necessarily neglecting or ignoring other aspects. Thus the particular choice of metaphor or metaphors is of great importance:

> *"In most cases, what is at issue is not the truth or falsity of a metaphor but the perceptions and inferences that follow from it and the actions that are sanctioned by it. In all aspects of life, not just in politics or love, we define our reality in terms of metaphors and then proceed to act on the basis of those metaphors. We draw inferences, set goals, make commitments and execute plans, all on the basis of how we in part structure our experience, consciously and unconsciously, by means of metaphor"* (Lakoff and Johnson 1980: 158).

Taken together, these ideas suggests that in thinking about 'changing minds' in relation to social research in health care, the choice of language and the metaphors employed may be extremely influential. *Appreciative enquiry*, for example, is both a research process and a change process used in organisations that focuses on trying to appreciate what organisations do well. It takes this perspective as a deliberate counterpoint to much of the analysis on organisations that focuses on dysfunction, disorganisation and failure: *"if we devote our attention to what is wrong with organizations and communities, we lose the ability to see and understand what gives life to organizations and to discover ways to sustain and enhance that life-giving potential"* (Ludema et al 2001: 189). As a result of this deliberate choice of positive language and metaphor, appreciative enquiry can "*unleash a positive revolution of conversation and change in organizations by unseating existing reified patterns of discourse, creating space for new voices and new discoveries, and expanding circles of dialogue to provide a community of support for innovative action"* (Ludema et al 2001: 189).

Some further examples in action

There is no genuinely neutral language that can be deployed, so choice in language is, of course, unavoidable. Many metaphors get smuggled along in even the blandest of communication attempts. However, some authors make rather more deliberate use of striking language and/or metaphor for persuasive effect:

- *'Emotional credit crunch in the medical profession?'* A banking metaphor employing concepts of labour, saving, spending and debt was used to explore issues around the *emotional* labour performed by medical students and junior doctors and its impact on their health and on the quality and safety of the care they provided. (Boyd-Quinn, presentation at the meeting of the Health Organisation Research Network, Glasgow, November 2010).

- The metaphor of a traffic roundabout has been used to explore researchers' experience of knowledge translation (KT) (Kho et al 2009): *"...the continuous*

stream of traffic around the central island represents the core team in a KT project: this group has a constant presence and is engaged throughout the project. The vehicles entering in and out of the roundabout represent the various partners and stakeholders (e.g. community members, content experts, service delivery personnel, methodological experts, policy makers, users, evaluators) who provide input and expertise along the way."

- *Equity and Excellence: Liberating the NHS* (White Paper 2010). Here we might ask what impact does the choice of words and the juxtaposition of these phrases have on the range of audiences (national and local politicians, journalists, patients, managers, health professionals, researchers, entrepreneurs)? Research on the challenges of engaging clinicians in 'quality improvement' and in evidence-based practice illustrates the importance of language used in policy initiatives: some degree of non-engagement may stem from clinicians' irritation or defensiveness in response to the implication that the care they are currently providing is poor quality or not based on current evidence (Davies, Powell and Rushmer 2006).

More creative use of language and metaphor, then, may open up better ways of communicating social research. At present, there is much in the academic environment that militates against this: the prevailing norms over research communication impose a rigidity of structure and expression that many academics take with them to other venues and in engagement with other stakeholders. Moreover, there are real dangers in the seductive metaphor (one need only think of *the war on drugs*, or worse, *the war on terror*). However, while being alert to the deficits of any given language framing, there may be much more we can do as both researchers *and* social change agents to communicate more persuasively by more careful use of language and more creative use of metaphor.

Advertising, marketing and social marketing

Influencing lies at the heart of marketing. The advertising and marketing industries are based on a substantial body of theory and experience about how people respond to words and images and how their behaviour is affected as a result. Insights from these industries, and from the communication theory on which their practices are based, are also now being used to make communication more effective in some fields of health care (e.g. in health promotion and social marketing) and have the potential to be used more comprehensively to increase the impact of social research in health care.

Effective communication

Research on health communication models has looked in detail at the impact that health messages have on recipients' intentions to follow health-related recommendations (Keller and Lehmann 2008). Moreover, such work also explores the impact of particular tactics used within messages (e.g. relating to fear, framing, vividness, physical *versus* social consequences, source credibility etc.). From their meta-analysis of 60 studies they suggest that there is a significant opportunity to tailor health communications more efficiently to different market segments and to use certain message factors (and not others) to enhance the effectiveness of health communications aimed at broad audiences. There may be lessons here in this distillation of experience for those aiming at wide communication of research-based findings.

Work on the psychology of persuasion (e.g. the elaboration likelihood model – ELM) is used to tailor more effective communications to consumers when the objective is to change consumer attitudes (Rucker and Petty 2006). Communications are then based on prior assessment of the nature of the audience (e.g. their elaboration level – the likelihood that the audience will do any thinking - or 'elaboration' – in response to the message or whether they will be persuaded by simple associations and cues) and on the message characteristics and objectives (e.g. immediate or enduring change). Work on the ELM and related theories can be used to create effective public policy communications and to 'diagnose' faulty ones. This emphasis on prior assessment of the audience is often lacking when we attempt to communicate messages from research.

In exploring the effectiveness of the design of hospital performance reports for consumers, Vaiana and McGlynn (2002) draw attention to the fact that users' ability to understand and evaluate data is affected by the way that information is presented. They observe that much health services literature currently comes from an 'information-telling' rather than a 'knowledge-construction' perspective and is therefore less effective than it might be. Although this paper uses the design of hospital performance reports as the example, many of the principles are applicable to the task of researchers in conveying other kinds of information and messages to a range of audiences who will be asking themselves *what can I do with these findings?*

In considering how information on hospital performance can be communicated in ways that facilitate comprehension and use, Vaiana and McGlynn (2002) suggest that the format should fit with what is known about how humans perceive, process and understand information. To achieve this, content experts need to work closely with document designers to develop reports, web sites and other materials that are useful to

non-experts. This partnering of content area experts with design and communication experts has been utilised by The Joseph Rowntree Foundation (JRF), a significant research agency and research broker. The JRF has a long history of employing journalists to write accessible summaries of research, distributing these widely to potential research-user communities (Martin 2010).

Insights from research on how the brain works can also be used in designing effective oral presentations and workshops (Jacobs 2010). For example, in broad terms, *surprise* is needed for messages to break through the automatic processing of the brain: the default is to respond to new material in line with what the individual already knows, and there is a psychological need to maintain the individual's current view of the world to avoid cognitive dissonance. Oral presentations and workshops require changes in pace and style of delivery, and need to be interesting and even entertaining. Observation of the format and approaches adopted by commercial media (fast-paced, interactive) may also be instructive as producers and advertisers have a financial stake in eliciting attention from viewers or internet users and therefore they rapidly jettison approaches that are not working.

Crucial among the persuasive techniques of marketing is identity and emotion. Iconic brands (e.g. Coca-Cola, BMW, Rolls Royce, Nike etc) built and retain their position through emphasising the emotional rather than the functional rewards associated with purchasing the product or service. Visual metaphors convey a number of brand values including superior performance, and the social and psychological rewards associated with ownership or use (Morgan and Pritchard 2000). Research on persuasion points to the importance of these less rational/cognitive aspects for securing consumer buy-in. Although marketing to health-care professionals has traditionally focused solely on developing rational arguments based on the product's clinical attributes, such marketing is increasingly shifting to take account of the role of emotions and values in the decisions made by health professionals (Kelly and Rupert 2009).

Social marketing

Social marketing is the application of traditional marketing techniques – aimed at changing consumer attitudes and behaviour – in the promotion of other types of behaviour change. It uses marketing principles and techniques to analyse, plan, execute and evaluate programmes aimed at changing the behaviour of individuals or groups. Social marketers identify consumers' needs and desires and use that information to create attractive options for their consideration. The aim is to create incentives for people to adopt and maintain a new idea or practice over time. Social marketing also seeks to alter the environment to make the recommended behaviour more advantageous than the current behaviour it is designed to replace. Social marketing concepts have been applied in public health and health promotion (do Paco et al 2010, Grier and Bryant 2005). They have also been used to encourage under-served groups to attend health care services (e.g. antenatal care) by making the services more attractive and appealing to the needs and interests of the local population (Quinn et al 2009).

There is growing interest in using social marketing techniques to effect change among health care providers. A recent article describes how these concepts were used to encourage the spread of evidence-based collaborative care models for patients with depression (Luck et al 2009). Particular attention was given to the need to target

different 'market segments' (e.g. regional managers, frontline providers, patients) with tailored communications according to the respective behaviour change goals for that group (e.g. managers who needed to decide to implement the programme and allocate resources to it; clinicians who needed to refer patients to it; patients who enrolled in the programme as a way of managing their depression).

Other examples in action

Of course, one only has to look around to see the slick and sometimes devious nature of marketing and its devilish side-kick, advertising. What follows though are some examples of the art being applied for the communication of, and influencing of change around, health and social issues.

- iHobo – an iPhone App created by an advertising agency for one of the largest homelessness charities in the UK. This app aims to raise awareness and generate funds for the charity. The app uses video-based content to bring to life the experiences of a young person who has found himself sleeping rough for the first time. Over the course of several days the phone user is sent alerts and asked to help the homeless person decide what to do when faced with typical problems, such as where to sleep. The launch of the app has generated much debate: does it do a good job of reaching and interacting with iPhone users who might otherwise ignore homeless people or is it patronising, equating a homeless person with a pet like a Tamagotchi?

- A controversial advertising campaign for the children's charity Barnardo's featured graphic images of child abuse, suicide and prostitution, and scooped the top prize at the IPA Advertising Effectiveness Awards in 2002. The award said that the campaign, created by ad agency Bartle Bogle Hegarty, had *"transformed the charity's image in the two and a half years since it was launched, making it relevant to a new generation previously unaware of its work"* (Claire Cozens, The Guardian 3 December 2002). A year later, the charity ran another provocative campaign designed to overcome indifference about the continuing impact of poverty on children's lives. But the choice of such a powerful image provoked a hostile reaction from the public and other charities. The first ad that ran in the Guardian and other national papers showed a full-page image of a newborn baby with a hospital tag around its wrist and a large cockroach crawling out of its mouth. The slogan was: *"there are no silver spoons for children born into poverty"*. Other ads in the campaign featured a baby with a syringe, and one with a bottle of methylated spirits poking out of its mouth. The images were based on research showing that babies born into poverty were more likely to grow up to be addicted to alcohol and drugs, become victims and perpetrators of crime and to be homeless. (John Carvel, The Guardian 13 November 2003)

- The controversial "Kill Jill" TV ad campaign run by the Scottish government in 2008 featured a picture of a young girl's head with a voiceover and text asking: *"Would you allow your organs to save a life? You have 20 seconds to decide"*. The girl's face then slowly became faded and distorted, with the voiceover and text stating*: "Kill Jill? Yes or no... Register and you could save a life"*.

More than 100,000 people signed up to the register following the campaign, outperforming the rest of the UK by a factor of three. The Advertising Standards Authority received 10 complaints about the ad, but cleared it of being misleading, causing serious or widespread offence or undue distress. (Mark Sweney Guardian 21 May 2008)

- Greenpeace recently ran a successful campaign against Nestle's use of palm oil in its products. Arguing that the companies that supplied the palm oil were destroying Indonesian rainforests, threatening the livelihoods of local people and pushing orang-utans towards extinction, Greenpeace ran a spoof ad that depicted blood running from one of Nestle's best-selling products (Kit Kat): http://www.greenpeace.org/international/campaigns/climate-change/kitkat/

- Amnesty International is currently using a series of short films *'The Invisibles'* posted on YouTube to highlight human rights issues affecting migrants who travel through Mexico to the US.

What is interesting in these examples is that they are notable exceptions: only rarely have hard-hitting campaigns been used to communicate evidence-informed messages aimed at shifting mental models rather than those aimed more directly at behaviour change (one can think here of any number of road safety or anti-smoking messages). The ground-breaking approach from Barnardo's – although controversial – shows the power and potential of the approach.

Journeying together: co-producing knowledge; co-producing design

"Engaged scholarship implies a fundamental shift in how scholars define their relationships with the communities in which they are located… Engagement is a relationship that involves negotiation and collaboration between researchers and practitioners in a learning community; such a community jointly produces knowledge that can both advance the scientific enterprise and enlighten a community of practitioners" (Van de Ven and Johnson 2006: 809).

We're all in it together may have a rather dubious ring to it in the current political climate, but nonetheless there are many strands of influencing that are based around doing things together and ideas of co-production. Indeed, there is growing evidence in health care in support of more collaborative and integrative models of research production and research use (co-production). Some authors suggest that the sustained involvement of potential research users in the research process may be one of the most important determinants of research impact on policy and elsewhere (Nutley et al 2007; Armstrong and Alsop 2010).

Of course, research-user engagement is not an all-or-nothing process: there are many models of engagement that specify different levels of the involvement of others in the research process: seeing users variably as informants, recipients, endorsers and commissioners of research, as well as full knowledge co-producers (Martin 2010). The potential benefits of co-produced research for practitioners and for researchers have been posited as encouraging new ways of thinking, and fostering improved communication and understanding between researchers and practitioners about key issues and challenges (Lunt et al 2010, Antonacopoulou 2010). Practitioners who have not previously seen research as relevant to their practice may have their perceptions shifted: *"…the responses of some practitioners to the experience of doing fieldwork… [is that research] has the potential to yield understanding and insight that often escapes day-to-day practice"* (Lunt et al 2010: 239).

Interestingly, this evolution from the traditional position of *'research, then disseminate'* has parallel development in the field of marketing, which has moved from the mid-20th century stance that *marketing begins where the manufacturing process ends* to increasingly a philosophy of marketing *with* customers from the very outset (Lusch 2007).

In addressing knowledge co-production, Van de Ven and Johnson (2006) discuss three ways in which the gap between theory and practice has been framed: i) the gap is a knowledge transfer problem; ii) theory and practice represent different kinds of knowledge, and iii) the gap is a knowledge production problem. They argue that (iii) offers a clearer way forwards in the form of 'engaged scholarship': researchers and practitioners co-producing knowledge that can advance theory *and* practice. Van de Ven and Johnson (2006) base this argument on the concept of 'arbitrage' (in this case, exploiting the differences in the kinds of knowledge that researchers and practitioners can bring to bear on a problem of interest to them both).

One form of research that has always had 'co-production' at its heart is *action research*, which emphasises that the research 'subjects' (and potential users, more

commonly termed co-researchers) work with the researchers to ask and answer the questions in a collaborative way. Other terms used for this approach include action science, participatory research and community-based participatory research.

Related to action research is *action learning*. Action learning is based on the idea that people learn most effectively when working with others to reflect on and address real-time problems (De Fillippi 2001, McCormack et al 2008). Building on these ideas, *emancipatory practice development* (McCormack et al 2008) encompasses a range of activities that aim to enable practitioners to think differently about what providing person-centred evidence-based health care really means for them and for their patients. Features of the emancipatory practice development approach include (McCormack et al 2008; Boomer et al 2008):

- Cycles of critical reflection, planning, action and evaluation
- Using 'transactional spaces' (opportunities for creative problem-solving and determining practical context-specific solutions)
- Visioning (e.g. using creative arts as a stimulus to ideas or to represent/depict aspects of the vision)
- Collaborative action learning
- Providing an environment of 'psychological safety' to allow individuals and groups to explore new ways of thinking and behaving.

In a related development, the rapidly-expanding field of *experience-based design* (EBD) provides another example of an approach which involves working alongside: assisted by facilitators, staff and patients share their experiences of providing or receiving care in a particular service environment (e.g. a clinic) and work together to co-design solutions to identified problems. Through the use of narratives, mapping and facilitated discussion, staff are given insight into the experience of patients attending the service and enabled to see aspects of the service which may be invisible to them as service providers but which may cause patients significant inconvenience or distress (Bate and Robert 2007).

The approach in EBD emphasises the importance of capturing the experience and emotions of staff through, for example, observation and staff interviews. In the later stages of the approach, staff and patients work together to discuss the findings and to seek solutions. Instead of just including stories and experiences in the design process, the users and staff are there in person and are directly involved in examining and interpreting their own experience and in assessing the potential impact of proposed solutions. The process generates collective momentum for change: *"…once staff and patients have come together on a regular basis, have listened to each other's stories and experiences, shared their moving videos, and have had some (serious) fun with scissors and paper in prototyping new solutions, they find it difficult to walk away with the job incomplete."* (Bate and Robert 2007: 62).

In addition to the tangible improvements made to the service, the process itself can be transforming of staff and patients' perceptions of each other and of the service. EBD commonly uses locally-collected interviews and other forms of data; the question of whether 'trigger films' based on nationally-collected data can still be effective in changing minds locally is unclear and is being considered (Locock 2010 – personal communication).

Some examples of the approach in action

- The ‘world café’ approach: an approach to hosting conversations for which the goal is thinking together and creating actionable knowledge. The approach is based on seven principles (set the context; create hospitable space; explore questions that matter; encourage everyone’s contribution; connect diverse perspectives; listen together and notice patterns; share collective discoveries). The approach has been used by hundreds of groups, including large multinational corporations, small non-profit organisations, government departments, community-based organisations, and educational institutions (www.theworldcafe.com).

- US researchers developed a health promotion programme involving training barbers as community health advisors so that they could educate their clients about colorectal cancer screening and informed decision making for prostate cancer screening. Working with an advisory panel of local barbers, cancer survivors and clients, the educational materials were developed and piloted through focus groups and interviews (Holt et al 2009).

- Schwartz Center Rounds – one hour case-based interactive multidisciplinary discussions held once or twice a month led by a clinician and/or a professional facilitator (Lown and Manning 2010). Each session opens with a brief presentation of a patient/family case by members of the healthcare team who cared for the patient. The presentation introduces multiple perspectives on selected psychosocial topics (e.g. management of team conflicts, the impact on professionals of making a mistake, the impact of patient violence etc) and is followed by a facilitated group discussion involving the audience members and the presentation team. The aims are to improve relationships and communication with patients and between providers and to enhance providers’ sense of personal support. Originated in the US, now being used in the NHS.

- The National Patient Safety Foundation uses a Listserv to encourage discussion on patient safety; Paul Levy, CEO of Beth Israel Deaconess Medical Center in Boston writes a blog ‘Running a Hospital’ which includes discussion of the organisation’s safety initiatives and commitment to transparency and draws responses from clinicians, employees and patients (Carr 2009).

- Organisations can use ‘scenario thinking’ – a structured approach to story telling about the future - to uncover and to challenge the mind sets (or mental models) that individuals and teams are using. Thinking through a series of ‘what if’ stories, and talking in depth about their implications brings individuals’ unspoken assumptions about the future to the surface. It is therefore a powerful way to challenge ‘mental models’ about the organisation and its context and to stimulate reflection on how the organisation might prepare strategically to face such scenarios more effectively (Schwartz 1998).

- Paxton Green general practice in south east London has set up a timebanking system: a mutual volunteering approach that enables people to swap skills with each other using an equal currency of time. People who live in the area can get

involved in activities including befriending, visiting, lifts, art, creative writing, walking etc.

"What makes Paxton Green…different from the mainstream is their attitude to their patients. They recognise that these are people who, whatever health problems they might have, also have huge experience, skills, often time – certainly the human ability to connect with other people. They also recognise that both the prevention and management of someone's health often needs more than a prescription."

'The time bank has broadened the view of how we as clinicians see patients' one of the doctors told researchers. 'So patients get some benefit even if we don't refer them to the time bank. We consider patients in more societal terms. The time bank has helped form an identity for the practice, and a focus for patients. Patients groups often fail because they focus too much on illness, but through the time bank we've formed a community" (Boyle et al 2010: 23).

The past several decades have seen a proliferation of terms for these kinds of 'working together': action research, participatory research, co-production, mode 2, engaged scholarship to name but a few. This is one area where much has gone on, but often away from the mainstream, and often under-evaluated. Moreover, much of this work has had a practitioner and/or service user focus, and more may yet be learnt by an extension of these ideas into managerial and policy worlds.

Immersion and experiential learning

If a picture is worth a thousand words, then maybe walking a mile in others' shoes is worth considerably more again:

> *"Your vision is blurry because your glasses have been smeared with Vaseline; your sense of sound is muffled by earplugs, and your right arm is bound to your body, inhibiting your movement. You lean heavily on the stranger who leads you into the day room, but she's talking over you, moaning to a colleague about her cigarette break. Out of nowhere, a spoon is pushed into your mouth full of slippery, tepid oats. You don't like porridge, but if you refuse, you'll be punished for kicking off."*

This experience is part of a new experiential training programme for care staff designed to invoke a sense of empathy with residents who have dementia (Rowena Davis, The Guardian, Nov 3rd 2010). The life of a resident is not just described or analysed – it is directly experienced by those taking part in the training: *"[they] are ignored, and fake pills are pushed down their throat without consent. Sometimes a wet pad is left between their legs to give them a sense of what it is like to be incontinent"*. The purpose of such training is not just to inculcate empathy, but to draw attention to, and provoke changes in attitudes about, incontinence care and over-medication. Immersion in direct experience is being used as a means of communicating important findings from research about these aspects of care – research that usually gets ignored.

Experiential learning or, going further, full immersion, seek to change attitudes, perceptions, understanding, and perhaps even values, through rich and personal experience. While much qualitative and ethnographic research seeks rich descriptions of lived experience, experiential learning and immersion go further in seeking to replicate those very experiences first hand.

Such approaches range from the simple 'fact finding walk around' so beloved of politicians, to long spells of participant observation by (typically) social anthropologists. While these approaches might be seen as forms of data gathering, at times they blur into influencing techniques, as for example, when Michael Portillo took over for one week the life, family and income of a single mother living on benefits (*When Michael Portillo became a Single Mum,* BBC2 2003). Portillo was reported as saying that caring for the girl in a terraced house in Merseyside while holding down a job in a supermarket was harder than anything he had faced in the Commons (http://news.bbc.co.uk/1/hi/uk_politics/3110657.stm). Immersion then, stepping into others' shoes, can be a powerful way of reshaping prior assumptions and mental models.

Experiential learning may be more limited than full immersion, involving replicating only a part of an experience. 'Pregnancy belts' for men, which seek to mimic the latter stages of pregnancy to induce empathic learning, provide (only!) a part of the experience of being pregnant, while projects to encourage school children to carry a bag of flour around with them for several days are designed to bring home some of the realities of early parenthood. What is striking in these examples is their relative rarity. This is especially interesting when the realities of care, for patients, but also, to

a degree, for staff, are so much ‘whole body, all senses’ in nature. Yet we mostly seek to communicate about these realities using almost entirely linguistic means.

Other examples of immersion or experiential learning

- The 2009 Channel 4 ‘fly on the wall’ television documentary “One Born Every Minute” filmed at the Princess Anne Maternity Hospital in Southampton is being used by local midwifery tutors to stimulate learning and reflection with student midwives.

- The ‘3rd Ring Out: Rehearsing the Future’ project run by Metis Arts (a not for profit organisation which creates arts projects to explore innovative ways of connecting with audiences) takes place in adapted shipping containers located in public spaces in which team leaders guide participants through a simulation set in the future, focusing on the human consequences of climate change.

It is hard to avoid the conclusion, when looking at the communication of research, how little actual participation there usually is. While we often, as researchers, strive to communicate the nature of ‘lived experience’ we very rarely aim to recreate that experience so that those we seek to influence can live it themselves. Moreover, in communicating research, we make startlingly little use of artefacts of any kind – linguistic and (sometimes) pictorial representations are made to do all the work. There are surely missed opportunities here for more creative, active and experiential means of engagement.

Creativity and the arts

"Social action is ultimately predicated on the relationship between personal and collective suffering, and the image has the unique ability to bring to consciousness the reality of a current collective predicament, as well as the universality and timelessness of an individual's suffering." (Hocoy 2007: 22)

Art may, in some senses, be transformative. It can be capable of shaking our basic beliefs and assumptions, destabilising our certainties, creating new empathies and galvanising us to action. In this then, it may share common purpose with the better findings from social research. Indeed, there is a growing emphasis on using the arts in health care, but to date, less has been done in terms of using art to share and communicate research.

There have been various initiatives in the UK to encourage the use of arts in health from at least the mid 1980s (Coats 2004), and these have covered a range of activities involving visual media (e.g. paint, collage, clay modelling), drama, movement, poetry, creative writing and music. These activities have had a range of therapeutic and educational objectives (Coats 2004, Hume 2010), but have also included aims such as supporting health professionals to engage with their own creativity for educational, practice development and research purposes.

Pictures and other visual images can be used as a way to stimulate the conscious and unconscious mind and to prompt new ideas. Individuals or groups can be invited to represent ideas pictorially e.g. their perceptions of a situation; their vision for the future of their local service; or their ideas about how a problem might be solved (Boomer et al 2008). Background music may help people to reflect on the images created prior to an open debate about the ideas that the images portray (Molden 1996). Constructed representations (e.g. with clay, Lego-like building bricks, toy construction sets etc) can be used instead of drawings or photographs: participants are invited to construct, build, mould or sculpt a form that represents the situation being discussed.

A common example of this is the use of patient process mapping: the visual depiction of pathway/process may show things that would not otherwise be visible (e.g. multiple routes, repetition, conflicting routes, the complexity of the pathway and the potential for confusion and uncertainty on the part of patients and health care staff about the next step to be taken). These depictions may then prompt reflection on ways that the pathway could be improved. Moreover, the act of creating the map is itself an interactive event for patients and staff that can help to break down barriers, stimulate conversation and create empathies.

Using drama

Drama and other forms of artistic expression have been used both to develop and to present data in health research (Simons and McCormack 2007). In critical ethnodrama (a form of action research), the aim is to ensure that the voices that are heard are those of the informants. The informants (e.g. individuals in a particular community setting or patients with a particular health condition) decide on the purpose of the enquiry. The researchers collect data (e.g. through recording ethnographic accounts, participant

observation etc) relating to the informants experience of living and working in that setting. Once data have been collected and returned to informants for additional comment, informant groups are asked specifically: *"What do you want to tell an audience of medical health workers, health service providers, care givers or young people about the experience [of schizophrenia or alcoholism]?"* (Mienczakowski 2001: 220).

Where possible an ethnodrama script incorporates as much verbatim narrative as possible. No fictional characters/scenarios/dialogues are used unless they have been validated by informants and researchers as reasonable, likely, typical and representative of the range of behaviours and outcomes experienced in that setting. The aim is to convince the predominantly health audiences ('expert' 'informed') of the credibility of the researchers and the data before engaging them in "*reflecting upon their professional and personal relationship to the representations we make"* (Mienczakowski 2001: 221). Each performance is also considered an opportunity to add further data to the analysis: every performance includes an opportunity for the audience and actors to debate and comment, and this material then feeds back into the work.

Using music
The use of music may also serve to set mood and steer this in certain ways. For example, in films, the background 'mood music' and choice of soundtrack can fundamentally alter the viewing experience, often in ways that are difficult to predict or explain (Lampel et al 2000). Music is clearly influential in setting mental and emotional states, for example: arousal music to gee-up participants before combat or competition; or the use of classical music in public spaces to discourage loitering by young people; or the careful choice of music in bars and restaurants to encourage either sustained stays or rapid turnover. Music may thus exert a powerful influence, but is rarely heard as part of attempts to communicate around research.

The arts in action: some health and research examples

- In the Paper People Project in the US, participants from a range of countries created artwork (paper people) in response to their feelings about gun violence. The project was launched at a march against gun violence and subsequently used in schools, colleges, treatment centres, prisons etc. The format has subsequently been altered to address other issues including sexual abuse, teenage pregnancy, eating disorders, homelessness, domestic abuse. A visual 'die-in' on top of the Paper People images – the first US 'die-in' – held in 2003 as part of a protest against the Iraq war attracted significant media attention (Hocoy 2007).

- US medical students have used the *Photovoice* approach (a participatory research approach with photography; www.photovoice.org) to depict issues they cared about (e.g. implications of the nursing shortage for quality of care, the limited opportunities in their programme to work with under-served populations). Through photography, the students captured real life stories of patients and colleagues and presented their work to influential leaders e.g. deans, other interested faculty and journalists. The surgeon general of that state then chose three students to present their work to policy makers at the

state capitol (Wang et al 2004). The use of photography in this way has a dual role: both as an art form, and as a means to record data, and intrinsic to the method is a powerful means of communication that compels a degree of attention.

- A community mask-making project was developed to raise awareness about issues of homelessness, to break down stereotypes about who is homeless and to experiment with art-based action as a way of creating community and exploring a social problem (Hocoy 2007). Around 300 people were involved in creating, exhibiting and auctioning over 100 plaster gauze masks. Each participant was interviewed and vignettes from each interview were displayed next to the mask along with myths and facts about homelessness and inspirational quotations.

- A children's hospital in London used scenes from children's real life experiences, played by actors, to help staff to reflect on what aspects of the experience of children and their families in hospital could be improved (Bate and Robert 2006).

- As part of a recent collective learning event, members of one CLAHRC[1] prepared in advance a model (using cardboard, plasticine figures, chicken wire etc) to represent their CLAHRC and the relationships within it. The model prompted lively discussion between participants from other CLAHRCs who reflected on what the model depicted in terms of the distances between different organisations within the CLAHRC, the conflicting objectives that different groups were pursuing and the impact of spatial and communication boundaries. Further discussion centred on how the CLAHRC might use the model or other activities as a way to start to address the difficulties they were facing in integrating members from across their geographical patch.

'Creativity and the arts' covers a vast panoply of possibilities and with growing interest in how these creative processes may interact more productively with research (more often expressed as 'science and the arts'). The distinctive nature of social research, and the special personal and resonant qualities of health/healthcare, suggests that there are further unexplored opportunities to utilise creativity and the arts in communicating around research.

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Huw Davies & Alison Powell, November 2010

[1] The nine CLAHRCs – Collaborations for Leadership in Applied Health Research and Care – are collaborations between NHS organisations and academic institutions aimed at increasing the production and implementation of applied health research.

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