Critical Healthcare Management Studies: Green Shoots

Martin Kitchener*, Aoife M. McDermott and Simon Cooper

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Cardiff Business School
Cardiff University
Aberconway Building, Colum Drive
Cardiff, CF10 3EU, UK
Tel: +(44) (0)2920 876951

*Corresponding author:
Kitchenermj@cardiff.ac.uk

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Abstract

Purpose: While critical approaches have enriched research in proximate fields, their impact has been less marked in studies of healthcare management. In response, the 2016 Organizational Behaviour in Health Care Conference (OBHC) hosted its first ever session dedicated to the emergent field of Critical Healthcare Management Studies (CHMS). This special edition presents five papers selected from that conference.

Approach: In this introductory paper, we frame the contributions as 'green shoots' in a field of CHMS which contains four main furrows of activity: (a) questioning the taken-for-granted, (b) moving beyond instrumentalism, (c) reflexivity and meanings in research, and (d) challenging structures of domination (Kitchener and Thomas 2016). We conclude by presenting an agenda for further cultivating the field of CHMS.

Findings: The papers evidence the value of CHMS, and provide insight into the benefits of broadening theoretical and methodological approaches in pursuit of critical insights.

Research implications: CHMS works to explicate the multiple and competing ideologies and interests inherent in healthcare. As pragmatic imperatives push the provision of health and social care out of organisational contexts and into private space, there is a particular need to simultaneously understand, and critically interrogate, the implications of new, as well as existing, forms of care.

Practical implications: This paper reviews, frames and details practical next steps in developing CHMS. These include: enhanced engagement with a wider range of actors than is currently the norm in mainstream healthcare management research; a broadening of theoretical and methodological lenses; support for critical approaches among editors and reviewers; and enhanced communication of critical research via its incorporation into education and training programmes.

Originality/value: The paper contributes to an emerging stream of CHMS research, and works to consolidate next steps for the field.

Keywords: critical healthcare management studies, questioning the taken-for-granted, beyond instrumentalism, reflexivity, structures of domination

Introduction

Although studies of healthcare organization and management have made considerable contributions to the professional, public and policy domains of the discipline, a critical domain remains under-developed (Burawoy, 2004; Currie *et al*., 2014). Kitchener and Thomas's (2016) review of critical healthcare management scholarship (teaching and research) found that it was represented in less than 1% of the healthcare management articles published over the last 25 years (including an earlier special edition of this Journal in 2014; see Hujala *et al*., 2014), and appears only rarely in leading Master's programmes internationally. A vibrant fourth domain is required in healthcare management, as in other disciplines, to provide the critique that is necessary to counterbalance the pathologies of the other domains. In acting as "the conscience" of professional studies (Burawoy, 2004: 1609), the critical domain should examine the implicit and explicit, normative and descriptive foundations of professional studies. It should also consider the values under which policy studies are conducted, and the moral commitments of public research. In the absence of an effective critical domain, healthcare management scholarship has remained generally conservative (in terms of objectives, definitions of appropriate subjects, and knowledge produced), and its relevance has been questioned by academics and practitioners (Alexander *et al*., 2007).

In some ways, the condition of healthcare management scholarship is surprising. For nearly two decades the critical domains of proximate disciplines (e.g. general management) have flourished, and it has been shown that the contexts of healthcare organization and management present both the need for critical scholarship, and a fertile field within which it could be conducted (Learmonth, 2003). The condition persists perhaps because of some combination of failures to appreciate the potential of critical perspectives, an acceptance of the role of researchers as 'servants of power' (Baritz, 1960), and some pragmatics faced by healthcare researchers and practitioners. Over the past three decades, healthcare has encountered unprecedented challenges and changes: to funding, governance, structures, managerial responsibilities, and patient roles. Behind the repeated policies and strategies aiming to achieve 'transformation', 'improvement' and 'sustainability' lie questions of power, influence, and control (McKee *et al*., 2008). Unpicking ideology and understanding influence and impact requires a critical interrogation of service structure, staffing, delivery and improvement and patient roles, as well as resultant implications for a range of stakeholders. In so doing, the challenge for CHMS is to work to simultaneously understand and critically interrogate the nature and implications of ongoing reform efforts.

To help address these issues, Kitchener and Thomas (2016) drew from the relatively mature tradition of critical management studies (CMS) to produce an articulating framework for the development of CHMS. Inspiration was sought from CMS because it is a broad church that has an agenda that directly confronts healthcare management scholarship's weaknesses (Adler *et al*., 2007). At its foundation, CMS aims to offer alternative ways of seeing the world by questioning and re-imagining management (Lancione and Clegg, 2014). Scholarship in this tradition is typically undertaken with the intention of altering management practices and organizational systems. Although that aspiration has rarely been achieved, CMS exists in part to "show that the world does not have to be the way it is" (Burawoy, 2004: 1612). As a result, critical management scholarship seeks to provide analysis and explanation that connects questions of power

with issues of "efficiency", extending beyond standard managerial(ist) definitions. Beyond this (largely) shared mission of CMS scholars, the broad church houses a wide (and sometimes competing) range of philosophical assumptions about the nature of the social world (ontology), and ideas about how knowledge of that world may be acquired (epistemology).

Following Delbridge's (2010, 2014) explication and celebration of the plurality of CMS, Kitchener and Thomas (2016) proposed an articulating framework for the emerging field of CHMS that comprises four main concerns, for: (a) questioning the taken-for-granted, (b) moving beyond instrumentalism, (c) reflexivity, and meanings in research, and (d) challenging structures of domination. Each concern is elaborated in turn below, and used to frame the contributions of the papers within this special issue.

Questioning the Taken-for-Granted

Following a foundational premise of CMS, critical approaches to healthcare management should develop to challenge the conventions of managerialist thinking (Fotaki, 2011). To contest assumptions of shared corporate goals and functionalist concerns with efficiency, CHMS should focus on the power relations in organizations, making inequalities transparent, and questioning their rationales and consequences (Waring and Bishop, 2010, Finn *et al*., 2010, Martin and Learmonth, 2012). For example, one stream of healthcare management scholarship has begun to problematize dominant research conventions, including those of apparent value, language neutrality and objectivity (McDonald, 2004; MacEachen *et al*., 2008). Fournier and Grey (2000: 18) describe this as the "unmasking" of mainstream management theory, which has constructed versions of appropriateness while obscuring these in a language of science, rationality and "naturalness".

Among early attempts to 'denaturalise' healthcare management research, some have begun to challenge hitherto taken-for-granted assumptions including: the inevitability of globalization, the dominance of market forces, the efficacy of managerial techniques such as lean, and the political neutrality of healthcare organizations (Kitchener and Leca, 2009, Dickinson and Sullivan 2014). This critical project of "denaturalization" has also included attempts to surface the partiality of both managers and researchers (Jermier, 1998). Contributors to this volume note the importance of surfacing the partiality of healthcare professionals (McDonald, Furtado and Vollm, 2017), while previous contributors to the journal have noted the importance of giving voice to patients and volunteers, in questioning the taken-for-granted in health and social care (Hujala *et al*., 2014). Thus, the basic premise of CHMS is to 'call into question the self-evident truths and conventional views on management […] the unconscious and unnoticed consequences of taken-for-granted practices' (Hujala *et al*., 2014: 592).

Within the contributions to this special issue, we note particular concern with reinterpreting existing narratives (Learmonth, 2017) and research projects (Pope and Turnbull, 2017) to offer both critical and complementary counter-framing of 'taken-for-granted' accounts. Revisiting existing narratives with historical distance and/or different lenses can help to question explanations, highlight oversights, and identify competing interests. Learmonth's (2017) retelling of the history of management within the NHS is undertaken with this aim. He problematizes the discourse used to describe management, with particular emphasis on the shift from the designation of such work as administration,

to management and, later, leadership. For him, such words can act as resources, resonant of normative notions of how healthcare should be organised; the relative position of managerial and clinical professionals within this; and the differential valuing of work. He notes how language shapes understandings of work and power relations, citing for example the transition from 'administration' undertaken in service of clinical professionals to 'management' activities undertaken independently of them. Thus, Learmonth elaborates how terms are inherently value-laden, and calls upon researchers to both consider the effects (rather than the accuracy or truth) of discourses, and be reflexive in how they are used.

In a similar vein, Pope and Turnbull (2017) question the taken-for-granted thesis of digital labour substitution, which suggests that technology adoption provides a clear route to reduce the labour required to meet rising healthcare demand in a cost effective way. In contrast, they emphasise and demonstrate the creation of new and different forms of work – and work intensification – associated with technology adoption.

In different ways, each of the other papers in this volume also question aspects of the currently taken-for-granted. This includes problematizing reform ideologies and interventions (Hyde *et al*., 2017); challenging the convention that improvement predominantly emanates from addressing deficits in performance (Coleman and Wiggins, 2017); and deconstructing the apparent 'neutrality' of the social and physical context in which care is provided (McDonald *et al*., 2017). Cumulatively, the authors demonstrate the widespread potential for questioning the taken-for-granted – and the capacity to do so using a broad range of methodological approaches.

Beyond Instrumentalism and Performative Intent

A second concern of CHMS challenges the emphasis given, in mainstream research, to material and financial measurements of inputs and outputs. Instead, it encourages moving beyond seeing management as a technical activity to consider a wider range of issues and outcomes. In laying the foundation for this agenda, CMS has focused on the inherent contradictions in managerial work: with managers mediating between those 'who deploy resources to dominate or exploit others, and others who are subordinated in such processes' (Alvesson and Willmott, 2012: 21). This directs CHMS to consider both managerial means and ends.

Early work in this regard concentrated on the ways in which the imposition of market mechanisms into healthcare systems produced outcomes including the loss of professional autonomy, and the adoption of business-like practices by healthcare professionals (Dixon-Woods *et al*., 2012; Hyde *et al*., 2016). Other authors (e.g. McDermott *et al*., 2015) note the enhanced use of routinized instruments for enhancing performance (e.g. standards, monitoring), with some evidencing resulting in challenges to professional autonomy and power (Hujala *et al*., 2014). Another stream of work has called attention to the potentially dysfunctional consequences of economic and performance oriented rationales for service users. For example, Hujala *et al*. (2014) note particular concern that vulnerable patients may lose opportunities for active agency when care is reformed to enhance economic efficiency. Others note that the recent emphasis placed on 'self-management' and 'independence' can marginalise some citizens, and reduce the quality of care they receive (Thomas and Hollinrake, 2014). This strongly suggests that there is a need to tailor and temper private sector ideology, to reflect

citizens and service users' differential levels of capacity and willingness to engage in co-creation of care (McDermott and Pedersen, 2016). Thus, at its heart, a concern with moving beyond instrumentalism and performative intent involves interrogating managerial interventions to capture broader implications than those evident in narrow technical measurements of performance.

In this special issue, Coleman and Wiggins (2017) analyse the use of an action research project to introduce conversation and listening as strategies to support improvement. They present action research as both a research and change oriented approach, grounded in a recognition of employees' humanity. Importantly, they position their work as a response to tension between instrumental, directive and control oriented approaches associated with measurement and outcomes, and participative and meaning-making approaches that afford primacy to staff and patient experiences. Thus, they explicitly distance themselves from the management of improvement as a technical activity, and recognize the relational nature of engagement within organisations. This is reflected in both the framing of their study and their research approach: their interviews opened with a focus on employees' lives, enabling relational connection.

Turning to the other end of the spectrum, Pope and Turnbull (2017) consider digital technology replacing human contributions. They move beyond a focus on instrumentalism when they ask: 'what if we stopped seeing robots and computers as replacements for human workers, and instead began to understand the work entailed in using these kinds of digital technologies in healthcare?' In taking this novel approach, the authors evidence the challenges in delivering the cost savings and standardisation perceived to drive the adoption of computer decision support systems (CDSS) for emergency call handling. While non-clinical staff were cheaper to employ, they required training and supervision, and faced intensive working conditions with substantive emotional demands. Further, the supporting workforce expanded to ensure the availability of clinical and technological expertise. Use of CDSS enhanced requirements for the particular aspects of the role that computers were unable to undertake, namely emotional labour, clinical discretion, and technology management. For Pope and Turnbull (2017), digital technologies have the potential to both substitute for and intensify labour. They note a need to take account of, and provide support for, the ongoing human investment associated with utilising digital technologies.

Third, McDonald *et al.* (2017) note the contested nature of some healthcare outcomes, and the need to balance the – potentially divergent – concerns of providers and patients. Indeed, they note different conceptions of care evident across nations, as well as across institutions and within patient-provider relationships. Specifically, the authors consider conceptions of care in the context of English forensic psychiatric hospitals. The authors characterise these as 'total institutions', subject to mandatory security standards, and hosting patients who have committed serious criminal offences and who are therefore detained against their will. These patients are encouraged to engage in rehabilitation oriented activities. However, McDonald *et al.* (2017) note concern that the 'cure' orientated model of care does not recognise the needs of the many patients who will never leave these institutions (Harty *et al.*, 2004). This reinforces the idea that healthcare management researchers should pay more attention to the context-specific, subjective and co-created nature of healthcare outcomes – rather than accepting narrow technical definitions.

Within a refreshing incorporation of insights from political economy into healthcare management research, Hyde *et al*. (2017) draw attention to the overarching role of ideology in shaping systems of healthcare provision, and detail how a focus on the short-term attainment of performance measures can obfuscate broader dynamics affecting longer-term capacity to deliver sustainable healthcare services. In an extreme form, they build upon their earlier work (Hyde *et al*., 2016), to detail the use of managerialism to deconstruct public healthcare services.

Together, these attempts to move beyond the instrumentalism of managerialist healthcare evidence the contested nature of performance, the need for interrogation of the complexities of delivering instrumental goals over the short, medium and longer-term, and draw attention to the limits of technical conceptions of performance in value-laden, human capital intensive and relationally oriented places of work.

Reflexivity, Meaning and Difference

As noted earlier, CMS houses a broad collection of researchers with assorted interests, research methods and philosophical assumptions. As Burawoy (2004) notes, such plurality, and even its attendant conflicts, can be a productive source of advances in theorizing and understanding. CMS has shown that for this to be achieved, however, explicit and reflexive (taking account of itself) consideration must be given to researchers' epistemological, methodological and ontological positions (Herepath and Kitchener, 2015). In addition, in being attendant on issues of privilege and power, CHMS has scope to think about who is involved in research, with emerging recognition of the potential to involve care providers (Coleman and Wiggins, this volume) and patients as co-researchers (Backhouse *et al*., 2016; Thomas and Hollinrake, 2014).

While the concerns of CMS for reflexivity, meaning and difference have received scant attention in healthcare management research, they have clear relevance. In this field, while some critics have bemoaned the dominance of positivism and quantitative research methods, there is no necessary assumption that any particular approaches and methods might be found in the emergent critical domain of healthcare management. Rather, what will be required is an explicit reflection upon the limitations and implications of any research approach, and the recognition that the currently dominant paradigm presents a naturalizing discourse around positivism and "scientific methods" that must be unpacked and examined.

In this volume, two papers afford particular reflexive attention to the nature, limitations and implications of their research approach. First, Coleman and Wiggins (2017) are unusual in explicating their ontological and epistemological position. They position their work in opposition to positivist and variance oriented conceptions, and detail their participatory approach to research, grounded in a desire to produce actionable knowledge. In pursuing the participation of research subjects, they note the nuances of the power dynamics within the healthcare workplace and research process (e.g. between migrant and host country workers; between staff at different ranks; and between research respondents and authors who develop narratives regarding the research findings). Their recruitment of internal co-researchers – reflecting the major languages and nationalities evident among staff – served to develop co-ownership of the research process, and aimed to develop sustainable research skills that could be utilised after the departure of the research team. This approach also led to reflexivity among research participants,

regarding their relationships and interactions with colleagues. Thus, Coleman and Wiggins' (2017) approach explicitly addressed the CMS aim of questioning extant management approaches, and aiming to alter management practices (c.f. Lancione and Clegg, 2014), albeit from a starting position of appreciation and positivity, rather than the traditional focus on deficit and problems. The authors emphasise the product of their research as employees' perceiving themselves as collaborators, with scope to change practice. However, they close with reflexive consideration of the power differentials evident between their respondents, co-researchers and the research team, and potential cultural constraints on understanding. In doing so, they recognise both their attempts to manage power differentials, and the outstanding and ongoing challenges to the realisation of power-sharing.

Also in this volume, Hyde et al. (2017) provide a reflexive methodological account of the sense-making undertaken by a multidisciplinary research team. They detail how this resulted in the development of a Critical-Action research approach, as a result of going 'back to basics' and exploring paradigmatic issues relevant to the research questions being pursued. Their critical-action approach draws upon critical theory and action theory, both characterised by anti-structural approaches. Importantly, the authors illustrate how the application of their approach enabled the emergence of critical insights into the role of ideology and instrumentalism in healthcare. More specifically, they identified paradoxes in how these played out in practice, with national reforms making little local sense. They also note the challenges posed to the longer-term delivery of sustainable healthcare services, in the light of short-term focus on instrumentalism.

Beyond reflexivity regarding research philosophies and methods, there is considerable potential to broaden the theoretical base drawn upon in CHMS. Reflecting this, Hujala et al. (2014) critique researchers for focusing on spotting gaps in existing theories when generating research questions, rather than challenging the assumptions inherent in existing framings. Illustrating the benefits of plurality in theoretical framing, Pope and Turnbull (2017) utilise a metaphor – drawn from popular culture in the form of a television drama about 'hubots' widely syndicated across Europe – to generate new insights about technology in use. They demonstrate the promise and power of using metaphor and other alternative approaches to generate a spirit of critical enquiry. In particular, and as alluded to above, they question the narrative that digital technology can provide an unproblematic substitution for human workers (Ford, 2015). Instead, they note the energy and effort exerted in introducing, managing and using these technologies. Thus, rather than removing labour, the use of technology creates new forms of work. It is this paradox, that technology increases the overall burden of labour and indeed intensifies particular aspects of it, that conventional analyses have failed to capture. Beyond their contribution to the body of metaphor-based research in organisation theory – encouraged by Morgan (1980) and others (e.g. Cornelissen, 2005) – Pope and Turnbull evidence the generative potential of novel theoretical as well as methodological framing. Similarly, McDonald *et al*. (2017) step beyond the bounds of organisational and management theory, and draw on the work of Lefebvre (1991) in framing their analyses.

Challenging Structures of Domination

Structures of domination refer to the systemic use of power, including the resolution of conflict in favour of particular groups. They can operate at a variety of levels –

reflecting the fact that staff work within institutional contexts that are, in turn, influenced by macro sectoral dynamics and national policy – and can be reinforced by education and training, as well as institutional acculturation. Reflecting this, Sambrook (2009) reported an attempt to develop a critical pedagogy within an MSc programme, premised on creating 'better management' via challenging norms and changing practice. This approach is characteristic of working with management practitioners to transform systems and practices (although some advocate a more radical anti-management stance, premised on undermining its influence through critique; see Alvesson and Willmott, 2012). Yet effectively challenging contextually embedded structures of domination can require attention to ideology and macro, as well as meso and micro, levels.

With its commitment to social improvement, some critical scholarship in healthcare has focussed attention on groups that have been mistreated by healthcare management (e.g. women, LGBT and nurses), and the conditions that support such oppression (Lee, 2004; Traynor, 2004; Ford, 2005; Kitchener *et al*., 2008). In one example, Fotaki (2001) concentrates on patients as a marginalized group within mainstream healthcare management research. As noted in the previous section on instrumentalism and performance, Fotaki argues that increased concern for economic efficiency under austerity has led healthcare management practice and research to emphasize issues of patient choice. While some argue that this may redress power balances and help develop better services, it may also turn (relegate) service users into customers or co-producers of care.

In this special issue, McDonald *et al*. (2017) draw attention to the situated nature of power and knowledge, and the influence of the state, institutional history, and professional training on social structures and situational priorities. In addition, they illustrate how particular interpretations of situations can become reinforced through space – which privileges some understandings over others, and influences attitudes and behaviours (c.f. Ashkanasy *et al*., 2014). In particular, they detail how the physical constraints and professional control inherent in the physical context of forensic hospitals may become taken-for-granted over time. For example, they give examples of systematic enactment of professional power via cure-oriented interventions, even where patients are unlikely to re-enter society, and in the face of legal challenges by patients who wished to cease therapeutic interventions. However, in other instances a focus on improved quality of life emerged. These differential trajectories illuminate the potentially co-created and dynamic nature of context, and the potential for providers and patients to engage in ways that reinforce or challenge extant power relations. Unusually, McDonald *et al*. (2017) note that their study was overtly aimed at making recommendations for change. As a result, the question of how to open up alternatives to dominant structures is raised by their analysis. Taking the example of forensic psychiatry, the authors note alternative conceptions of care in other countries, where more homelike space is provided for 'long-term' patients. Despite this, few professionals within their study challenged the status quo. An ongoing concern, then, is how to create supportive yet productive challenges to structures of domination that are supported by the physical and social contexts of healthcare delivery.

From a methodological perspective, as noted previously, Hyde *et al*. (2017) develop a research perspective – Critical-Action Theory – for directing critical empirical investigations, and illustrate its application. Hyde *et al*. (2017) begin by considering and

extending Burrell and Morgan's (1979) classification of management theories and methods in reflexively considering the research issues and process that underpinned their work. In their paper, they highlight the importance of temporal and multilevel analyses, given the influence of macro legislative, economic and political concerns on experiences of work (at meso and micro levels). In particular, they elaborate how healthcare organisations can often be affected by higher level and historical decisions outside their control, that have dysfunctional local implications. As a result, they emphasise the importance of critical theorists identifying ideology – as a key mechanism through which actors come to accept structures of domination, even where these fundamentally differ from the ethos of local services and actors. For Hyde *et al*. (2017), explicating ideology and its impact creates potential for the provision of alternative explanations and – where appropriate – the mounting of challenge to structures of domination.

It is perhaps fitting to close in considering this theme. While a focus on questioning the taken-for-granted is apparent across all the papers included in this special issue, a shift to challenging the structures of domination (involving an action orientation) is less consistently evident. Next, we finish by considering how we can consolidate the insights derived across our four themes and from our five papers.

From Green Shoots to a Vibrant Field of CHMS

Critical work can have an impact. Historically, we note how questioning the taken-for-granted relationships between providers and patients has resulted in transitions towards a wider acceptance of the importance of patient-centred care and an interrogation of what constitutes 'value' for service users (Hardyman *et al*., 2015; Keating *et al*., 2013). This special issue offers many other areas that may be ripe for for potential development, including: discourse and roles (Learmonth, 2017), spaces (McDonald *et al*., 2017), service delivery (Pope and Turnbull, 2017), improvement processes (Coleman and Wiggins, 2017), and ideologies and their impact (Hyde *et al*., 2017). The authors in the special issue have examined these wide-ranging interests in a variety of settings including call handling centres (Pope and Turnbull, 2017), ambulance services (Coleman and Wiggins, 2017; Hyde *et al*., 2017), primary care, acute care, and mental health (Hyde *et al*., 2017), and forensic psychiatric hospitals (McDonald *et al*., 2017). In moving forward, we note the importance of consolidating the attention afforded to these diverse themes and settings to encompass new areas of work (e.g. social and home care), delivered in new locations, by workers undertaking new roles. For example, the move to involve patients and carers in activities previously under the auspices of professions, in home environments outside the physical boundaries of the health service, will create substantive shifts in roles, power relations and resources in healthcare delivery, that require critical consideration (Vincent and Amalberti, 2016; Fitzgerald and McDermott, 2017). Thus, the current and emerging challenges of healthcare service organisation and delivery require critical interrogation. In addition, we note the importance of affording critical consideration to issues raised in different national contexts, given the contextual nature of structures of dominance and power-relations.

Establishing a vibrant critical field of healthcare organisation and management scholarship has not been, and is unlikely to be, quick or straightforward. This may be in part because scholars feel that engagement comes at the expense of critique (Delbridge, 2014). It must also be recognized that there are professional risks associated with any

attempts to speak the truth to power (Pollock, 2004). It is therefore necessary for the Academy (especially senior academics) to create safe havens for critical healthcare management scholarship through, for example, funded research posts, flexibility within curricula, and dedicated conferences and tracks. It was in this spirit that OBHC 2016 hosted its first-ever track of papers dedicated to critical healthcare management. We hope that the selection of papers from that landmark event presented here will represent green shoots in an emergent field of critical healthcare management studies.

While the papers presented in this special edition each recognize that CHMS will never provide a neat set of alternative ideas, they offer examples of a less conservative approach to the study of healthcare management and organization. Further development of the field will require a reflexive and constructive engagement between a wider variety of organizational and institutional actors than is currently the norm in mainstream healthcare management research. These include: trade unionists, policy makers, charities and non-governmental organizations, professional bodies and associations, and lobbyists. Even more radically, Willmott (2008: 929) notes the potential for links between critical management scholars, activists and social movements, and scope to reach out 'beyond the self-referential sphere of scholarship to provide resources for informed protests and progressive challenges'.

In turn, the new challenges implied in this approach will require a diversity of theoretical lenses, and a much broader range of topics will need to be studied. CHMS also requires support from the Academy. As evident here, critical interrogation can be supported by the use of novel theoretical and methodological approaches. Deviation from traditional sources of literature (e.g. popular culture, as per Pope and Turnbull (2017)), research approaches, and paper formats all require support from the designers of curricula, conference hosts, editors, reviewers, mentors, and line managers.

A key aspect of communicating the findings of critical healthcare management research must be their incorporation in educational programmes, ranging from the vocational to the academic. These are the vehicles that currently promote the dominant managerialist discourse and performance orientation (Sambrook, 2009). Thus, critical healthcare management scholars will need to disseminate their ideas and findings through educational materials to influence the development of both students and healthcare management professionals. Broader engagement with the full range of stakeholders and issues is necessary for the development of a vibrant fourth field of healthcare management scholarship that is less conservative, more relevant, and which provides the critique that is necessary to counterbalance the pathologies of the professional, public and policy domains. The papers in this special edition represent a promising set of green shoots within the emerging field of CHMS.

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