A Critical Discourse Study:
Dominant Discourse and Medical Resource Procurement

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Dedication

This project is dedicated to my family, for those who are with me now, those who are watching over me, and those to come.

To my children, Lauren, and Thomas, who inspire me and whom I learn from every day: My wish for both of you is to continue to be inquisitive, invest in yourself, and forge your own path. Remember to make each and every day the best day possible, "seeing through the weeds" and allowing yourself to soar on your journey. This is for you; I love you both with all my heart!

To my parents, who are watching down on me from above: Mom and Dad, you have always instilled in me the value of education and pursuing my dreams. I thank you and love you both. Mom, through your love, actions, and deeds, you showed me the way to be strong and independent. You embodied the spirit and dedication of continued growth, were my loudest cheerleader, had the most impact on who I am today and now are the wind beneath my wings. For that I am eternally grateful and love you till we meet again.

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Abstract of the Dissertation

A Critical Discourse Study:
Dominant Discourse and Medical Resource Procurement

Healthcare delivery is extraordinarily expensive, with healthcare systems focusing cost reduction efforts on expenses for medical resources. A multitude of healthcare professionals engage in conversations to decide which pharmaceuticals, supplies, and implants to purchase. However, professionals have different foci, and these conversations are not just an exchange of information but are situated in the practices of language and power relations—in other words, in discourse.

This case study explored the social and historical processes, power relations, and knowledge that frames discourse during the formulary process to answer the research question—*How does a dominant discourse emerge during the procurement of medical resources?*—and two subquestions: *What are the influences on the procurement of medical resources? How do the influences on medical resource procurement occur?*

Three types of data were collected and analyzed: semi-structured interviews, documents, and nonparticipant observations. Six major themes emerged during the data analysis in answering the research question: (1) insurance and site of care frame the conversations; (2) corporate practices establish conversational boundaries; (3) the approval structure and process limit what is discussed; (4) discussions are continuously characterized in terms of financial implications; (5) power is dispersed; and (6) decisions are not always final.

These six themes informed the interpretations and conclusions that a dominant discourse emerges during the formulary process in a recursive manner, with the healthcare sector structuring the conversations and power exercised at differing points along the process through corporate practices and by different professionals.

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CHAPTER 1:

INTRODUCTION

This study sought to understand how a dominant discourse emerges within a healthcare system during the procurement process. Healthcare delivery is extraordinarily complex and expensive (Abdulsalam et al., 2015; Montgomery & Schneller, 2007). Year after year, healthcare spending continues to grow, and in 2019 the U.S. annual spend on healthcare services and goods was $3.8 trillion, with $1.2 trillion related to hospital care (Centers for Medicare & Medicaid Services, 2018). With healthcare expenditures continually on the rise, healthcare systems are seeking to reduce costs in several ways: by reducing staffing, identifying alternative therapies, delaying infrastructure investments (NORC, 2019), reducing costs for medical devices (Lee, 2013), and reducing supply budgets (Pennington & DeRienzo, 2013). Cost reduction efforts tend to focus on procurement areas (Atilla et al., 2018), as a significant portion of a hospital's budget is allocated to medical supplies, implants, and devices (Peck, 2019). Although overall, healthcare systems look to control and decrease costs while increasing the quality of care (Atilla et al., 2018), these reductions can result in "negative impacts on patient care" (NORC, 2019, p. 13), with reductions imposed without consideration of the best mix of resources needed to deliver excellent patient outcomes (Kaplan & Haas, 2014). Reducing supply expense while maintaining quality and safety is challenging (Pennington & DeRienzo, 2013) because a key contributor to high clinical quality is the utilization of medical supplies (Abdulsalam & Schneller, 2019).

To reduce costs and promote cost-effectiveness, hospitals are bringing together clinicians and nonclinicians in the decision-making process (Grundy, 2016).

Professionals in healthcare include both clinical professionals, those who provide the principal care for a patient such as physicians, nurses, and other clinically trained personnel (Centers for Medicare & Medicaid Services, n.d.), and nonclinical professionals, a term commonly used to refer to those professionals who do not provide the principal care for a patient, such as those who work in the areas of finance, supply chain, legal, or revenue cycle. As clinical and nonclinical professionals have different job-related foci (Brown et al., 2010), their perspectives may differ on which resources are required, how many, and of what quality (Kaplan & Haas, 2014). These differences can result in decision-making and resource selections that are based on clinician preference or cost and are not guided by evidence or effectiveness (McInnes et al, 2021). As these decisions are predicated on conversations between a multitude of professionals (Atilla et al., 2018), restraining healthcare costs while maintaining quality of care becomes a challenge because of the power relationships among professionals (Montgomery & Schneller, 2007). These conversations are not just an exchange of information but are embedded in a realm of discourse that includes historical, social, and power elements related to what is spoken or written (Foucault, 1979; Hardy & Phillips, 2004). This study furthers the healthcare literature on discourse by considering the social and historic processes, power, and knowledge that frame discourse and impact the decisions on medical resource procurement.

Overview of the Study

This study was performed to understand how the procurement of medical supplies, implants, devices, or pharmaceuticals, collectively referred to in this study as medical resources, is influenced by the emergence of a dominant discourse. The mission

of healthcare systems, including hospitals and other sites of care delivery, is to provide quality medical services to the patient population they serve (Porter & Lee, 2013). However, hospitals are business entities and must balance the need to provide quality medical services to patients with the financial health of the organization (Saviano et al., 2018). As healthcare expenditures continue to grow, with over $1.2 trillion spent within the hospital sectors (Centers for Medicare & Medicaid Services, 2018), hospitals are faced with the difficult task of concurrently reducing costs and improving financial performance while improving quality (Atilla et al., 2018). To survive, hospitals must achieve an economic and financial equilibrium (Saviano et al., 2018), and controlling costs related to medical resources is one way to achieve that equilibrium (Kaplan & Haas, 2014).

Most often the cost of hospital care is covered by either a governmental payor (Medicare or Medicaid programs) or a private commercial payor (Schreck, 2020). Medicare's hospital reimbursement is a per-case payment based on the diagnosis of the patient and is intended to cover all the services provided by the hospital, including supplies, devices, implants, and pharmaceuticals (Montgomery & Schneller, 2007). However, costs are outpacing Medicare reimbursement. Supply costs alone account for about 31% of a hospital's costs per case (Montgomery & Schneller, 2007), with approximately 33% of a hospital's operating budget related to supplies, implants, and pharmaceuticals (Peck, 2019). It is estimated that hospitals could reduce their supply spend by about 18% (Morse, 2017) with additional cost savings opportunities through standardizing practices and increasing patient throughput. The challenge is to manage the cost without creating a negative impact on quality (Atilla et al., 2018; Kaplan & Haas,

2014; Montgomery & Schneller, 2007; Okpala, 2018). With economic and reimbursement factors putting constant pressure on health systems to reduce costs (Kaplan & Haas, 2014; Paulus, 2020; Porter & Lee, 2013) and significant opportunities to reduce costs in supply procurement (McGinnis et al., 2005), hospitals seek to use less costly alternatives (Kaplan & Haas, 2014; Okpala, 2018), impose a rationing of resources (Zita et al., 2020), and/or consider a value analysis that considers the performance of the resource and not just its cost (Grundy, 2016). Which medical resources are procured and what workflows are adopted directly impact the cost of care (Porter & Lee, 2013).

The responsibility for the procurement of medical resources broadly falls under the domain of supply chain management and collectively includes physicians and other healthcare providers, hospital managers, manufacturers, and supplier representatives (Abdulsalam et al., 2015; Montgomery & Schneller, 2007). These various professionals are jointly responsible for the supply chain effectiveness and efficiency (Abdulsalam et al., 2015). As supply chain includes professionals from both the clinical and nonclinical areas, this study utilized the term *clinical professionals* to refer to those with direct patient care responsibilities, who provide the principal care for a patient, and *nonclinical professionals* to refer to those professionals who do not provide the principal care of a patient, with their job duties related to finance, supply chain, revenue cycle, legal, or management.

Decisions about the procurement of medical resources are usually made by clinical and nonclinical managers (McInnes et al., 2021; Shbool & Rossetti, 2020) with the goal to minimize cost and optimize quality (Grundy, 2016). However, different professional foci create tensions between sets of professionals, with the nonclinical

professional seeking to maintain cost margins and the clinical professional seeking to provide high-quality care (Kaplan & Haas, 2014). Overwhelmingly the literature has indicated that clinical professionals exercise decision making based on product preference, peer influence, marketing information, and perceived industry benefit (McInnes et al, 2021; Montgomery & Schneller, 2007). Physicians also enjoy significant autonomy with product choices without following practice guidelines or evidence-based medicine (Montgomery & Schneller, 2007). Schneller and Smeltzer (2006) identified that up to 61% of total supply costs are related to physician preference, which generally are high-cost items such as hip and knee implants, cardiac stents, or mechanical devices used in spine surgery.

Although new medical devices are evaluated for safety and efficacy by the U.S. Food and Drug Administration, there are no national standards for device deployment; despite huge cost differences, there are no criteria to determine whether existing or newer devices should be used (Montgomery & Schneller, 2007). In addition, there has been a significant increase in new cancer-treating pharmaceuticals, with many of these drugs priced at more than $100,000 per patient, some more than $400,000 per patient (Rimer, 2018), and a few such as Danyelza priced at over $950,000 per patient per year (Chase, 2021). Hospitals are identifying alternative therapies to mitigate the impact of drug price increases (NORC, 2019) and are switching to less costly agents or changing the route of drug administration (Dalton & Byrne, 2017; McMullin et al., 1999). Clinical professionals are reporting that at times the procurement of certain medical resources is justified by the hospital's cost rhetoric only and not based on the effectiveness of the product (McInnes et al, 2021). Nonclinical professionals focus on cost-saving initiatives,

reducing expenses, and maintaining margins (Ballard, 2005; Clark, 2006; Kaplan & Haas, 2014; Schneller & Wilson, 2009), with financial executives more comfortable focusing on and discussing cost as it is an unemotional data point (Peck, 2019). McInnes et al. (2021) argued that medical resource procurement should be the result of evidence that considers both cost and quality.

Since healthcare organizations are polyphonic in nature (Hujala & Rissanen, 2012) and most organizational activities include people talking (Alvesson & Kärreman, 2011), both the clinical and the nonclinical professionals engage in regular conversations to make decisions on the procurement of medical resources, pharmaceuticals included in the formulary, and availability of resources, which may impact cost and quality (Atilla et al., 2018). Some researchers have argued that an organization's decisions and actions are conditioned by its prevailing discourse (Phillips et al., 2004), with organizational, economic, and institutional objectives highlighting the increased importance of talk (Alvesson & Kärreman, 2011), language, and discourse in social life and the interventions to control and shape language practices (Fairclough et al., 2011). However, decisions on medical resource procurement should be predicated on discussions that are honest and forthright, leading to the development of a consensus amicable to all (McGinnis et al., 2005), based on collaboration and alignment among multiple stakeholders (Marques et al., 2020) and education on the costs of care (Kulkarni & Shephard, 2018). However, with the convergence of different professionals with different job-related foci (Brown et al., 2010), power issues occur (Brown et al., 2010), with discourse serving the particular interests of each individual or group (Koeberlé, 2012). Discourse practices allow for stakeholders to engage in conversation to persuade others in

the direction of a preferred outcome (Koeberlé, 2012), which is not value neutral and may be influenced by the social context and taken-for-granted social and power structures (Hart, 2014). Decisions based on the emergent dominant discourse are then predicated on practices favoring one group and marginalizing another (Kure, 2010) and silencing contrasting opinions (Du-Babcock & Chan, 2018). Underlying the discourse are practices that are socially embedded (Gee, 1990), create power relations (Knights & Morgan, 1991; Leclercq-Vandelannoitte, 2011), are visible or invisible (Foucault, 1979; Gutting, 2005), and may result in a dominant or privileged discourse (Cooren, 2004; Cooren & Taylor, 1997; Hardy & Maguire, 2016; Mumby & Stohl, 1991; Thurlow & Mills, 2009).

This study drew from critical discourse studies, Foucault's theorization on discourse, and its representation as depicted by Hardy and Thomas's (2004) model on the realm of discourse. Foucault (1979) theorized discourse as historically constructed and grounded in power and knowledge relationships, which allows for some things to be said and other things to be suppressed (Alvesson & Kärreman, 2011; Hatch, 2018). Hence, discourse is not just about what is spoken or written or the exchange of information; it is about the practices of language that continue to maintain power relations producing knowledge which guides meaning making (Hatch, 2018) in daily activities and inquiries. This study adds to our understanding of how a dominant discourse emerges through the realm of discourse influencing the procurement of medical resources. This chapter presents the reader with a statement of the problem, purpose of the study, research question, significance of the problem, conceptual framework, methodology summary, limitations, and definitions of key terms.

Statement of the Problem

Medical resources affect quality of care (Abdulsalam & Schneller, 2019) and are very costly (Montgomery & Schneller, 2007; Peck, 2019). Hospitals seek to reduce costs related to medical resources secondary to rising medical costs, budget constraints, and medical resources accounting for over 33% of hospital budgets (Peck, 2019). Clinical and nonclinical professionals engage in conversations to make decisions for medical resource procurement (McInnes et al., 2021); however, they have different foci (Brown et al., 2010). The literature has identified that clinical professionals focus on product preference, peer influence, marketing information, and perceived industry benefit (McInnes et al., 2021), while nonclinical professionals focus on cost (Ballard, 2005; Clark, 2006; Kaplan & Haas, 2014).

With different foci, these clinical and nonclinical professionals engage in conversations to make decisions on medical resource procurement (McInnes et al., 2021); however, talk and language are complicated (Alvesson & Kärreman, 2011), with these professionals rarely collaborating to ensure best practice and cost reduction (Kaplan & Haas, 2014). These conversations are not just talk or communication but are situated within a context related to the historical, social, and power aspects related to what is spoken about or written, leading to perceptions and ways of doing things (Foucault, 1979; Hardy & Philips, 2004).

Discourse practices allow for stakeholders to engage in conversation to persuade others in the direction of a preferred outcome (Koeberlé, 2012). These practices are not value neutral but may be influenced by the social context and taken-for-granted social and power structures (Hart, 2014). Decisions based on the emergent dominant discourse

are then predicated on practices favoring one group and marginalizing another (Kure, 2010) and silencing contrasting opinions (Du-Babcock & Chan, 2018). As discourse plays a fundamental role in decision-making (van Dijk, 1993; Wodak, 2000), the dominant discourse emerging will impact the procurement of medical resources and thus affect a patient's quality of care. With a dominant discourse responsible for a significant amount of a hospital's expenditures, how a dominant discourse emerges predicated on sociocultural and power relations factors among professionals is unclear.

Purpose of the Study and Research Question

The purpose of this study was to understand how a dominant discourse emerges during the procurement of medical resources. This study explored how within the realm of discourse a dominant discourse emerges through text and related interactions during the procurement of medical resources.

This study had a primary question and two subquestions:

Research question: *How does a dominant discourse emerge during the procurement of medical resources?*

Subquestion 1: What are the influences on the procurement of medical resources?

Subquestion 2: How do the influences on medical resource procurement occur?

Statement of Potential Significance

This study contributes to both the practical and theoretical domains in three areas: understanding the realm of discourse between professionals as more than just communication, drawing on the discourse of nonclinical professionals as well as clinical

professionals during medical resource procurement, and understanding how a dominant discourse emerges.

First, communication refers to transmission of information through verbal and nonverbal methods (Syyrila et al., 2020), while discourse refers to examination of relations through the realm of discourse, allowing for the historical nature, social process, and relation to power to be made visible (Hardy & Philipss, 2004). In general, there is a dearth of studies related to discourse in healthcare and on discourse as defined by this study. Many healthcare studies revolve around communication and the interprofessional work (i.e., tasks performed) among clinical professionals (Chreim et al., 2013; Martin & Finn, 2011) and not discourse. Studies related to communication in healthcare often use the terms *communication* and *discourse* interchangeably, as in work of Liu, Gerdtz, and Manias (2016). A recent study by Noyes (2021) examining how healthcare groups used text and conversation in everyday interaction to negotiate the tension between an established power hierarchy and collaborative care models did not use the term *discourse*. This study found that communication is "not as a process of information exchange but as a constitutive process through which groups create and perpetuate relationships of power" (Noyes, 2021, p. 21) without discussing the role of discourse. Research on discourse in healthcare is needed for clinical and nonclinical professionals to understand any potential social practices and underlying power relations that may underscore decision making and by extension the procurement of medical resources.

Second, as healthcare studies focus on the communication between clinical professionals, the professional boundary between clinical and nonclinical professionals arises. Simpson (2012) argued that hospitals provide a valuable opportunity to study

professional boundaries given the intensity of knowledge-based hierarchies and the competition to treat specialized patients with increasingly limited resources, and Heusinkveld et al. (2018) called for research on how different knowledge-based occupations delineate work, resulting in certain organizational outcomes.

The practitioner literature clearly identifies the goals of the nonclinical professional as cost reduction and maintenance or improvement of financial margins (Grundy, 2016; Kaplan & Haas, 2014). Both the relevant practitioner and academic literature related to the clinical professional references the mission of the hospital and the significance of the clinical professional role in patient care; however, there is a gap in the literature related to the degree of impact on patient care of the nonclinical professional. Extrapolating from Simpson (2012), whose work referred to professional boundaries among clinical professionals, and drawing from Heusinkveld et al. (2018), this research sought to understand the impact of interprofessional boundaries through the effect of the nonclinical professional's discourse on medical resource procurement.

Lastly, this study's significance to the practical domain is advancing the understanding of clinical and nonclinical professionals' social practices and the realm of discourse resulting in a dominant discourse that may impact the healthcare system's procurement of medical resources. This study brought in the discourse of the nonclinical professional and how nonclinical professional discourse may emerge as dominant, thus affecting the procurement of medical resources which may in turn affect the access, cost, and quality of care provided by a healthcare organization. Clinical and nonclinical professionals should engage in discourse that results in practices of collaboration and consensus and not in a discourse created by social practices embedded in power and

knowledge relations. Thus, the findings of this study contribute to how healthcare systems devise conversations related to procurement.

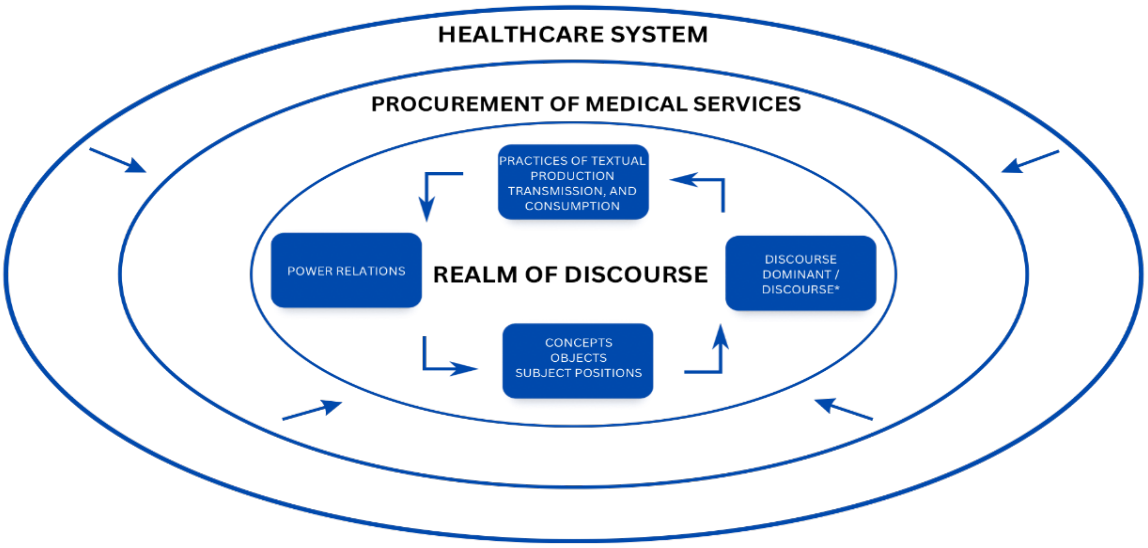
Conceptual Framework

To understand how a dominant discourse emerges during the procurement of medical resources, this study drew on critical discourse studies, the theorization of discourse according to Foucault (1979, 1981), and Hardy and Phillips' (2004) model, the realm of discourse. This study's conceptual frame utilized concentric circles to illustrate the macro level of the healthcare system, with funnels (as illustrated by the arrows) to the micro level where discourse occurs. Moving inward, each circle represents and narrows the process related to resource procurement. The outermost circle represents the healthcare system, which is complex and comprises the economic and political environment, the hospitals, the care team, and the patients (Reid et al., 2005). The next circle represents the procurement process, including the clinical and nonclinical professionals who engage in decisions related to medical resource procurement (Grundy, 2016). The inner circle represents Hardy and Phillips' (2004) model on the realm of discourse, which is used to explore how a dominant discourse emerges among these professionals. Hardy and Phillips' (2004) model draws heavily on Foucault's (1979) theorization on discourse. The model consists of

1. Practices of textual production, transmission, and consumption
2. Discourse—dominant discourse
3. Concepts, objects, and subject positions
4. Power relations (Hardy & Phillips, 2004)

Figure 1.1

Conceptual Frame of the Study



Note. Based on Foucault (1979) and Hardy and Phillips (2004).
*How does a dominant discourse emerge during the procurement of medical resources?

Hardy and Phillips' (2004) textual practices consist of a set of rules that govern producing text, transmitting text, and consuming text and result in a series of or several related texts that can refer to or challenge one another. These practices create a discourse constructed in a social context with what can be said by whom and when. This discourse is constituted in concepts, objects, and subject positions (Fairclough, 1992; Hardy & Phillips, 1999). The meanings associated with these concepts, objects, and subject positions are how one makes sense of and acts in the world (Hardy & Phillips, 2004). Concepts aid in the understanding of social reality by using social constructions that form cultural and historic frames with different subject positions, which refer to the positions one holds in a social space (Knights & Willmott, 1989; Townley, 1993), with different rights to speak (Hardy & Phillips, 1999, 2004). Holding in place meanings associated

with concepts, objects, and subject positions influences what can be said by whom and shapes power relations. Hence, through the practice of discourse, texts continue to maintain power relations, producing knowledge that guides meaning making (Hatch, 2018) in daily activities and inquiries. This study expanded on Hardy and Phillips' (2004) model and drew on critical discourse studies, contending that from this framework a dominant discourse emerges through which the decision to procure medical resources is predicated. A dominant discourse emerges when these texts and practices produce a view of reality that is perceived to be normal and taken for granted (Hardy & Maguire, 2010; Hart, 2014; Maguire & Hardy, 2009).

In summary, this study's conceptual framework draws on Hardy and Phillips' (2004) model (the realm of discourse) and Foucault's theorization on discourse, illustrating how through the realm of discourse, text practices hold into place meanings of concepts, objects, and subject positions (Fairclough, 1992; Hardy & Phillips, 1999), creating power relations, normalizing a discourse for what is taken for granted, and leading to an emerging dominant discourse. The methods used to explore the realm of discourse are summarized in the following section.

Summary of Methodology

This research used a case study design. Overall, qualitative research's central characteristic is that "individuals construct reality in interaction with their social worlds" (Merriam & Tisdell, 2016, p. 24). Qualitative research is based on knowledge that is constructed as people interact, engage, and make meaning of their experiences. The belief that knowledge is created differs from the belief that knowledge is pre-existing, as held in quantitative research. A case study explores a contemporary phenomenon, the case (Yin,

2018), searching for meaning and understanding with an in-depth description of a bounded system (Merriam & Tisdell, 2016). The primary goal is to uncover and interpret how meaning is constructed and how people make sense of their worlds (Merriam & Tisdell, 2016). Central to this study was the perspective of criticality with the analysis of power dynamics and questioning of the categories and notions of knowledge (Merriam & Tisdell, 2016).

A case study design was selected for this research as it aligns with the purpose of this study to uncover how a dominant discourse emerges during the procurement of medical resources, a distinct, bounded process. Data collection and analysis focused on whose interests were being served, who had the power, how things were being negotiated (to understand how one's group interests were being advanced), power relations, the construction of knowledge, and hence the nature of truth (Merriam & Tisdell, 2016).

Site and Participant Selection

A healthcare system in the Northeast United States was purposely chosen for the research site. This site has an extensive procurement matrix, which included a centralized procurement office and local leadership at its six acute care hospitals. Since there were six hospitals within the system, there was extensive engagement around procurement and a significant number of services that utilized high-dollar supplies, devices, implants, or pharmaceuticals.

Participant selection was based on purposeful sampling (Creswell, 2014) and comprised both clinical and nonclinical professionals who had direct involvement with identifying and procuring medical resources. In addition, to ensure selection of

participants with knowledge and experience related to procurement, snowball sampling (Patton, 1990) was used.

Data Collection, Data Analysis, and Trustworthiness

This case study utilized multiple data sources: semi-structured interviews, nonparticipatory observations, and document review (Merriam & Tisdell, 2016). Nonparticipatory observations were material to this study to experience and document the texts and social conditions. One of the goals was to observe the practices of textual production and consumption of text within the social context (Hardy & Phillips, 2004). Interviews and documents were also data sources. Professionals who had direct involvement with the procurement of medical resources were invited to participate in individual face-to-face or virtual interviews. The interviews adhered to the preestablished interview protocol and were audio recorded with the interviewees' consent. The interview questions were guided by this study's critical perspective and designed to stimulate a response (Merriam & Tisdell, 2016). The documents reviewed included policies and procedures.

Data analysis included both organization by the components of the conceptual framework and inductive coding. Coding was performed iteratively and involved identifying recurring patterns or themes (Merriam & Tisdell, 2016). The coding was consistent across all data sources.

Trustworthiness refers to the degree to which the findings of the study can be trusted (Korstjens & Moser, 2018). This study incorporated several strategies to ensure trustworthiness, including data triangulation, which is identified as one of the best strategies to ensure validity (Merriam & Tisdell, 2016). Data triangulation refers to

utilizing multiple data sources that are examined and converged. Other trustworthiness strategies included a subjectivity statement, reflexivity statements, chair and peer review of interview transcripts, member checking, chair and peer review of coding, and thick, rich descriptions.

Limitations

This research faced a variety of potential limitations. First, the site was a religious-based healthcare system, and it was not within the scope of this research to determine if the religious nature of the system had a bearing on medical resource procurement. Second, the research focused on the discourse among professionals in medical resource procurement. As this study was concerned with textual practices, it did not consider nontextual practices such as body language or the materiality aspect of spaces. Third, discourses occur in varying environmental contexts and landscapes. This study did not take into consideration how these landscapes feed into power and may change the meaning of the discourse. Fourth, this research focused on the process related to the emergence of a dominant discourse and not on how decisions are made.

Notably, this research was performed during a pandemic and a public health emergency, which caused limitations to stakeholder availability, access to meetings, and the ability to perform in-person interviews as well as attend in-person meetings to collect data. It is unknown if discourse or discourse practices change in the context of a virtual meeting compared to an in-person meeting. To date, no relevant research reviewed has studied procurement discourse and discourse practices through virtual interactions.

Definition of Key Terms

Table 1.1 defines key terms used throughout this dissertation.

Table 1.1

Definitions of Key Terms

Key term	Definition (source)
Clinical professionals	Those who provide principal care for the patient with expertise needed for the ongoing management of a chronic disease or condition (Centers for Medicare & Medicaid Services, n.d.).
Nonclinical professionals	Those who do not provide direct care to a patient. Considered professionals based on specialized knowledge, academic training, and existence of professional organizations (Abbott, 1988; Larson, 1977).
Text	Symbolic forms of representation (Maguire & Hardy, 2009), including speech acts, written documents, pictures, and symbols (Grant et al., 2004).
Discourse	A collection of interrelated texts of bodies of knowledge that forms the objects of which they speak (Foucault, 1979, p. 49) and "is shorthand for a whole set of power/knowledge relations which are written, spoken and communicated and embedded in social practices" (Knights & Morgan, 1991, p. 254).
Dominant discourse	Texts and practices to construct widely shared meanings of a particular phenomenon (Phillips et al., 2004), producing what is normal (Hardy & Maguire, 2010) and having a particular view of reality as taken for granted (Maguire & Hardy, 2009).
Concepts	"Ideas, categories, relationship and theories through which we understand the world and relate to one another" (Hardy & Phillips, 1999, p. 3).
Healthcare system	The individual patient, the care team, the hospital (organization), and the economic and political environment (Reid et al., 2005).
Object	Formed when material reality becomes meaningful (Grant et al., 2004).
Power relations	A social position from where individuals can act (Grant et al., 2004).
Practices of textual production, transmission, and consumption	Rules of formation with practices of textual production involving the construction of texts to convey a particular meaning or to produce a particular effect (Hardy & Phillips, 2004) and practices of consumption of text constituted through the interpretation of the intended meaning or an alternative meaning (Hardy & Phillips, 2004).

Realm of discourse	Encompasses how discourse produces power relationships and constitutes the social contest for action (Hardy & Philips, 2004).
Procurement	The process an organization uses to buy products or services it needs (Cambridge University Press, n.d.).
Subject position	The position one holds in a social space (Townley, 1993).

CHAPTER 2:

LITERATURE REVIEW

Introduction

This chapter reviews the literature related to the research question: How does a dominant discourse emerge during the procurement of medical resources? The review is organized into five sections. The first section reviews the literature search strategies. The second section reviews the relevant literature related to healthcare systems and professionals. This section establishes the elements of a healthcare system, describes the operating environment, identifying the constitutive parts of supply chain, and provides an understanding of professionals, professional asymmetry, distinguishing features of clinical and nonclinical professionals with their different foci, and interprofessional relationships. The third section reviews the literature related to discourse. This section begins with literature related to the roots of discourse to provide a historical perspective of the development of discourse and the significance of the linguistic turn. This section also includes discourse definitions, the approaches to discourse, critical discourse related to Foucault's theorization on discourse, the realm of discourse as depicted by Hardy and Thomas (2004), and the criticisms of discourse. The fourth section summarizes the literature review. The fifth section identifies the inferences for the current study.

Literature Search Strategies

An array of resources was utilized to inform this study from a variety of sources, including scholarly and practitioner literature. Literature was obtained through an iterative database search, previously known articles from prior related literature reviews,

review of the references of key peer-reviewed articles, and the recommendations and guidance of faculty from the George Washington University Graduate School of Education and Human Development. Searches were limited to articles in English.

The literature pertaining to healthcare systems and professionals was obtained through database searches in PubMed, Web of Science, and Google Scholar and from known practitioner organizations such as the American Hospital Association, the American Academy of Professional Coders, the American College of Health Care Executives, and the Advisory Board. The search terms of healthcare, healthcare system, professional, clinical, nonclinical, interprofessional relationship, interprofessional communications, decision-making, supply chain, procurement, and medical resources were utilized to find the pertinent literature for this study. Some terms were also combined, including "healthcare and professionals," "healthcare and discourse," "decision making in healthcare," and "healthcare and supply chain." As the relevant literature related to professionals appeared as early as 1900, the search date started with 1900 to 2020.

The literature related to discourse and power was obtained through searches from the following databases: ABI/Inform Complete, Academic Search Complete, Google Scholar, ProQuest, and Web of Science. These databases were chosen as they contain multidisciplinary journals with peer-reviewed empirical and theoretical articles. Web of Science was specifically included as it provides citations to the articles, which was helpful in an iterative search to find additional articles. The search date range was 1950 to 2020. The start date of 1950 was chosen since this was the time of the linguistic turn (explained in the section "Literature on Discourse") and the theoretical origins of

discourse as a social construction. Multiple iterations and combinations of search terms were used. Search words of discourse, discourse practice(s), discursive practice(s), critical discourse analysis, discourse theory, text, power, "discourse and power," "discourse and Fairclough" and "discourse and Foucault" were utilized to identify the most relevant literature for this review. As this study was heavily informed by the work of Norman Fairclough and Michel Foucault, these scholars were searched by name to locate their original publications.

Literature on Healthcare Systems and Professionals

This section reviews the relevant literature related to healthcare systems and professionals to set the context for this study. It is divided into four sections. The first section discusses the elements of healthcare systems, broadly identifying the healthcare sector and the components of a healthcare system. The second section explains a healthcare system's operating environment with respect to the balance of costs and care, the supply chain, and the role of a professional. The third section, "Professionals in the Healthcare Environment," distinguishes how different healthcare governing bodies designate professionals and clinicians, describes clinical and nonclinical professionals, discusses interprofessional relationships, and characterizes how professional asymmetry arises. The fourth and final section summarizes the literature on healthcare systems and professionals.

Elements of Healthcare Systems

Healthcare systems are one of the most complex systems serving the needs of people (Camillo, 2016). The term *healthcare* is broad and may have different meanings

depending on the user and the context. In general, the healthcare sector is composed of hospitals, other healthcare facilities (such as clinics, testing centers, and nursing homes), insurance plans, clinicians, governmental agencies, and private regulators all working in various groups, networks, and practices (Reid et al., 2005). Hospitals can be independent standalone single facilities or part of a healthcare system containing multiple hospitals or other healthcare facilities such as nursing homes.

Adapting Ferlie and Shortell's (2001) model, the Institute of Medicine and the National Academy of Engineering divided the healthcare system into four levels. Broadly, the four levels refer to the individual patient, the care team (which includes professional care providers such as physicians and other clinicians), the organization (i.e., the hospitals), and the economic and political environment (Reid et al., 2005). According to this model, the care team consists of physicians, health professionals, and personal caregivers and is the basic building block of the 'clinical microsystem' (Reid et al., 2005). The organization or hospital provides the infrastructure and resources and encompasses systems such as operating and information systems as well as administrative, clinical, financial, and human resources processes. Accordingly, a healthcare system utilizes various levels of management based in administration, human resources, finance, revenue cycle, and supply chain as well as varied professionals.

Healthcare systems are large and complex, composed of an interrelated system of professions (Kirkpatrick et al., 2011), and depend on a professional workforce to carry out core operations (Dobrzykowski et al., 2016). Working in interdisciplinary teams (Pennington & DeRienzo, 2013) or cross-functional teams, these professionals discuss and decide which medical items to purchase (Shbool & Rossetti, 2020). These

professionals have roles with and without direct patient care. Direct patient care is defined as “hands on, face-to-face contact with patients for the purpose of diagnosis, treatment, and monitoring” (Centers for Disease Control and Prevention, 2013) and includes services performed by clinicians such as physicians, nurses, and physician assistants. Healthcare systems also have nonclinical professionals who do not provide direct patient care, usually within the areas of administration, finance, human resources, environmental services, revenue cycle, and supply chain.

Healthcare Systems’ Operating Environment

Healthcare is a costly business, with annual expenditures of over $3.8 trillion, with $1.2 trillion causally related to hospitals (Centers for Medicare & Medicaid Services, 2018), and healthcare costs are continually on the rise (Kaplan & Haas, 2014). Overall, healthcare systems seek to provide quality medical services to the patient population served with the fundamental goal to “improve the value of care” (Porter & Lee, 2013, p. 22) but also to increase the quality of care while reducing costs (Atilla et al., 2018). Aligned with these goals, healthcare systems have a dual function: the first function is to deal with the health of all populations with effectiveness of service, and the second function is to achieve financial and economic equilibrium to survive (Saviano et al., 2018).

To achieve financial and economic equilibrium, healthcare systems focus on the costs associated with providing medical care (Okike et al., 2014), as economic and reimbursement factors put constant pressure on healthcare systems to reduce costs (Paulus, 2020; Porter & Lee, 2013) while maintaining quality. With healthcare systems everywhere struggling with rising costs, uneven quality (Porter & Lee, 2013), growing

financial pressure, and sweeping policy changes (Centers for Medicare & Medicaid Services, 2018), the goal is not to reduce costs at the expense of quality (Porter & Lee, 2013). In response to these escalating healthcare costs, hospitals are under pressure to use less costly alternative services and procedures (Okpala, 2018), impose rationing of resources (Zita et al., 2020), and accomplish more work with fewer people to keep revenue ahead of costs (Reid et al., 2005). With increasing medical supply costs accounting for about 31% of hospital costs per case, with supply-intensive admissions (Schneller & Wilson, 2009), and with approximately 33% of a hospital's operating budget related to supplies, implants, and pharmaceuticals (Peck, 2019), supply chain management is central, and there are efforts and opportunities to reduce costs in supply procurement (Atilla et al., 2018).

Supply Chain

Supply chain management, which involves coordinating and collaborating among all stakeholders (Kritchanchai et al., 2019), is defined as "planning and management of all activities involved in sourcing and procurement, conversion and all logistics management activities" (Council of Supply Chain Management Professionals, 2013). However, supply chains in healthcare are not like those in other industries (Kritchanchai et al., 2019) as they are extraordinarily complex (Abdulsalam & Schneller, 2019) and include many professionals such as physicians and other healthcare providers, hospital managers, manufacturers, supplier representatives, and patients (Abdulsalam et al., 2015; Montgomery & Schneller, 2007).

Supply chain decision-making processes include various professionals who perform a value analysis with the goal of determining the value or outcomes per dollar

spent (Grundy, 2016; Porter, 2010). Value is defined as dividing the quality by the cost (Pennington & DeRienzo, 2013), with some studies noting that durability and ease of implantation may play a role in value (Milken et al., 2018). Increasingly, the value analysis has been used to rationalize decision making around products and treatments (Grundy, 2016). Historically, value analysis has been led by supply chain professionals; however, clinical professionals increasingly have become engaged over the years (Grundy, 2016) with various professionals jointly responsible for supply chain effectiveness and efficiency (Abdulsalam et al., 2015). Although there is a broadening of professionals involved, Miller and Lehoux's (2020) recent embedded case study on the role of the procurement office (supply chain) in healthcare innovation indicated that the procurement office continues to be a critical participant in shaping what is sought after and provided.

Procurement Decisions

Overall, studies have indicated that decisions on procurement are subjective (Shbool & Rossetti, 2020), based on identified physician preference, which is influenced by vendor relationships, medical training, and personal experience (Pennington & DeRienzo, 2013; Shbool & Rossetti, 2020) and without cost considerations from physicians (Burns et al., 2009; Milken et al., 2018; Pennington & DeRienzo, 2013). A quantitative survey study found that orthopedic surgeons did not align with hospital cost containment efforts (Burns et al., 2009). Instead, orthopedic surgeons aligned with vendors based on their tenured relationship and incentives received from the vendor. These researchers suggested that for hospitals to align orthopedic surgeons with hospital cost containment initiatives, hospitals will need to offer comparable benefits. An

ethnographic study by Grundy (2016) of four acute care hospitals, from January 2012 to October 2014, analyzed how committee members constructed and evaluated medical products, equipment, and device value. Their findings indicated that decisions were based on local knowledge and individual expertise and lacked evidence-based data related to price or efficacy. The quantitative study of Nyaga, Young, and Zepeda (2015), using data from 200 California hospitals, examined the impact of incentive mechanisms for internal stakeholders such as physicians and nurses on supply chain efficiency. One of their findings was that hospitals with a higher percentage of employed or contracted physicians had greater supply chain efficiency. Their findings suggest that employed medical staff are more financially and emotionally committed to the hospital and "thus more inclined to cooperate with decisions that reduce supply chain costs" (p. 349). This finding was not the same on the nursing side. As most hospitals employ their nursing staff, the researchers noted that having a larger contingent of employed nurses may actually empower nurses to challenge policies undermining supply chain operations.

For the past two decades, the literature from healthcare-centric journals has mostly looked at how the procurement of resources improved our understanding of the healthcare environment to improve performance (Abdulsalam et al., 2015). The field of supply chain management has changed considerably over the years, with scholars calling for theoretical advancement (Hardy et al., 2020). Arguments have been made for additional research on the "supply chain of healthcare" related to adherence to evidence-based medical guidance, the triad between the physician-hospital-supplier, and the vendor as a physician resource and ally (Abdulsalam et al., 2015). In addition, scholars have suggested that research should take a broader conceptualization of supply chain

management, reducing the use of single response surveys and including more qualitative methods (Hardy et al., 2020). Hardy et al. (2020) argued that discourse and discourse analysis can introduce new ways of thinking about the supply chain, as procurement decisions are predicated on conversations between numerous professionals (Atilla et al., 2018).

Professionals in the Healthcare Environment

As with most terms, the word *professional* can have different meanings depending on the communicator, audience, and context; however, the term has identifiable characteristics and relates to the concept of having a profession (Friedson, 1973). Members of a profession have cognitive exclusiveness of knowledge (Larson, 1977), are experts (Abbott, 1988), and have differentiation of work (Abbott, 1988), with professionalism used as a form of control by imposing certain needs and services (Johnson, 1972). Hence, relationships are between the expert and the client with institutional guarantees through licensure, associations, ethics, and codes (Abbott, 1988). Historically, the role of the professional was distinguished from the role of management (Brint, 1994); however, today professionals are included in management (Muzio & Kirkpatrick, 2011) in the field of medicine (Noordegraaf, 2015).

Healthcare systems comprise various types of professionals, which can be categorized into two main groups: clinical and nonclinical. Given the inclusion of professionals in management (Muzio & Kirkpatrick, 2011; Noordegraaf, 2015), this study broadly includes management when referring to clinical and nonclinical professionals. Distinguishing the different professional roles is material, as professionals with different roles also have different foci (Brown et al., 2010). Since professionals have

different foci, conversations ensue to persuade others in the direction of preferred outcomes (Koeberlé, 2012).

Clinical Professionals

In everyday use, the terms *healthcare professional*, *clinical professional, clinician,* and *care team* are sometimes used interchangeably. However, within healthcare systems and under governance from regulatory agencies and governmental and nongovernment payors, these terms are defined differently. The concept of a clinical professional can be established by coupling how the national organization for hospitals, the American Hospital Association (AHA), defines a professional with how the Centers for Medicare & Medicaid Services (n.d.) defines a clinician.

The AHA distinguishes between healthcare professional and clinical staff based on how the respective services are reported, charged, and billed. The AHA uses the term qualified healthcare professional (QHP), defining it as "an individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service" (Derricks, 2015, para. 1). According to the AHA, examples of QHPs are physicians, nurse practitioners, certified nurse specialists, physician assistants, clinical social workers, and physical therapists (Derricks, 2015). The AHA defines clinical staff as those who assist in the performance of a specific professional service but who do not individually report that professional service, such as a nurse. The AHA definition of a QHP omits nurses, as nursing services do not independently report their services from a billing perspective. However, although the

AHA does not refer to nurses as QHPs, the AHA references both QHPs and clinical staff (i.e., nurses, among others) as providing a professional service. The Centers for Medicare & Medicaid Services takes a broader view and defines clinicians as those who provide principal care for a patient, with expertise needed for the ongoing management of a chronic disease or condition. Using this definition, a clinician may be a physician, a nurse, a pharmacist, or an allied health professional (Centers for Medicare & Medicaid Services, n.d.).

Based on the AHA definition, coupled with the concepts of a professional having specialized knowledge (Abbott, 1988; Larson, 1977), having professional organizations (Abbott, 1988), and having expertise (Adler et al., 2008), physicians, physician assistants, physical therapists, nurse practitioners, and nurses all fall under the category of a professional. As established by the scholarly literature related to professionals, the AHA and the Centers for Medicare & Medicaid Services, this study utilized the term *clinical professional* to refer to physicians, physician assistants, nurses, physical therapists, and other allied health professionals.

Nonclinical Professionals

As the Centers for Medicare & Medicaid Services has established clinicians as those who provide principal care for a patient with expertise needed for the ongoing management of a chronic disease or condition, the term *nonclinical* in this study is used to represent individuals within a healthcare system who do not provide principal care for the patient. Nonclinical departments within healthcare systems include administration, environmental services, finance, human resources, information technology, revenue cycle, and supply chain. Broadly, supply chain has dedicated professionals with the

responsibility of procuring and allocating resources (Abdulsalam et al., 2015; Montgomery & Schneller, 2007). Numerous professionals are involved, both clinical and nonclinical. Even among those with nonclinical roles, there may be examples of staff or management who, at one time or another, provided the principal care for patients and were thus categorized as clinicians. For this study, the distinguishing factor for nonclinical professionals is that they are currently working in a role that does not provide the principal care for a patient.

Managers within these nonclinical areas are also considered professionals based on their specialized knowledge, academic training, and existence of professional organizations. Based on a review of several university websites, degrees are conferred in such areas as healthcare management, human resources, finance, information technology, and supply chain. There are numerous established professional organizations for management professionals, such as the American College of Healthcare Executives, the American Association of Healthcare Administration Management, the Healthcare Financial Management Association, the American Society for Health Care Human Resources Administration, the Association of Supply Chain Management, and the Association of Information Technology Professionals.

Interprofessional Relationships

Health systems have been referred to as systems of "negotiated order" (Strauss et al., 1963), which characterizes the social environment in health services. According to Martin et al. (2009), a set of social orders exists in healthcare, which includes influences on relations between professions. As healthcare systems are composed of various professionals who have distinct knowledge, expertise, and professional organizations

(Friedson, 2001), the materiality of interprofessional relationships is pertinent. Interprofessionality refers to the cohesive practice between professionals from different disciplines to provide a well-integrated means of meeting one's needs (D'Amour & Oandasan, 2005). However, interprofessional interactions are laden with pressure from their respective professional institutions, cultural forces, and regulatory agencies (Finn et al., 2010) because each profession has a distinct role, socialized membership, and historically developed and institutionalized hierarchical relations with other professions (Friedson, 2001). This provides for the basis of professional hierarchy (Fox & Comeau-Vallee, 2020), fundamentally different professional interests (Brown et al., 2010), and different professionals exerting influence (Fox & Comeau-Vallee, 2020).

Bidirectional mistrust has developed between clinical professionals and healthcare management due to different perspectives, roles, and culture (Kornacki et al., 2019). Reid et al. (2005) identified the deeply held belief that the ultimate responsibility of the clinical care professional is to the patient, not the organization (Reid et al., 2005). Core to the clinical professional is optimal patient care, with conflict occurring between physicians and hospitals surrounding cost (Schneller & Wilson, 2009). "Increasingly nonphysicians are interjecting issues of cost-effectiveness, value, reimbursement, comparative performance" (Schneller & Wilson, 2009, p. 2562). When professionals disagree, their respective power comes into play (Brown & Lewis, 2012). Consequently, the tendency is towards conflict and contestation, to the detriment of professional integration (Allen, 2000; Dingwall, 1980; Dingwall & MacIntosh, 1978; Webb & Hobdell, 1980). Power issues occur when bringing together different professionals (Brown et al., 2010), and professionals' interface is critical to outcomes (Harvey, 2016).

Chreim et al. (2013) acknowledged the boundaries between clinical and managerial leaders, identifying various tribes in healthcare—"the doctors and managers, the doctors and nurses, the clinical versus the nonclinical" (p. 4)—with the values of management and clinicians offering contrary agendas (Correia, 2013; Nugus et al., 2010; Numerato et al., 2012). Hence, the care of a patient is the product of not only the pathology of the patient but a continual interaction or negotiation of the players involved (Strauss et al., 1963).

Summary of the Literature on Healthcare Systems and Professionals

The mission and function of healthcare systems is to provide quality medical care to the patients they serve (Porter & Lee, 2013) and to ensure financial equilibrium (Saviano et al., 2018). Healthcare systems comprise an array of professionals who are clinically based as part of the care team, and professionals who are part of the administrative, financial, human resource, and supply chain infrastructure and processes (Centers for Medicare & Medicaid Services, n.d.). In general, the literature supports the construct of professionals portrayed as experts in their field (Abbott, 1988), with extensive education and specialized knowledge for the betterment of society (Larson, 1977), with professionals included in management (Muzio & Kirkpatrick, 2011). Within healthcare systems, there are two distinguishing professional categories: clinical professionals and nonclinical professionals. Clinical professionals are those who provide the principal care to the patient with expertise needed for ongoing management (Centers for Medicare & Medicaid Services, n.d.), and nonclinical professionals are those who do not provide the principal care to the patient.

With healthcare systems having a diverse set of professionals guided by different interests and 'negotiated order' (Strauss et al., 1963), differences are created between the clinical and nonclinical professionals as to the need for services and the procurement and distribution of various resources (Montgomery & Schneller, 2007). Mistrust between professionals and management (Reid et al., 2005) may lead to contrary agendas with misaligned interprofessional interests, which can impact the procurement of resources, resulting in a negative impact on patient care (Kaplan & Haas, 2014; NORC, 2019). The clinical and nonclinical professionals' engagement in verbal or written exchanges may result in a course of action secondary to the emergence of what is believed to be a normal and taken-for-granted or dominant discourse (Hardy & Maguire, 2010; Hart, 2014) and not predicated on discussions that are honest and forthright, leading to the development of a consensus amicable to all (McGinnis et al., 2005). Healthcare journals have provided little empirical research related to supply expenses (Abdulsalam & Schneller, 2019), and recently the supply chain literature has called for new theories and novel ways of thinking about supply chain and has looked toward discourse analysis (Hardy et al., 2020). Discourse analysis shows how things that appear to be straightforward and natural are rarely what they seem (Phillips et al., 2004).

Literature on Discourse

The literature on discourse has seven sections. The first section addresses the relevant literature related to discourse roots, tracing how the meaning of language changed over time and delineating the importance of the linguistic turn, shifting language as passive to language actively constructing reality. The second section reviews a selection of the numerous definitions associated with discourse and defines discourse in

relation to this study. The third section provides an overview of the relevant literature related to three different approaches to discourse: Laclau and Mouffe's (1985) classical discourse theory, critical discourse studies (CDS), and the cognitive-pragmalinguistic model. This study draws heavily on CDS and the work of Foucault. The fourth section further explores the relevant literature on Foucault's (1979, 1980, 1982) theorization related to construction of the social world through discourse in constituting concepts, objects, and subject positions; the role of knowledge; the role of power; power related to social practice and individual agency; and the relation between power and knowledge. The fifth section illustrates how Foucault's theorization on discourse is modeled by Hardy and Thomas's (2004) realm of discourse. With much of Foucault's work being conceptual in nature, this section also includes the related empirical work. The sixth section reviews the relevant literature on the criticism of discourse studies. The seventh and final section provides a summary of the literature related to discourse.

Discourse Roots: Language and the Linguistic Turn

The notion of discourse has evolved over time as the social sciences began to challenge the function of language. During the early 20th century, the term *language* was used to denote the function of providing effective communication and as a passive descriptor of a pre-existing object (Ashcraft et al., 2009). Hence, language described things and was considered a reflection of reality, or "a mirror of nature" (Deetz, 2003, p. 423) and a mechanical method of information transfer (Grant et al., 2004). In the post-war era and early 1950s, a shift in the social sciences occurred which started to challenge the function of language. The thought that language was a passive descriptor and a conduit for communication was challenged, with language being seen as part of creating

and producing social reality (Phillips & Oswick, 2012). This shift from language describing reality to language actively constructing reality was part of the 'linguistic turn' (Alvesson & Kärreman, 2011).

Broadly, the linguistic turn refers to a philosophical tradition from how knowledge is produced to the notion of knowledge and meaning rooted in language (Alvesson & Kärreman, 2011). Language is therefore used as a resource, using certain terms to provide a particular version of the world that suits one's interests and "in ways that appear plausible, legitimate and factual" (Finn, 2008, p. 109). Contributing to the linguistic turn was social constructionism (Deetz, 2003) and the work of philosopher Michel Foucault. Social constructionism is the recognition of the "jointly constructed understanding of the world based on shared assumptions or the constitutive conditions of experience" (Deetz, 2003, p. 422). Social constructionist influences during the linguistic turn shifted language as a reflection of pre-existing reality to an understanding of language as having a role in the actual constitution of what we experience as a pre-existing and independent social reality (Cap, 2019; Grant et al., 1998; Leclercq-Vandelannoitte, 2011). Structuralism, during the 1960s, started to influence the role of language in social construction (Sturrock, 2003), with structuralism embodying the way in which systems of meaning (as those inherent in language) emerge from the relationships of words. In addition, Foucault's writings on discourse and language from 1963 to 1971 were increasingly embraced and were an important part of the linguistic turn (Raffnsoe et al., 2017). Foucault's (1979) conceptualization of discourse was grounded in the historical and social nature of how concepts were formed and how power relations were created.

The linguistic turn and the shift toward language actively constructing reality promulgated a way to account for the ways 'levels of talk' shape how subjects can act and be (Alvesson & Kärreman, 2000; Kärreman, 2014). From an organizational perspective, the tide was able to shift slightly from organizations to be 'counted' to organizations socially constructed and 'deconstructed' to identify meaning. Scholars began to recognize language as fundamental in the production of social reality which produced and mediated organizations (Leclercq-Vandelannoitte, 2011). Since the linguistic turn, the scholarly work has distinguished the "potency, function, and use of words in a business setting" (Lockwood et al., 2019). In 2014, the Academy of Management's annual meeting theme was "The Power of Words," with articles varied in context (multinational corporations, sports, healthcare, etc.) and work, such as words conveying a message (Fox & Johnson, 2014), dominant stories and action (Hendy, 2014), narratives and organizational change (Logemann, 2014), and the role of words in generating meaning (Ocasio, 2014).

The management literature categorizes words into five common theorizations: discourse, stories and narratives, rhetoric, public language or strategic communication, and frames (Lockwood et al., 2019). Stories and narratives are similar, as they both make the unfamiliar familiar by providing order and meaning to otherwise disordered cues and attributes (Lockwood et al., 2019). A narrative provides a means for sensemaking and sensegiving (Vaara et al., 2016) with a temporal aspect. A story is a distinct type of narrative that links sequences of events that have a beginning, a middle, and an end (Giorgi et al., 2015). Rhetoric refers to the use of language "to change others' attitudes, beliefs, values, or actions" (Cheney et al., 2004, p. 79) and influence others'

interpretations and judgment (Carter & Jackson, 2004; Hoefer & Green, 2016). Rhetoric occurs using logical argumentation and reasoning, with individuals structuring their claims that appeal to logic (Suddaby & Greenwood, 2005). Frames function to categorize and delineate a situation to "simplify and condense the world" (Fiss & Zajac, 2006, p. 1174) and define "a situation through inclusion and exclusion" (Giorgi et al., 2015, p. 11). Frames are effective when they "match or align with the audience's beliefs, values, aspirations, or ideas" (Giorgi, 2017, p. 712). Public language refers to "words or texts broadcast by an organization through widely available media" (Gao et al., 2016, p. 22) with a particular strategic intent (Lockwood et al., 2019). Public language aligns with the traditional view of communicating or providing information. Lastly, discourse goes beyond the use of simple language; organizational discourse is about how organizational reality is brought about through the processes of social construction (Phillips & Hardy, 2002) and how discourse privileges one's goals and interest (Phillips et al., 2004).

Discourse Definitions

The scholarly literature presents significant challenges in providing a clear meaning of the concept of discourse, with the "meaning of discourse highly contested and ambiguous" (Phillips & Oswick, 2012, p. 442). Over the years, many scholars have put forth definitions and descriptions of discourse encompassing a plethora of meanings and contradictions (Aidi & Yechouti, 2017; Fairclough, 1995; Potter & Wetherell, 1987). Discourse proponents and critics have both agreed that there are challenges in defining discourse, with the concept of discourse being fuzzy (van Dijk, 1997) and the terms *discourse* and *discursive practices* often being used interchangeably. Proponents of discourse research acknowledge the gluttony of definitions: "Discourse is a difficult

concept, largely because there are so many conflicting and overlapping definitions formulated from various theoretical and disciplinary standpoints" (Fairclough, 1995, p. 3). Potter and Wetherell (1987), proponents of discourse research, identified discourse as "an area in which terminological confusion abounds" (p. 6). Discourse critics have claimed that discourse is poorly defined (Alvesson & Kärreman, 2011; Iedema, 2008), has too many concepts (Iedema, 2008), and is too focused on language at the expense of context (Deetz, 2003). However, overall, discourse analysts agree that discourse is a form of language (van Dijk, 1997).

As a form of language, discourse includes both spoken and written language (van Dijk, 1997) with speech acts, written documents, pictures, and symbols collectively referred to as texts (Grant et al., 2004). In this study, the term *text* then encompasses the most basic part of discourse and refers to both speech acts and written documents.

As the concept of discourse has moved away from the linguistic notion relating to language, a multitude of disciplines have contributed to defining discourse (Aidi & Yechouti, 2017). Linguistics, sociology, philosophy, and anthropology have all contributed to the development of discourse, and for some theorists, discourse is now regarded as a way of "thinking and talking about something" (Aidi & Yechouti, 2017, p. 1060). With discourse being used by a range of different theorists and in different ways, the term has more than one meaning (Kärreman, 2014). Therefore, the meaning of discourse is dependent on context (Aidi & Yechouti, 2017), with scholars utilizing the definition most relevant to their research. Table 2.1 illustrates the breadth of discourse definitions, with examples from the dominant disciplines contributing to the development of the definition of discourse.

Table 2.1

Definitions of Discourse

Author	Discipline	Definition
Knights & Morgan, 1991	Sociology	Discourse "is shorthand for a whole set of power/knowledge relations which are written, spoken and communicated and embedded in social practices" (p. 254).
Potter & Wetherell, 1987	Sociology	Discourses "do not just describe things; they do things" (p. 6).
Parker, 1992	Psychology	Discourse is "a system of statements which constructs an object" (p. 5).
		Discourse "makes sense of meaningless reality by not just describing the social world, but discourse constitutes the social world by bringing certain phenomena into being" (p. 5).
Fairclough, 1992, 2005	Linguistics	Discourse is a structured set of texts and textual practices which are produced, transmitted, and consumed (1992, p. 73).
		Discourse is also a practice: "Discourse practices are social practices" (2005, p. 922).
Fairclough & Wodak, 1997	Linguistics	Discourse brings in "situations, objects of knowledge, and the social identities of and relations between people and groups of people" (p. 258).
Hall, 2001	Sociology	Discourse "rules in certain ways of talking about a topic, defining an acceptable and intelligible way to talk, write or conduct oneself … and rules out, limits and restricts other ways of talking, of conducting ourselves in relation to the topic or constructing knowledge about it" (p. 72).
Foucault, 1979	Philosophy	Discourse is "a collection of interrelated texts and practices that systematically form the objects of which they speak" (p. 49).
Koeberlé, 2012	Management/ organizational theory	"Discourse is a way of representing an aspect of the world, i.e., it is particular point of view on this aspect of the world" (p. 396).
Phillips & Oswick, 2012	Management/ organizational theory	Discourse is language in use and language as an interrelated set of texts, with how these ideas "came to be constructed and how they affect the context in which they occur" (p. 443).

This study, taking a critical approach to discourse, viewed discourse as a way of thinking and talking about something within a relationship of power and the set of rules

preconditioning the emergence of a dominant discourse (Hart, 2014; Phillips et al., 2004). As this study was heavily influenced by the work of Foucault (1979, 1980, 1982), it used the discourse definition of "a collection of interrelated texts of bodies of knowledge which form the objects of which they speak" (Foucault, 1979, p. 49), also viewing discourse as "shorthand for a whole set of power/knowledge relations which are written, spoken, and communicated and embedded in social practices" (Knights & Morgan, 1991, p. 254).

Approaches to Understanding Discourse

Discourse theory has its roots in linguistics from the ideas of Saussure (Dabirimehr & Fatmi, 2014), with approaches to discourse theory sharing a common philosophical base of linguistics and social constructionism (Cap, 2019). Grounded in this common philosophical base, three strands of thought have emerged over the past 35 years: Laclau and Mouffe's classical discourse theory, CDS, and cognitive-pragmalinguistic models (Cap, 2019).

Laclau and Mouffe's Classical Discourse Theory

Laclau and Mouffe's (1985) classical discourse theory has traditionally been used to study political movements (Kure, 2010) and postulates that discourse mediates all social phenomena, with an array of discourses competing to define what is true (Cap, 2019). According to Laclau and Mouffe (1985), we enter a world where discourse already exists, with our perception of reality mediated through discourse. They illustrated this concept with an example of a brick falling. The brick falling is independent of one's will; however, depending on the discourse, such events can be constructed as "natural phenomena or expressions of the wrath of God" (Laclau & Mouffe, 1985, p. 108). Laclau

and Mouffe argued that all social phenomena are mediated through discourse and therefore discourse meaning is never really fixed because a change in the focus of discourse will impact what aspect of reality becomes true or correct (Cap, 2019).

Central to Laclau and Mouffe's theory are the three concepts of articulation, elements, and sedimented discourse (Hopkinson & Aman, 2017). Elements refer to words in a linguistic domain and social groups. Articulation occurs when a practice establishes a relation among elements (Laclau & Mouffe, 1985), with the results of these practices as discourse (Hopkinson & Aman, 2017). Those discourses that then become established, appear to be objective or real (Laclau, 1990), and seem to exist outside the practices (Hopkinson & Aman, 2017) are then deemed sedimented discourse.

Critical Discourse Studies

CDS, also referred to as critical discourse analysis (Unger, 2016), joins together scholars of multiple disciplines including linguistics, social psychology, political science, philosophy, and anthropology (Cap, 2019; Grant et al., 1998; Leitch & Palmer, 2010). CDS is characterized by the link between language and social reality mediated by power (Cap, 2019; Fairclough, 1995) and is useful in exploring power relations (McCabe & Sambrook, 2019).

CDS is heavily dependent on the Foucauldian theorization of discourse (Hardy & Thomas, 2015; Raffnsoe et al., 2017) by analyzing discursive and material processes to examine how they are co-constitutive (Mumby, 2011) and by understanding the meaning of texts within the relations of power (Hook, 2007). Foucault's (1979) theorization establishes discourse as a way of seeing and thinking about a topic based on a historical context and a social system that produces knowledge. Discourse constructs the social

world through the creation of concepts, objects, and subject positions, with discourse bringing into being objects of knowledge (Foucault, 1979). Certain texts are accepted as truths by giving phenomena meaning through including, excluding, categorizing, or ordering (Hardy & Maguire, 2016) and joining together knowledge and power (Foucault, 1980).

Foucault's theoretical contribution has been cited as classical discourse (Cap, 2019), yet many scholars identify the work of Foucault as laying the early groundwork for critical discourse analysis (Raffnsoe et al., 2017). Some authors contend that CDS has also been influenced by classical discourse theory, yet their work is rarely acknowledged secondary to its synthetic nature (Macgilchrist, 2014), minimal use of key phrases (Cap, 2019), and views on discourse that are too similar to Foucault's. CDS and discourse theory sound similar, as they both agree that social reality is mediated through discourse (Cap, 2019; Foucault, 1979; Laclau & Mouffe, 1985).

However, there is a material difference between CDS and discourse theory, with CDS's critical perspective and text-based analysis (Hart & Cap, 2014). Discourse theory does not position itself from a critical perspective, whereas CDS takes a critical perspective referring to a "position or attitude, signposting a specific research agenda" (Cap, 2019, p. 7) emphasizing "how power and interests intersect to create a privileged version of things" (Marshak & Grant, 2008, p. 35). CDS uses a text-based study to uncover language's role in power and ideology (Fairclough, 1995; Wodak & Meyer, 2016), which is lacking in discourse theory (Cap, 2019).

Cognitive-Pragmalinguistic Model

The cognitive-pragmalinguistic models grew from CDS, and some consider these the more contemporary CDS (Cap, 2019; Hart & Cap, 2014). These models grew as a response to developments in linguistics and communication science as well as to account for new genres of computer-mediated communication. These models draw from six areas: systemic functional grammar, pragmatics, cognitive linguistics, cognitive psychology, poststructuralism, and corpus linguistics (Cap, 2019). Overall, these models are text-based to demystify ideologies by lexical and grammatical means (Cap, 2019), with some utilizing a cognitive approach of how people interpret events using their mind, memory, and cognitive processes (van Dijk, 1997). For example, systemic functional grammar looks at the grammatical system of language and identifies three functions of language (Hart, 2014). Pragmatics relates to language in use (Lexico Dictionary, n.d.), and the corpus linguistics uses the body of text focusing on lexical grammar for linguistic description and argumentation (Kennedy, 2014). Cognitive linguistics and cognitive psychology relate to the mind and theorize the relationship between linguistic structures in text and concepts in the minds of discourse participants (Hart, 2014).

In summary, over the last several decades, three streams of thought related to discourse have emerged: classical discourse theory, CDS, and cognitive-pragmalinguistic models (Cap, 2019). All three espouse some degree of discourse embedded in social reality, yet they differ related to the notions of criticality, power, and focus of study. CDS and Foucault's theorization on discourse were chosen for this study for several reasons. First, this study took a critical lens, which "is the ways knowledge, subjects, and power relations are produced, reproduced and transformed within discourse" (Leitch & Palmer,

2010, p. 1195). CDS and the Foucault theorization of discourse critical perspective draw on how power and interests intersect (Marshak & Grant, 2008), with an emphasis on power relations, which most readily aligns with the CDS approach. Classical discourse theory is more concerned with defining power (Dabirimehr & Fatmi, 2014), and the cognitive-pragmalinguistic models are less concerned with power. Second, given the critical nature, Foucault is considered to have laid the groundwork (Raffnsoe et al., 2017), is the one to cite, relate to, and modify (Jorgensen & Phillips, 2002), and is the hinterland for all CDS (Raffnsoe et al., 2017). Third, Foucault's (1979) theorization on discourse relies heavily on the concept of the social world producing knowledge, which aligns with this study, as healthcare is dominated by professionals with given knowledge.

Critical Discourse: Foucault's Theorization on Discourse

Foucault has been identified as one of the most influential theorists in modern times (Aidi & Yechouti, 2017), with his theorization of discourse moving away from the ordinary notion of discourse (Aidi & Yechouti, 2017) and his theoretical approach considered seminal for discourse analysis (Raffnsoe et al., 2017). Foucault's theorization of discourse is based on his general challenges to philosophical traditions, preferring to critically examine *how* philosophical questions were answered less so than answering them. Foucault (1979) embodies discourse as a group of statements that are historical and knowledge based, shaping power relations.

Discourse's historical foundation is based on statements that allow a certain way of seeing and thinking about a topic. Foucault (1972) wrote:

> We shall call discourse a group of statements in so far as they belong to the same discursive formation.… It is made up of a limited number of statements for which a group of conditions of existence can be defined. Discourse in this sense is not an

> ideal timeless form.… It is, from beginning to end, historical—a fragment of history … posing its own limits, its division, its transformation, the specific modes of its temporality. (p. 117)

Foucault (1972) identified the historical basis of discourse when he wrote that "all manifest discourse is secretly based on already-said" (p. 25) and termed this historical component an 'a priori' (Foucault, 1980). According to Aidi and Yechouti (2017), we think "within the limits set by what has already been said" (p. 1062), and what has been said about an object influences what will be said in the future. The phrase "limited number of statements" (p. 117) refers to statements that have common traits that unify a particular discourse (Aidi & Yechouti, 2017), with all statements referring to the same object (Cousins & Hussain, 1984).

Concept, Object, Subject Position

Concepts, objects, and subject relations are constructed through discourse (Hardy & Phillips, 2004). Discourse creates the context of conceptual frameworks, objects of knowledge, and categories of social subjects (Fairclough, 1992, 1995; Fairclough & Wodak, 1997) and "systematically form[s] the objects of which they speak" (Foucault, 1979, p. 49). Using the concept of criminality, Foucault's earlier work illustrated how the concepts of madness and criminality are based on a categorization in a particular social context.

> They did not introduce science, but a personality, whose powers borrowed from science only a disguise, or at most their justification. These powers, by their nature, were of moral and social order, they took root in the madman's minority status, in the insanity of his person, not of his mind. If the medical personage could isolate madness, it was not because he knows but because he mastered it and what for positivism would be an image of objectivity was only the other side of this dominant. (Foucault, 1965, p. 271)

Based on these categories of social practices, subjects come to understand the world and continually validate this perception of truth (Mumby & Stohl, 1991). Discourse creates the context of conceptual frameworks, objects of knowledge, and categories of social subjects (Fairclough, 1992, 1995; Fairclough & Wodak, 1997) and "systematically form[s] the objects of which they speak" (Foucault, 1979, p. 49). Hence, the social world is normalized through discursive practices (Foucault, 1972).

Concepts. Concepts are "ideas, categories, relationships and theories through which we understand the world and relate to one another" (Hardy & Phillips, 1999, p. 3); they are "objects of knowledge" (Fairclough & Wodak, 1997, p. 258) and bodies of knowledge (Foucault, 1979, 1980). Concepts are then social constructions from historical and cultural frames through which we understand the social reality (Harre, 1979). In essence, concepts provide the meanings that "underlie social action and influence practices" (Grant et al., 2004, p. 4). For example, the concept of medicine is known through discourse, with the meaning of medicine having effects in the material world through underlying social action and practices (Hardy & Phillips, 2004).

Objects. An object is constituted when a concept is used to make a material reality meaningful (Grant et al., 2004). Objects come into being based on knowledge. As Hook (2007) stated, "Objects in question are constituted by the relevant bodies of knowledge as components of their own conditions of possibility" (p. 148). That is, when concepts are attached to the material world, which has a physical existence, they are understood through referencing prevailing discourse (Laclau & Mouffe, 1985). An object is described by how it was made, "a result of an assembling of practices; only the process of objectifying and reifying these practices has led to what we think of as objects" (Carter

et al., 2008, p. 92). Objects serve to produce identities (Hardy & Thomas, 2015). These identities are not static; identities have variable meanings and emerge from power resistance among organizational members (Harre, 2002). Concept and object can be illustrated by the concept of medicine created through discourse that establishes a physician as an object within medicine. The concept of a physician, the relationship of a physician to training and medicine, and the discursive practices determined the individual to be labeled as a physician.

Subject Position. Subject positions are "places of enunciation that subjects can occupy in speaking and acting" (Howarth, 2010, p. 314). Foucault's idea of subject positioning refers to the idea that the self is not determined solely by social structures but is always in the making through interactions with others and individual agency (Engstrand & Enberg, 2020). It is a social position from where individuals can act (Grant et al., 2004). These positions allow for the type of voice individuals may warrant, from a louder voice to no voice (Hardy & Phillips, 1999). What a person says, feels, thinks, and does is dependent on the social groups to which she or he belongs (Gee, 1990). Hence, discourses can create certain identities as meaningful and legitimate (Hardy & Maguire, 2016), with only those who have these certain identities being able to speak (Maguire et al., 2004). According to Foucault (1980), the type of discourse that is accepted and true occurs through mechanisms and the status of those charged in determining true and false statements. What is true or false then is predicated on the knowledge of a relevant community of experts holding in place certain practices (Howarth, 2010).

Knowledge

The concept of knowledge in discourse is posited by many, including Foucault (1979), Knights and Morgan (1991), and Fairclough and Wodak (1997). Foucault (1972, 1981) focused on the production of texts, with texts and practices converging to produce a body of knowledge (Hardy & Maguire, 2016). These bodies of knowledge are determined through the application of scientific knowledge and predicated on expert analysis (Hardy & Maguire, 2016) derived from past applications (Knights & Vurdubakis, 2003; Lupton, 2013). Texts conform to a historical system of rules and are hence held "to be true or false because they are accepted as such by the relevant community of experts" (Howarth, 2010, p. 315). Foucault (1979) argued that it is this knowledge that forms the objects "of which they speak" (p. 49).

Fields of knowledge are created through discourse, which contains "sociohistorical contingent linguistic, cultural, technical and organizational resources" (Reed, 1998, p. 195). Subjects are thus empowered to make truth claims about objects within certain discursive practices "because of their training, institutional location and mode of discourse" (Howarth, 2010, p. 315). However, there is knowledge that may be outside the unified knowledge which creates an object where "certain statements are condemned" (Howarth, 2010, p. 315). Foucault (1980) referred to this knowledge as subjugated knowledge. Subjugated knowledge is "the historical contents that have been buried and disguised" (Foucault, 1980, p. 81) and "a whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated: naïve knowledge, located low down on the hierarchy, beneath the required level of cognition or scientific" (p. 82). This subjugated knowledge is seen as "the historical knowledge of

struggles" (Foucault, 1980, p. 83). There is a silence of the subjugated knowledge within a discourse that needs to be emancipated, and it is the task of the research to expose these struggles and "emancipate historical knowledges" (Foucault, 1980, p. 85).

The rediscovery of subjugated knowledge, its reappearance, and how this knowledge imparts itself today is what Foucault (1980) termed *genealogy*. He contended that the formation of discourse and the genealogy of knowledge need to be analyzed in terms of "tactics and strategies of power" (Foucault, 1980, p. 77).

Power

Power refers to one's ability to control resources, whether material, social, or symbolic (Abrahamson, 1996; Bourdieu & Passeron, 1977; Foucault, 1980; Hardy & Thomas, 2014). Over time, Foucault connected discourse to power in a multitude of ways. His earlier works connected discourse to power through what one says, through the production of statements and speech acts (Foucault, 1972, 1981). These statements and speech acts are held to be true or false because they conform to a historical set of rules and are "accepted as such by the relevant community of experts" (Howarth, 2010, p. 315). Subjects can make objects to be true or false because of "their training, institutional location, and mode of discourse" (Howarth, 2010, p. 315). From the production of statements and speech acts, power is related to discourse by the practices that make the discourse possible as well as which statements are excluded (Foucault, 1981).

In Foucault's later works (1979), a strategic relation of power emerged. Foucault (1979) argued that "power is everywhere: not because it embraces everything, but because it comes from everywhere.… Power is not an institution, nor a structure, nor a

possession. It is the name we give a complex strategic situation in a particular society" (p. 93). The mechanism of power is "the point where power reaches into the very grain of individuals, touches their bodies and inserts itself into their actions and attitudes, their discourse, learning processed and everyday lives" (Foucault, 1980, p. 39). Power then is considered "a productive network which runs through the whole social body" (Foucault, 1980, p. 119). Discourse constitutes power relations, distributes power, and privileges individuals (Hardy & Phillips, 2004). Foucault's focus was the concept of the relations of power rather than meaning, "relations of power, not relations of meaning" (Foucault, 1980, p. 114). Mumby and Stohl (1991) argued that power relations have power and truth effects which are produced as an "outcome of the actions of subjects who do otherwise" (p. 254) and not as a result of values. Enabling certain outcomes (or constraining others) by privileging certain identities and prioritizing certain bodies of knowledge shows how discourse can embody subtle power relations (Hardy et al., 2020).

As power is embedded in discourse practices, the influences of power can be invisible. According to Gutting (2005), "In the modern age the exercise of power is typically highly invisible" (p. 86). The invisible nature of power becomes noticeable when power is seen as relational, as power "becomes apparent when it is exercised" (Townley, 1993, p. 520). Hence, those who have subject positions associated with formal power, critical resources, network links, and discursive legitimacy may be able to create texts that produce a particular outcome (Hardy & Phillips, 2004).

"The exercise of power itself creates and causes to emerge new objects of knowledge and accumulates new bodies of information" (Foucault, 1980, p. 51). Hence, for Foucault, discourses are an institutional infrastructure for the distribution of power

and knowledge, providing opportunities as well as constraints for individuals (Deppermann, 2015, p. 370). Power produces knowledge (Foucault, 1980), with power so deeply rooted that one cannot escape it due to its effects on all its connections. "The exercise of power perpetually creates knowledge and conversely, knowledge constantly induces the effect of power" (Foucault, 1980, p. 52).

Power and Social Practice. Foucault (1979) focused on power related to social practices. Power is embedded in social relationships, with discourse exchanges occurring within the context of social practices, as the social world is wrought with power and is produced and reproduced in social relationships (Marshall & Rollinson, 2004). Power, thus, is embedded in social relationships, with discourse seen as the "crucial way to exercise power" (Leclercq-Vandelannoitte, 2011, p. 1250) and not seen as a reflection of social reality or a rule-governed system (Raffnsoe et al., 2017, p. 164).

Foucault also situated power not solely in social relations but in individual agency. "Power in its exercise … passes through much finer channels, and is much more ambiguous, since each individual has at his disposal a certain power, and for that very reason can also act as the vehicle for transmitting a wider power" (Foucault, 1980, p. 72). For Foucault (1991), "subjects must be free" (p. 12) for there to be a relation of power, even though the relation of power may be unbalanced (Foucault, 1991). "To exercise a relation of power, there must be on both sides at least a certain form of liberty" (Foucault, 1991, p. 12).

Power and Individual Agency. Discourse then represents individual agency within limitations of social structures (Finn, 2008). These social structures shape what, when, how, and by whom things can be said (Finn, 2008). Individual agency and social

structures are in a co-constitutive relationship, with discourse occurring at their juncture (Fairclough, 2005). With this relationship, local-level discourse can have an impact and effects beyond that of a single individual (Hardy et al., 2000).

Foucault did not convey power as a passive commodity over another individual, but rather described how the notion of power on subjectivity can be understood as a product of mechanisms and power-knowledge struggles (Raffnsoe et al., 2017). Foucault articulated how one of the ways subjectivity could be understood was as a product of power-knowledge strategies and suggested that the interaction of power "with knowledge and expertise was a productive and constitutive activity" (Raffnsoe et al., 2017, p. 162). Assuming there is to some extent individual agency, Marshall and Rollinson (2004) argued that this power is seen as enacted in webs of relations rather than used as an individual resource (Marshall & Rollinson, 2004).

In summary, Foucault argued that the social world is created through discourse with all discourse historical, with what is said influencing what will be said in the future (Aidi & Yechouti, 2017; Foucault, 1979, 1980). What was said, or these texts, converge to produce a body of knowledge (Hardy & Maguire, 2016) that forms "objects of which they speak" (Foucault, 1979, p. 49). With power embedded in knowledge, power produces knowledge as "knowledge and power are integrated with one another" (p. 52) and "it is not possible for power to be exercised without knowledge" (p. 52). Those in control (in power) can establish categories and norms, which in turn are the basis for knowledge (Gutting, 2005). The question lies in "what types of knowledge do you want to disqualify in the very instant of your demand" and "which speaking discourse subjects—which subjects of experience and knowledge—do you want to diminish"

(Foucault, 1980, p. 85). For Foucault (1980), power has real effects on "the direct and immediate relationship with that which we can provisionally call its object, it targets, its field of application" (p. 97). By holding in place certain meanings through concepts, objects, and subject positions, discourse shapes power relations and constitutes the social context. Hardy and Phillips (2004) referred to this as the realm of discourse.

Realm of Discourse: Hardy and Thomas's Model of Discourse

Heavily influenced by Foucault's (1976, 1979, 1982) theoretical work, Hardy and Thomas (2004) depicted a model referred to as the realm of discourse. Their model depicts the relationship between discourse and power constituted in a set of textual practices, concepts, objects, subject positions, power relations, and dominant discourse (Grant et al., 2004). The following three sections review some of the relevant literature.

Textual Practices and Concepts, Objects, Subject Position

Textual practices include the production, distribution, and consumption of texts (Hardy & Phillips, 2004). As discourses compete with one another, representing different orientations in line with those who produced the discourse, the questions of how texts were produced and by whom are relevant (Hardy & Thomas, 2015). Drawing on institutionalism, the deeper aspects of social structure, Maguire and Hardy's (2009) case study examining the institutional abandonment of practices related to an insecticide (DDT) by those outside the field found that who produced new texts and how they were produced weakened the established taken-for-granted meanings of established texts. Their findings showed that taken-for-granted texts weakened as new texts gained coherency. External individuals provoked the production of new texts by scientists outside the discipline, weakening the established taken-for-granted facts. The study also

concluded that over time, the cumulative effects of individual translations reconfigured power-knowledge relations (Maguire & Hardy, 2009). The weakening of the established facts and the controversy it generated resulted in interest from scientific researchers and doctoral dissertations, generating numerous reports and studies addressing DDT's safety. Over time, new patterns of production, distribution, and consumption of the information ensued, and as unified new texts emerged, increasing coherency, a new view of reality was reified (Phillips et al., 2004).

Using the concept of risk, Hardy and Maguire (2016) showed how text and practices established concepts. Drawing on Foucault and analyzing interrelated texts, Hardy and Maguire illustrated how the concept of risk within an organization was the object of knowledge. Text was shown to constitute risk as an object of knowledge through the numerous journal articles, textbooks, reports, handbooks, and checklists that were the means of knowing the meaning of risk. Hence, interrelated texts and practices are ways in which we know 'risk' (Hardy & Maguire, 2016). Texts also produce objects and subjects (Hardy & Philips, 2004; Hardy & Thomas, 2014). Hardy and Thomas's (2014) case study illustrated how objects and subjects are produced when power effects of discourses are intensified through discursive and material practices. By exploring two different discourses of a global telecommunications company during a significant change period, Hardy and Thomas illustrated how texts created a well-defined strategy through intensification and produced strategy as an object. Intensification occurred through discursive mechanisms of announcements and actions attached to timelines, through material changes of practice modifications, and through people losing or changing jobs. They argued that a subject is produced by "one who identifies with the strategy object

and who is competent to engage in practices that further intensify the power effects of discourse" (p. 344). Hence, subject positions are areas allowing one to speak and act (Grant et al., 2004; Howarth, 2010). Similarly, Maguire and Hardy's (2009) case study on DDT identified the emergence of a new subject position, that of the external scientist, as assertations from the external scientist became normalized and considered as new scientific facts.

Finn's (2008) case study analyzed discourse related to clinical care teamwork in a university hospital. Finn (2008) showed how discursive activities during teamwork reflect and reproduce privileged positions among surgeons and anesthetists over nurses and other operating room practitioners, perpetuating the inequalities between professions. Finn viewed discourse as language in social interaction, "bringing objects into being" (Hardy et al., 2000, p. 1231), as different professions utilize different language to promote their interests in ways that appear legitimate and factual. Different professions draw upon different terms that seek to maintain the status quo (Finn, 2008). For example, surgeons and anesthetists draw upon technical-instrumental terms which emphasize efficiency, while nurses and other operating room practitioners draw on relational terms such as courtesy, respect, and appreciation. Finn (2008) argued that these terms must be understood within the social context. The inequality between professions, with the privileged position of surgeons and anesthetists over nurses and other operating room practitioners, is perpetuated by positioning discursive actions as opportunities or constraints. Finn also argued that these discursive practices have effects beyond the team throughout the organization.

Power Relations

Discourse also constitutes power relations, distributing power and privileges among individuals (Hardy & Phillips, 2004). The exercise of power through discourse has been illustrated over time in the works of Foucault (1979), Knights and Morgan (1991), Ezzamel and Willmott (2008), Fairclough (1995), and Hardy and Thomas (2014, 2015). Drawing on Foucault (1980), Knights and Morgan (1991) illustrated the intersection of power and discourse. Their seminal theoretical paper developed a new approach to the study of corporate strategy based on "various exercises of power" (Knights & Morgan, 1991, p. 251) and used the term *discourse* to refer to "a whole set of power/knowledge relations which are written, spoken, communicated and embedded in social practice" (p. 254). Knights and Morgan (1991) argued that it is power "that transforms individuals into particular kinds of subjects" (p. 251); further, "managers and staff are not just passive victims of the power of strategic discourse; through it they are constituted as subjects who secure their sense of purpose and reality by formulating, evaluating, and conducting strategy" (p. 269).

Hardy et al. (2020), through the analysis of 'lean production' in supply chain management, exposed how established meanings can be exposed to identify how they reproduce power relations by giving primacy to certain bodies of knowledge, identifying actors privileged by a dominant discourse, and identifying those individuals who have been adjudicated as marginal or invisible. According to Hardy et al. (2020), when texts converge, "texts create a unified and taken-for-granted view of reality, leading to highly institutionalized, authoritative ways of addressing a topic" (p. 4). These prevailing views

of reality based on assumptions and understandings reveal "a dominant discourse of what is 'normal' in a particular domain" (Hardy et al., 2020).

Dominant Discourse

Of particular interest to discourse researchers is the dominant discourse (Hardy et al., 2020). Discourse is produced, consumed, and reproduced (Hardy & Thomas, 2015; Hart, 2014), with a dominant discourse arising when texts draw on one another and converge in their descriptions and explanations of a phenomenon (Phillips et al., 2004). When discourse is produced, consumed, and reproduced, it enters textual chains to be normalized as a dominant discourse through further comments or to be recontextualized (Hart, 2014). The relation between discourse and dominant discourse is of ideological normalization so that the discourse becomes so taken for granted it becomes dominant (Hart, 2014). Studies have revealed the emergence of a dominant discourse through various ways, including through competing discourses (Hart, 2014), the privileging of certain bodies of knowledge (Day & Patel, 2021; Hardy & Maguire, 2016), and a plethora of books and research (Bhamu & Sangwan, 2014; Hardy et al., 2020).

Hart (2014) argued that a dominant discourse emerges from competing discourse through the discourse of powerful speakers, through institutions where their ideology is articulated, and through social action that is legitimized. Phillips and Hardy (2002) illustrated how discourses compete and are produced in line with the interests of their producer by describing a physical event independent of people's thoughts and talk. In their example, a river is overflowing, leading to flooding and rising water, and those who get caught in it may drown. It may be called a natural phenomenon or a meteorological discourse, or it may be referred to as an El Niño phenomenon or consequences of global

warming. Yet some may say it is a result of politics, with the government failing to build dykes, which would prevent the flooding in these cases, and others may say it is an act of God. Phillips and Hardy (2002) argued that these different discourses ascribe different meanings, reflect a different course of possible action, and impact the course of events for the future.

Drawing on the work of Foucault (1979), Hardy and Maguire (2016) showed how the dominant discourse of risk is situated in privileging certain bodies of knowledge and sanctioning certain risk identities over others. The concept of *risk* came into existence and became an object of knowledge using texts in scientific, medical, engineering, medical, and legal journals, as well as textbooks on risk management, aggregated risk data reports, compliance reports, and practices such as rehearsing accident protocols, processing accident reports, or processing actuarial data tables. These texts and practices drew on each other and established a clear body of risk knowledge predicated on experts (Hardy & Maguire, 2016). The body of knowledge that brought risk into existence emphasized the role of the expert with professional language. Hence, the professional language became the authoritative knowledge created in this framework (Jasanoff, 1998), with Maguire and Hardy (2009) identifying that for a discourse to achieve dominance, there must be a high degree of fidelity.

Privileging certain bodies of knowledge was also illustrated by Day and Patel's (2021) case study on the removal of certain nonindigenous pine trees growing amidst indigenous vegetation. This study illustrated how environmental policy options are delimited by the way in which problems and solutions are articulated and defined. This study explored how the dominant discourse of nature, rooted in the assumed supremacy

of expert knowledge and science, was challenged by the discourse of nature as an amenity within the court system. The lower court found in favor of the proponents of the amenity discourse, and on appeal the higher court upheld this ruling. However, the higher court said that those favoring the discourse of nature were deprived of their right to be heard during decision making and ruled that the nonindigenous pine trees were to be removed but both parties were allowed to determine the removal date, highlighting the dominant discourse of science.

The discourse of 'lean' manufacturing, referring to producing products or services in the shortest time and lowest cost (Bhamu & Sangwan, 2014), denotes an institutionalized dominant discourse (Hardy et al., 2020). Although the concept and term *lean* are traced back to Japan's Toyota Production System, the concept of lean came into existence after the initiation of a Massachusetts Institute of Technology project bridging the performance gap between Japanese and Western automotive industries (Bhamu & Sangwan, 2014). Through the seminal book on lean, *The Machine That Changed the World,* and the subsequent numerous books and research articles, lean became widely taken up, explaining and normalizing certain practices (Hardy et al., 2020).

Associated with a dominant discourse are texts that have staying power (Cooren, 2004), narratives that have been taken up (Cooren & Taylor, 1997), or texts that are privileged (Mumby & Stohl, 1991; Thurlow & Mills, 2009). The conceptual work of Mumby and Stohl (1991) posited that power is rooted in the ways the social collective privileges certain articulations. Mumby (2004) argued that efforts to fix a meaning in a way over and against other possible discourses involves discourse and hegemony. Thurlow and Mills' (2009) concept of privilege identified how organizational narratives

became privileged during a hospital merger's change process. Privileged talk occurred largely through one's ability to "extract cues, convey plausible explanations, and resonate with the identities of those involved in the process" (p. 466). Their study found that although various narratives were available during the merger, only a few narratives became privileged and hence "dominant within the organization" (p. 466).

In summary, the realm of discourse shapes what can be said and by whom (Hardy & Philips, 2004; Hardy & Thomas, 2014; Maguire & Hardy, 2009; Merilainen et al., 2004) and controls which outcomes are realized (Reed, 1998). Enabling certain outcomes (or constraining others) by prioritizing certain bodies of knowledge, it shows how discourse can embody subtle power relations (Hardy et al., 2020). Power, thus, is embedded in social relationships, with discourse seen as the "crucial way to exercise power" (Leclercq-Vandelannoitte, 2011, p. 1250). A dominant discourse arises when texts draw on one another and converge in their descriptions and explanations of a phenomenon (Phillips et al., 2004). Dominant discourse provides a clear way "for talking about a topic and a particular kind of knowledge about a topic" (du Gay, 1996, p. 43), producing a clearly defined convergent body of knowledge (Hardy & Maguire, 2016).

Criticisms of the Discourse Literature

While many scholars have focused on the importance of discourse in explaining organizational phenomena (Phillips & Hardy, 2002), the discourse literature is also plagued with criticism related to its ambiguity, colonization, lack of regard for context, and determining behavior.

Discourse has been criticized for being poorly defined (Iedema, 2008; Phillips & Oswick, 2012), wrought with ambiguous definitions (Iedema, 2008), and having

conflicting and overlapping definitions (Aidi & Yechouti, 2017; Fairclough, 1995). Part of the confusion lies in the definitions of discourse based in linguistics related to words and sentences, or related to stories and novels, and broader definitions describing discourse related to cognition and social practice (Iedema, 2007). Hence, the ambiguity results in a wide range of interpretations (Iedema, 2007), with ongoing problems related to what discourse authors are really trying to say and the different uses and labeling of phenomena as discourse (Alvesson & Kärreman, 2011).

With a broad labeling of organizational phenomena as discursive based (Alvesson & Kärreman, 2011), critics have argued that discourse scholars have colonized social life, taking a siloed approach to analysis when a multimodal approach is warranted (Iedema, 2011; Reed, 2004). This siloed approach has resulted in discourse as the only legitimate conclusion, akin to a "hammer that can only conceive of hammering" (Iedema, 2011, p. 1164), with some arguing that discourse studies have moved outside the realm of reasonable conclusions and useful insights (Iedema, 2011).

Some (Deetz, 2003) also have argued that discourse is too focused on language at the expense of context. Embedding discourse related to the notions of knowledge accumulation, personal intention, structure, power, and marginalization subverts the possibility of other contexts related to situations involving unexplainable amplification of particular meanings or feelings (Iedema, 2011). The affective force or emotional tenor of discourse, the intense emotional relations, and attachments have largely been ignored (Cederström & Spicer, 2014). Some have also questioned the relationship between discourse and materiality (Iedema, 2007). Iedema (2007) argued that discourse research tends to separate materiality from discourse; however, the two are not separate and

distinct but coemerge. Broadly, material objects refer to phenomena such as earth and water, to artifacts such as ovens and dishwashers, or to social structures such as capitalism and democracy (Cederström & Spicer, 2014). The relation we have with things coarticulates meaning and materiality; it is not just discourse constructing reality or mirroring reality (Iedema, 2007).

Lastly, criticism specifically to a Foucauldian discourse perspective relates to the lack of a clear idea of how discourse influences the behavior for one to act in a prescribed way (Alvesson & Kärreman, 2011). For Foucault, discourse constitutes reality, including practical-behavioral, yet he does not identify how behavior happens (Alvesson & Kärreman, 2011).

Summary of the Literature on Discourse

Over time, the view of language has evolved, with the linguistic turn shifting language from being considered as a means of communication to being viewed as actively constructing reality (Alvesson & Kärreman, 2011), which also promulgated the way of how language produces social reality and mediates organizations (Leclercq-Vandelannoitte, 2011). The power of words has received much attention within organizations; the management literature has categorized words into five common theorizations, one of which is discourse (Lockwood et al., 2019). Overall, the meaning of discourse is highly contested, with a plethora of definitions (Phillips & Oswick, 2012), and over the last 35 years several strands of thought have emerged on discourse theory. This study took a critical approach heavily influenced by Foucault and CDS and used the discourse definition of "a collection of interrelated texts of bodies of knowledge which form the objects of which they speak" (Foucault, 1979, p. 49) coupled with a view of

discourse as “shorthand for a whole set of power/knowledge relations which are written, spoken, and communicated and embedded in social practices” (Knights & Morgan, 1991, p. 254).

A Foucauldian approach to discourse involves a historically based scheme of ideas that allows authoritative ways of addressing a topic (Alvesson & Kärreman, 2011) and contends that discourse creates the social world (Aidi & Yechouti, 2017). Texts converge and bodies of knowledge are produced (Hardy & Maguire, 2016), and through the practice of discourse, texts continue to maintain power relations, producing knowledge that guides meaning making (Hatch, 2018) in daily activities and inquiries. Through discourse, meanings are created and become taken for granted. Discourses embody historical phenomena and subtle power relations, privileging certain bodies of knowledge and identities, enabling certain outcomes and constraining others. By holding in place meanings associated with concepts, objects, and subject positions, discourse influences what can be said by whom and shapes power relations, which Hardy and Phillips (2004) referred to as the realm of discourse.

The dominant discourse arises when texts draw on each another and converge on their descriptions (Phillips et al., 2004) and become so taken for granted they become dominant (Hart, 2014). Dominant discourse has a clearly defined body of knowledge (Hardy & Maguire, 2016), providing a clear way of talking about a topic. Several studies (Day & Patel, 2021; Hardy & Maguire, 2016) have identified a dominant discourse rooted in certain concepts of knowledge becoming privileged.

While discourse has gained importance in explaining organizational phenomena (Hardy & Phillips, 2004), scholars continue to criticize the discourse literature for being

too vague with no clear convergent definition (Iedema, 2008), for taking a siloed approach to explaining organizational phenomena (Iedema, 2008; Reed, 2004), for being void of emotional tenor (Cederström & Spicer, 2014), and for lacking reference to how discourse influences behavior (Alvesson & Kärreman, 2011).

Summary of the Literature Review

This chapter reviewed the relevant literature associated with healthcare systems and discourse. Healthcare systems are complex (Camillo, 2016) and a costly business with over $1.2 trillion annually related to hospital costs (Centers for Medicare & Medicaid Services, 2018). Healthcare systems struggle with rising costs and are under continued pressure to reduce costs yet maintain quality (Porter & Lee, 2013). Medical resource procurement is targeted for cost reduction, as it accounts for about 31% of hospital costs per case and approximately 33% of a hospital's overall operating budget (Peck, 2019). To reduce costs, hospitals bring together professionals to make decisions regarding the procurement of medical resources (McInnes et al., 2021; Shbool & Rossetti, 2020).

Healthcare systems comprise interrelated systems of professions (Kirkpatrick et al., 2011), with the supply chain coordinating and managing all activities involved in procurement (Council of Supply Chain Management Professionals, 2013). As much of the work of a healthcare system depends on a professional workforce (Dobrzykowski et al., 2016), supply chain broadly includes various professionals in medical resource procurement decision making (Abdulsalam et al., 2015; Montgomery & Schneller, 2007). These professionals can be classified as clinical and nonclinical. Each group has varying interests and different foci (Brown et al., 2010). Hence, there are different views between

clinical and nonclinical professionals related to need for services and the procurement and distribution of various resources (Montgomery & Schneller, 2007). Overall, studies have revealed that procurement decisions are subjective (Shbool & Rossetti, 2020), based on identified physician preference, which is influenced by vendor relationships, medical training, and personal experience (Pennington & DeRienzo, 2013; Shbool & Rossetti, 2020). In addition, research has suggested that employed physicians may feel more emotionally tied to the hospital and inclined to support supply chain cost cutting; however, the opposite was true for employed nurses (Nyaga et al., 2015). Large contingencies of employed nurses may feel empowered to challenge supply chain policies and actually undermine operations (Nyaga et al., 2015).

Healthcare journals have provided little empirical research related to supply expenses (Abdulsalam & Schneller, 2019), with the literature calling for new theories and with discourse analysis proposed as a novel way to look at procurement (Hardy et al., 2020). The relevant literature on discourse was explored in several ways, providing a foundation for this study. Discourse roots established the concept of language actively constructing reality and how different talk shapes how one can act (Alvesson & Kärreman, 2000; Kärreman, 2014). A brief review was provided of the three discourse streams that have emerged over the last 35 years, identifying this study's critical approach predicated on the work of Foucault (1979). Foucault theorized how sociocultural practices hold meanings in place (Fairclough, 1992; Hardy & Phillips, 1999), normalizing a text that becomes taken for granted and constituted by power relations (Fairclough, 1995). Hardy and Phillips' (2004) conceptual model, the realm of discourse, constructs a social context, encompassing what can be said and by whom

(Hardy & Thomas, 2004, 2014; Maguire & Hardy, 2009; Merilainen et al., 2004), with a dominant discourse emerging that produces a body of knowledge (Hardy & Maguire, 2016) and a clearly defined way of talking about a topic (du Gay, 1996).

Inferences for the Current Study

Medical resources constitute a third of a hospital's operating budget (Peck, 2019) (Montgomery & Schneller, 2007). Overall, the literature has identified that decisions on medical resource procurement are subjective (Shbool & Rossetti, 2020), not evidence based (Grundy, 2016), and not based on effectiveness (McInnes et al., 2021). Physicians make decisions on procurement based on preference, external forces, and prior experience (McInnes et al., 2021; Pennington & DeRienzo, 2013; Shbool & Rossetti, 2020), with nonclinical professionals focusing on implementing cost-saving initiatives, reducing expenses, and maintaining margins (Ballard, 2005; Clark, 2006; Kaplan & Haas, 2014; Schneller & Wilson, 2009).

As decisions about resource procurement are predicated on conversations between various professionals (Atilla et al., 2018) with different foci (Brown et al., 2010), restraining healthcare costs while maintaining quality of care becomes a challenge because of the power relationships among professionals (Montgomery & Schneller, 2007). The use of language and discourse to control and shape language practices (Fairclough et al., 2011) is material to the procurement of medical resources because organizational activities include people talking (Alvesson & Kärreman, 2011) and increased importance is placed on talk (Alvesson & Kärreman, 2011), with some researchers arguing that organizational decisions and actions are conditioned by the prevailing discourse (Phillips et al., 2004). The role of language and discourse in medical

resource procurement needs to be explored, including practices that either favor or marginalize a particular group (Kure, 2010) and/or silence contrasting opinions (Du-Babcock & Chan, 2018), resulting in persuasion towards the direction of a preferred outcome (Koeberlé, 2012).

This study addressed the problem of medical resource procurement predicated on a dominant discourse based on social, historical, and power relations. This study sought to understand 'how' a dominant discourse emerges, which is best addressed through qualitative research (Creswell, 2014). The use of a qualitative methodology allowed for an in-depth focus on discovery, insight, and understandings (Merriam & Tisdell, 2016). The following issues were addressed: how social practices are created through discourse by what can be said and by whom, how meaning is created through the ideas, and the role of power relations. The methodology related to this exploration and research questions is presented in the following chapter.

CHAPTER 3:

METHODS

This chapter provides the methodology for this research study exploring the primary question—*How does a dominant discourse emerge during the procurement of medical resources?*—and two subquestions: *What are the influences on the procurement of medical resources? How do the influences on medical resource procurement occur?* This chapter details the study's research design, site and participant selection, data collection, data analysis, trustworthiness, and human participants and ethics precautions.

Research Design

Case Study

This study used a case study design. Qualitative research seeks to understand meanings that one ascribes to a social problem as well as the importance of the complexity of the situation (Creswell, 2014). Given the complexity of procuring medical resources and the desire to understand "how" a dominant discourse emerges, a qualitative design allowed the researcher to collect data aligned with understanding meaning. Specifically, a case study design was chosen because a case study provides a mechanism to explore 'how' and 'why' questions (Yin, 2018). According to Yin (2018), a case study has a twofold definition. The first part relates to a "contemporary phenomenon (the 'case') in depth and within its real-world context" (p. 15). The second part considers that in real-life situations the phenomenon and context are not always distinguishable. Based on this definition of a case study, the ability of a case study to answer 'how' and 'why' questions, and the goal of the research, a case study was the appropriate design for this

research. For this study, the case was the procurement of medical resources, specifically pharmaceuticals, which is referred to as the formulary process.

Case studies are bounded "by time and activity" (Creswell, 2014, p. 14) with research exploring a bounded system (a case) or multiple bounded systems (cases) (Merriam & Tisdell, 2016). This case study was bound by procurement decision-making.

Epistemology

Epistemology philosophical underpinnings are based on what one "believes about the nature of knowledge" (Merriam & Tisdell, 2016, p. 8), with researchers not finding knowledge but constructing knowledge (Merriam & Tisdell, 2016). This study was conducted from a critical philosophical perspective and framed using critical discourse studies (CDS) (Wodak & Meyer, 2016). A critical approach is grounded in the assumption that all thought is historically and socially constructed and mediated through power relations (Kincheloe et al., 2011). Hence, critical research supports subjugated knowledge against dominant knowledge (Sayer, 2009).

CDS analyzes "hidden, opaque, and visible structures of dominance, discrimination, power and control as manifested by language" (Wodak & Meyer, 2016, p. 12). Hence, CDS aims to make explicit power relations that are frequently obscure and to derive results with practical relevance (Wodak & Meyer, 2016). CDS also assumes an interest in uncovering the conditions of inequality, not just interpreting the language but explaining the work that language performs (Mullet, 2018). Overall, CDS critically describes, interprets, and explains the ways in which a discourse constructs, maintains, and legitimizes social inequalities (Wodak & Meyer, 2009). CDS is predicated on the use of language that is purposeful, whether consciously or unconsciously (Mullet, 2018),

emphasizing the role of language as a power resource (Willig, 2014). According to Wodak and Meyer (2016) and Mullet (2018), CDS has the following characteristics overall: is problem oriented, has an analysis of semiotic data, to some extent has power relations as discursive, situates discourse in time and place, sees language expression as never neutral, and has an analysis that is systematic, interpretive, descriptive, and explanatory. CDS studies integrate the following aspects:

1. A primary discursive focus on connecting local texts and wider social practices and a focus on power and power relations (Phillips & Oswick, 2012).
2. Examination of the language in use (the text dimension), identification of processes of textual production and consumption (the discursive practice dimension), and consideration of the institutional factors surrounding the event and how they shape the discourse (the social practice) (Phillips & Oswick, 2012).
3. An embrace of heterogeneity (Leitch & Palmer, 2010), referring to different conclusions by different researchers on the same data set.

CDS is derived from many different theoretical perspectives and approaches (Mullet, 2018; Wodak & Meyer, 2016). This study was guided by the dispositive analysis approach, which draws on Foucault (1980) and refers to knowledge that is synthesizing and built into linguistically performed practices, such as speaking and writing, nonlinguistically performed practices (doing), and materializations (things produced naturally or materially) (Wodak & Meyer, 2016). This approach aims to understand how knowledge is connected to power relations by identifying the knowledge contained in discourses (Wodak & Meyer, 2016). Knowledge is the basis for one's thinking, speaking, and production of things, which form the objects of which one speaks (Wodak & Meyer,

2016). Central to this method is the discourse analysis of texts. Discourse strands, discourse that centers on a common topic, are identified as well as discursive limits, which refer to what is not sayable (Wodak & Meyer, 2016). To understand the ideology of the subjects, their discourse position is identified. The dispositive approach also includes the knowledge related to nonlinguistic performed practices, as "people will know more than they tell" (Wodak & Meyer, 2016, p. 132), and materializations. According to Wodak and Meyer (2016), dispositive analysis includes the following:

1. Reconstructing the knowledge built into linguistically performed practices, which creates an important awareness of the dispositive and is performed through discourse analysis. The dispositive for this study is the formulary process.
2. Reconstructing the knowledge built into nonlinguistically performed discursive practices. To understand these practices, the researcher drew on existing texts of historical formulary processes and on policy documents.
3. Identifying the knowledge built into materialization. Materialization is a material object. In this study, materialization is the pharmaceutical to add, change, or delete from the formulary. Materialization refers to analyzing materializations by questioning those who are expert on the materialization to provide their knowledge and by using the researcher's background knowledge.

Role of the Researcher: Subjectivity and Reflective Statements

As in all qualitative research, the researcher was the primary instrument for this study (Merriam & Tisdell, 2016). With the researcher as the primary instrument, qualitative research is inherently subjective (Ayres et al., 2003) and interpretative, necessitating the researcher to reflect and identify her bias, values, and personal

background (Creswell, 2014). Wodak and Meyer (2015) noted that researchers within CDS need to be aware that the researcher's work is driven by "social, economic, and political motives, like any academic work, and that they are not in any superior position" (p. 7). "The point of critical research is generally to do research with people, not on people" (Merriam & Tisdell, 2016, p. 64). The critical researcher must consider the relationship the researcher has with the participants related to his/her positionality and insider/outsider status (Merriam & Tisdell, 2016). The researcher's positionality refers to race, gender, social class, background, and sexual orientation, and insider/outsider status refers to whether the researcher is an insider or outsider, which affects the research process (Merriam & Tisdell, 2016).

This study's researcher can be considered to have a mix of insider and outsider status. The researcher's insider status related to engagement in the field of healthcare for over 25 years in various clinical and nonclinical professional roles and for the last 4 years involvement in the finance side of healthcare. From time to time, the researcher may be asked questions related to the reimbursement structure of governmental and nongovernmental payors. From an outsider perspective, this researcher has no direct role or influence in decisions on medical resource procurement. In addition, an extension to insider/outsider status is the researcher's positionality. Hence, participants may have concerns related to the researcher's agenda, which may impact the stories conveyed by the participants (Merriam & Tisdell, 2016).

To mitigate these concerns, the researcher was reflexive, having an awareness of the influence the researcher had on the study and how the study influenced the researcher, and considered the issues of insider/outsider stances and positionality (Merriam &

Tisdell, 2016). Merriam and Tisdell (2016) noted that although it is important for all qualitative researchers to perform research reflexivity, critical researchers must emphasize the need for reflexivity because of the power relations inherent in the research act itself. The researcher addressed these concerns in several ways. First, the researcher completed a subjectivity statement before beginning the data collection. Second, the researcher completed a reflexivity statement summarizing any times during the interview that she perceived any exhibited power relation. Third, the researcher continually reinforced with the interview participants that her role was related to the research; she clearly stated the goal of the study and assured participants that all measures would be taken to ensure their anonymity.

Site and Participant Selection

Site Selection

This study utilized a healthcare provider organization in the Northeast region of the United States and received permission from the site to conduct this study. The site was selected for three reasons. First, this healthcare provider organization has both a centralized corporate structure and supply chain department and a localized hospital leadership with supply chain representatives. The combination of the centralized and decentralized nature of medical resource procurement provided a significant participant resource pool for both clinical and nonclinical professionals. In addition, this healthcare provider organization has six hospitals that merged to create a healthcare system. Having six hospitals that at one point were independent allowed for a setting rich in historical context and the ability to collect data from multiple hospitals. Second, with six hospitals, there is a material number of services that require the procurement of high-dollar and/or

high-volume pharmaceuticals, such as perioperative services, cardiology services, neurointerventional services, and oncology services. The existence of multiple hospitals also provided an opportunity to look across the system and different contexts. Third, the site is known to this researcher, which reduced the challenge of gaining organizational access. Although this researcher was known to the site, access to in-person meetings and professionals was limited due to the timing of data collection around the COVID-19 pandemic.

This multihospital healthcare system has community-based hospitals as well as specialty hospitals. This study utilized the formulary process as the case and looked across the system at the discursive practices that led to a dominant discourse informing decision making. Organizationally, the formulary process is a multilevel process and includes clinical and nonclinical professionals from a range of areas across the healthcare system, such as centralized supply chain, centralized service line leadership, local hospital leadership, and medical staff (employed and private physicians).

Participant Selection

This study selected participants based on purposeful sampling, choosing participants who had a great deal of knowledge and/or experience with the topic (Creswell, 2014). The participants comprised both clinical and nonclinical professionals who had direct involvement with the formulary process. The following criterion was used to select participants:

- Professionals involved in identification and decision making during the formulary process.

This criterion was chosen as pharmaceuticals contribute to a significant portion of the healthcare's operating budget. Participants were identified by recommendations from the organization's leadership; additional participants were identified through snowball sampling (Patton, 1990).

The researcher engaged clinical and nonclinical professionals through either email or phone. The researcher included phone communication, as many clinical professionals do not use email as frequently. When communication through email was used, the researcher attached the text shown in Appendix A. When telephone was used, the researcher read the content of Appendix A to the participant and advised the participant that the information just read would be emailed to them.

Sampling continued until the point of saturation within the interviews. Saturation or redundancy is achieved when the researcher begins to hear the same responses to the interview questions with no new insights forthcoming (Merriam & Tisdell, 2016; Wodak & Meyer, 2016). Saturation occurred after 13 interviews.

Data Collection and Procedures

According to Yin (2018), there are four overarching principles for data collection when performing a case study. The first principle relates to using multiple forms of data, or as Yin (2018) wrote, "evidence from two or more sources, converging on the same findings" (p. 110). The multiple forms of data used in this case study were semi-structured interviews, nonparticipatory observations, and document review. The second principle is to create a case study database, or in other words a formal assembly of evidence containing all the researcher's notes and documents (Yin, 2018). The third and fourth principle relate to maintaining chain of custody of the data and "exercising care

when using social media as a proxy" (Yin, 2018, p. 110). Data organization and chain of custody are discussed in greater detail in the section on data management. Social media as a proxy is not discussed, as this study did not use any social media. Data collection occurred over several months, with seven interviews completed, followed by the observation of two meetings and then the completion of six interviews. Document review occurred after the interviews and observations.

Semi-structured Interviews

According to Creswell (2014), interviews allow participants to provide in-depth descriptions related to the topic of study and to ask questions. This study used semi-structured interviews with open-ended questions to illicit participant views (Creswell, 2014). The use of semi-structured interviews is characterized by semi-structured questions, guided by a list of questions and issues related to the topic being explored, with questions asked in no predetermined order and with flexibility in their word choice (Merriam & Tisdell, 2016). As this was a case study, the interviews resembled "guided conversations rather than structured questions" (Yin, 2018, p. 118). Prior to beginning the semi-structured interview, the researcher confirmed the participant's consent. Participants were given a numeral identification based on a combination of a natural number and the date of the interview (Participant 1315, 2401, etc.) to maintain confidentiality. The researcher audio recorded the interviews after attaining participant consent (see Appendix B) as well as took handwritten notes. The audiotaped portion of the interview was transcribed by either a computer software program or a transcriptionist. The transcriptionist was part of a well-known online transcription service with an established confidentiality agreement signed, similar to Appendix C. An interview protocol was

followed for asking questions and recording answers (see Appendix D). Given this study's critical view, interview questions were included on power—who has the power, how it is negotiated (Merriam & Tisdell, 2016), and so on.

Nonparticipatory Observations

With case studies taking place in a real-world setting, there is the opportunity for direct observations (Yin, 2018). As Creswell (2014) pointed out, observations provide the researcher with the advantage of experiencing the phenomenon firsthand, coding information in real time, and noticing any unusual aspects. For this case, observations could aid in identifying professionals who were speaking more or less and the type of information offered. Observation also enabled the researcher to directly experience and document the text used by each person (Creswell, 2014). Direct observation was inherently material to this research to document and analyze the text utilized and observe the interactions and social determinants occurring during the procurement discussions. Two in-person nonparticipatory observations were performed; both were audio recorded, and the researcher took handwritten notes.

An observational protocol (see Appendix E) was used to record information. The protocol documented information related to the meeting such as time, date, place, and number of participants, and included both descriptive and reflective notes (Creswell, 2014). A sketch of the seating was drawn, identifying participants by number and title. The researcher's notes identified the participants only by their assigned number. Documentation of participants' titles was material to this study given this study's critical perspective. Descriptive notes included information related to reconstructing the text, the meeting structure and seating of the participants, and the length of time each participant

contributed to the conversation (Creswell, 2014). Reflective notes included the researcher's personal thoughts such as impressions, feelings, and hunches (Creswell, 2014).

Documents

Data from documents can provide descriptive information and be used in the same manner as interviews (Merriam & Tisdell, 2016). The formulary process includes a request document that contains multiple pieces of information, such as who requested the item, the purpose of the request, and for which hospital within the system the resource is to be used. The researcher requested documents related to the formulary request, as well as email exchanges, meeting minutes, and any documents the study participants referenced during the interviews. Document review consisted of formal policies, as overwhelmingly participants indicated that they either no longer had or were not comfortable sharing the email exchanges or the written information on the formulary request.

Data Management and Analytical Methods

This study included data from several sources as described above as well as the researcher's field notes and audio recordings related to observations. Analysis of the data was approached through both organization by the components of the conceptual frame and inductive coding. Analysis also included identifying recurring patterns and characterizations. Given the richness and density of the qualitative data, winnowing was required (Creswell, 2014). The winnowing process included focusing on some of the data and disregarding other data. This resulted in aggregation of data into a small number of themes (Creswell, 2014).

Data Management

Data management can be a struggle with case studies because of the tremendous amount of data generated (Merriam & Tisdell, 2016). Organization was key to analyzing and recording data and included both physical and computer management. The physical data were stored in a defined storage containment, what Yin (2014) called a case study database, with all data inventoried, including interviews, documents, and field notes. Data and information stored on the computer utilized a password-protected computer software program, and the researcher's computer was password protected. The data were categorized on an Excel spreadsheet. The use of a spreadsheet to record interview specifics (such as participants, dates, times, and location), observation of meetings (dates, times, and meeting participants), and documents assisted in maintaining organization and preparing the data for analysis. Participants were identified by combining a natural number and the date of the interview. A list of participants' numbers and names was kept in a locked filing cabinet accessible only to the researcher.

Analytical Methods

Overall, the analysis included a decontextualization and recontextualization of the data (Ayres et al., 2003). First, the interview data were organized by conceptual framework on an Excel spreadsheet and reviewed to get a general sense of the information (Creswell, 2014). Next, inductive coding was performed on the interview transcripts, assigning a shorthand designation to various aspects of the data, starting with the first two to three interviews. The interview transcripts were each read two to three times before coding began, followed by the establishment of a codebook. Codes were derived through what Merriam and Tisdell (2016) referred to as "interpretation and

reflection on meaning" (p. 206) and were either a word that the respondents used or a concept to represent the participant's response and its relation to the topic. The remaining interview transcripts were coded iteratively, with the codebook updated and modified based on continual review of the data. Creswell (2013) recommended beginning with 20 to 30 categories and then reducing those categories to four or five themes. This study's codes were grouped into 34 clusters or categories, from which six themes emerged.

Observational data and document data also underwent a coding and categorization process similar to that used for the interview transcripts, using the same codes identified in the interviews with new codes added as needed. Quotes were identified to ensure each theme had support, and the wording of the themes was revised as needed. The coding and categorizing of the interview transcripts, observation notes from meetings, and the documents were merged into one master list, indicating themes derived from the data analysis.

Trustworthiness

Trustworthiness in qualitative research refers to whether the findings can be trusted (Korstjens & Moser, 2018). The best criteria for trustworthiness relate to credibility, transferability, dependability, and confirmability, as defined by Lincoln and Gupta (Korstjens & Moser, 2018). Credibility refers to the findings representing plausible information from the data (Korstjens & Moser, 2018). Transferability refers to the use of thick descriptions so that the data can be transferred to other contexts (Korstjens & Moser, 2018). Dependability refers to the findings being supported by the data or the stability of the findings over time (Korstjens & Moser, 2018). Finally, confirmability

assures that other researchers can reproduce the findings, as the findings are not figments of the researcher's imagination (Korstjens & Moser, 2018).

According to Merriam and Tisdell (2016), researchers can incorporate multiple strategies to ensure trustworthiness. This study used the following strategies:

- Subjectivity/reflectivity statements: This study included a researcher's subjectivity statement to clarify any bias the researcher brought to the study. Before beginning data collection, the researcher documented a self-reflective narrative detailing how the interpretation of the findings may be shaped by the researcher's background. After each interview, the researcher completed a reflectivity summary indicating any perceived power relations.
- Peer and chair review of transcripts: This study also used review by the dissertation chair and a peer debriefer to obtain feedback and interpretation on the first two interviews, looking for any leading questions or any bias within the questions and ensuring that the researcher appropriately followed up on participants' responses (Merriam & Tisdell, 2016).
- Member checking or respondent validation: The researcher provided the interview participants with a copy of their transcript so they could clarify any information.
- Data triangulation: Triangulation involves using multiple sources, comparing and cross-checking the data (Creswell, 2014). Several sources of data—interview transcripts, meeting observations, and documents—were examined and converged to add validity to the study. According to Merriam and Tisdell (2016), one of the best strategies to ensure validity is data triangulation.

- Peer and chair review of coding: During the coding phase, the researcher sought feedback from the chair and peer reviewer to check the coding, categories, and themes for accuracy of representation.
- Thick, rich description: The researcher used detailed descriptions, providing the reader with a shared experience and providing a realistic view of the case (Creswell, 2014).

Human Participants and Ethics Precautions

This research adhered to The George Washington University Institutional Review Board requirements to conduct ethical research, protect all participants from harm, and follow the Data Protection Act related to data anonymity. The researcher of this study ensured all participant anonymity and confidentiality was maintained. The healthcare system and participants were not named, and the participants' identification numbers were stored separately in a secure location available only to the researcher.

CHAPTER 4:

FINDINGS

This chapter presents the data related to this case study to understand how a dominant discourse emerged during the formulary decision-making process. Data collection was guided by the primary research question—*How does a dominant discourse emerge during the procurement of medical resources?*—and two subquestions: *What are the influences on the procurement of medical resources? How do the influences on medical resource procurement occur?* For this research, medical resource procurement was confined to pharmaceuticals. The process of pharmaceutical procurement is known as the formulary process and refers to the act of deciding which drugs are purchased by the organization and made available for physicians to order. The findings were derived from 12 semi-structured interviews, observations of two different meetings of the hospital's Pharmaceutical and Therapeutic (P&T) committee, and policy documents related to the formulary process. Data collection was performed during the spring and summer of 2022 during the declared COVID public health emergency.

This chapter is divided into four sections. The first section describes the research site, participants, and the formulary process, including the P&T committee structure and formulary workflow. The second section outlines the major themes that emerged from the data, with detailed participant quotes and relevant information noted from the observations and document review. The third section describes the formulary process for one drug, illustrating the major themes. The fourth and final section presents a summary of the findings.

Research Site, Participants, and the Formulary Process

Research Site

This study was performed at a provider healthcare system in the Northeastern United States. The site has multiple acute care hospitals, a home care and hospice agency, multiple skilled nursing facilities, and a physician practice network. Given the inherent differences between these different domains, data collection was limited to the acute care hospitals.

Hospital services are designated as occurring in either an inpatient setting or an outpatient setting. Inpatient care is care a person receives when admitted to a hospital. Outpatient care is medical or surgical care a person receives without admission to a hospital and includes services at clinics, ambulatory surgery facilities, radiology, and infusion. The care provided within these two different settings has different reimbursement methodologies, clinical requirements, and goals, resulting in the use of different pharmaceuticals. The number of pharmaceuticals on the formulary is in the thousands, with different drugs primarily used within different settings. Within these two settings, the scope and use of drugs may be different.

Each of the acute care hospitals is part of one healthcare provider system. Each of the individual hospitals has an administration team consisting of a hospital president, chief medical officer, chief operating officer, chief nursing officer, senior vice president of finance, and other various leadership roles related to pharmacy, human resources, supply chain, dietary, etc. Each individual hospital administrative team reported to the corporate executive team. For example, the hospital president reported to the corporate president, and the hospital chief medical officer reported to the corporate chief medical

officer. In addition, various corporate departments had governing leadership over hospital areas such as compliance, human resources, regulatory, supply chain, and pharmacy. The regulatory department ensured that hospitals were adhering to any federal and state laws and governing body regulations; supply chain was responsible for the procurement of all medical resources.

Description of the Participants

Interviews were conducted with 13 participants, with the data analysis performed on 12 interviews (see Table 4.1). Data from Participant 10 were omitted from the findings. Although this participant provided verbal consent at the time of the interview, he failed to return the written consent form. All 12 participants who provided written consent held leadership-level roles and were involved to varying degrees in conversations and decisions for pharmaceuticals on the formulary. Participants had the choice of an in-person or virtual meeting; three participants chose an in-person interview and 10 participants chose a virtual or telephone interview.

To ensure confidentiality, all participants were assigned alphanumeric codes, their titles were categorized into roles, and since all participants had at least 5 years of organizational tenure, employment was identified as either greater than or equal to 5 years or greater than or equal to 10 years. Of the 12 participants, 11 are men. All references to specific people, staff, or employees in quotations were redacted and replaced with general terms such as participant, corporate leader, physician leader, etc. Participant quotes were presented verbatim with the exception of specifics related to participants or others and the removal of duplicative and filler words such as “uh,” “gotta,” “um,” or repetitive words for readability.

In lieu of titles, participants were assigned to one of three leadership categories: corporate, physician, or pharmacy. These roles were further categorized into clinical or nonclinical. As defined in Chapter 3, this study utilized the term *clinical professional* to refer to those involved in direct patient care who provide the principal care for a patient, and *nonclinical professional* for those who do not provide the principal care of a patient, with their job duties related to finance, supply chain, revenue cycle, legal, or management.

Table 4.1

Participant Demographics

Participant	Leadership role	Employment (years)	Clinical or nonclinical
P1	Corporate Operations	≥5	Nonclinical
P2	Pharmacy	≥5	Clinical
P3	Pharmacy	≥10	Clinical
P4	Pharmacy	≥10	Clinical
P5	Physician	≥5	Clinical
P6	Pharmacy	≥10	Clinical
P7	Physician	≥10	Clinical
P8	Physician	≥10	Clinical
P9	Physician	≥10	Clinical
P10	Physician	≥5	Clinical
P11	Pharmacy	≥10	Clinical
P12	Corporate Regulatory	≥5	Nonclinical
P13	Pharmacy	≥10	Clinical

Note: Data from P10 were not used in analysis, since this person did not return a signed written consent form.

The Formulary Process

This section describes the overall structure and approval process for a pharmaceutical to be added to either the corporate or hospital formulary. This process is multifaceted and includes input and decisions through corporate and hospital leaders and

committees. As described by Participant 2, the formulary process is meant to review and maintain the drugs used within the health system and encompasses the end-to-end process of a drug added to the formulary.

Pharmaceutical and Therapeutics Committee. In 2016, through the combined efforts of supply chain leadership and pharmacy regulatory affairs leadership, a corporate P&T committee was formed. This committee became responsible for reviewing, approving, and setting guidelines for all pharmaceuticals added to the corporate formulary. Participant 2 described the role of the committee as establishing "which are going to be the preferred drugs that we're going to use across the system, if they are high impact or high-cost drugs."

Prior to the creation of the corporate P&T committee, each hospital had a local decision-making process to add drugs to its formulary. Participant 11 shared how the inception of the corporate P&T in 2016 was based on a directive from corporate: "I think supply chain and regulatory pretty much mandated it a while back." Participant 2 described the transition:

> We went from doing it individually at each hospital to now adding medication on formulary at the corporate level. So we have a thing called [corporate] P&T. So now, if somebody comes to me and wants to add a product, they will have to present at [corporate] P&T and that's where we get it approved. Then it would filter back to each of the hospitals to get approval.

Participant 3 compared the formulary process before and after the creation of the mandated corporate P&T committee:

> I [historically] would look at my monthly new products … and I would read up on the product. And then usually maybe a drug company will contact all the [pharmacy] directors. I would talk to the sales representative and see where this product would be used and what's the benefit of adding it, rarely looking at the cost as much as I do now.… If I'll be honest with you, I think it takes much

> longer to get something on formulary now. Because if you think about it, you have to talk to the person [the requester]. It has to go to corporate. It gets presented 6 weeks or 2 months from then…. Sometimes a product we want to add might take 6 or 9 months to get approved, added in the electronic medical record, added to all the order sets, get approved by subcommittees.… It's a lot more complicated than what it used to be.

At the time of this research, this site had a corporate P&T committee with each hospital having dedicated P&T committees. Corporate P&T had leadership representation from the executive team, corporate departments, and leadership from across each of the hospitals. The hospital-based P&T committee consisted of that particular hospital's leadership (see Table 4.2).

Table 4.2

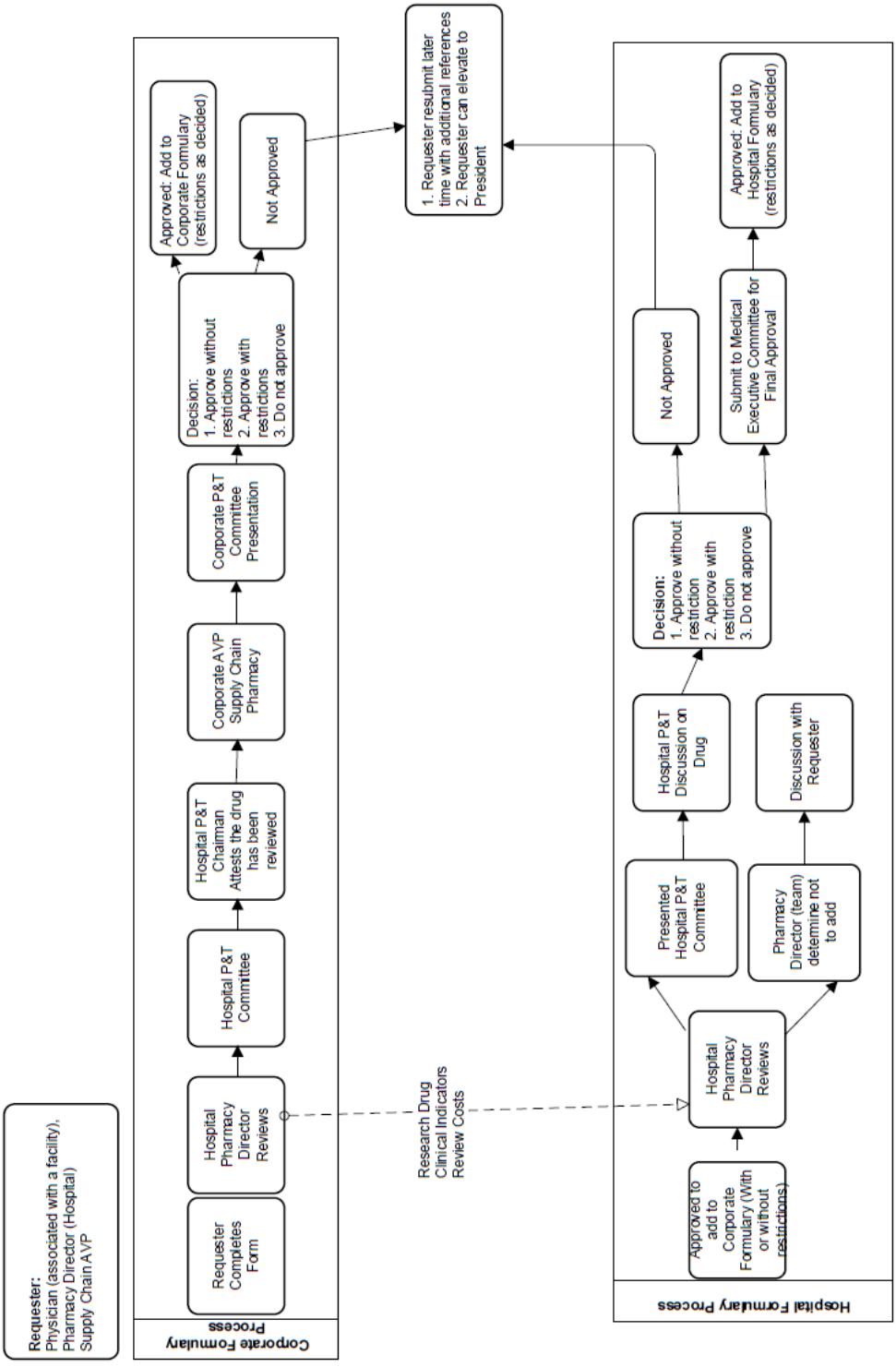
Pharmaceutical and Therapeutic Committee Members

Level	Committee members
Corporate	System chief medical officer System assistant vice president, supply chain pharmacy System assistant vice president, clinical pharmacy and regulatory affairs Hospital chief medical officers Hospital P&T chairs Hospital pharmacy directors Hospital assistant pharmacy directors Hospital clinical pharmacists Designated chief nursing officers Subject matter physician experts (as needed)
Hospital	Chair, physician Hospital chief medical officer or their designee Hospital chief nursing officer Hospital pharmacy director Assistant pharmacy director Clinical department heads

Formulary Workflow. A request to add a drug to the formulary could be brought forth by a physician, a corporate leader, or pharmacy leadership (see Figure 4.1).

Figure 4.1

Formulary Request and Approval Workflow



Participant 3 described the process:

> They [the physician] have to present at the corporate P&T.… Basically they come in and talk about the product, why they want to add it to formulary, … what's the benefits for it. Usually we have questions about price, efficacy, side effects.

Participant 11 provided more details:

> Typically it's a physician, for the most part, would need to make a formal request using a preprinted formulary request form they would complete, attach supporting documentation, showing the safety and efficacy of the product, and he or she would present the request at the corporate P&T meeting, which is chaired by executive physician leadership. And that's a monthly meeting.… It's attended by all the directors of pharmacy for all the hospitals, as well as clinical pharmacists or assistant directors, etc.… Depending on the hospital, once it's approved and added into the corporate formulary, then each hospital can then bring it on, if they desire, to their own hospital formulary.

Participant 4 described the hospital process:

> Once everything gets approved [by corporate P&T], you would have the lines of delineation going to the local hospitals. So, each local hospital it would go to, and then the director [of pharmacy] is responsible for implementing. Then we go to our local P&T and say, we want to add some [drug] to the formulary. Then we approve it at our local P&T or you don't approve it. There can be some conversations … and then we put a plan into effect with rolling it out, talking to anesthesia, talking to surgery, talking to others.… Once the hospital P&T approves, the pharmacy director presents the drug to the hospital's medical executive committee for final approval.

Major Themes on How a Dominant Discourse Emerges

This section presents the six key themes that surfaced during the data analysis describing how a dominant discourse emerged during the formulary process: (1) insurance and site of care frame the conversations; (2) corporate practices establish conversational boundaries; (3) the approval structure and process limit what is discussed; (4) discussions are continuously characterized in terms of financial implications; (5) power is dispersed; and (6) decisions are not always final. The themes are illustrated

by the participant interview responses with reference to the meeting observations and document review data material to the theme.

There were perceived differences between responses from the corporate leadership, who were nonclinical, and the other participants. The corporate leadership responses appeared more general, related to policy and how things should be, whereas responses of the pharmacy leadership, who are considered clinical, described actual events, processes, and examples. Overall, there were no perceived differences in the responses across the hospital pharmacy directors. There were also no perceived differences in responses between the hospital P&T committee members who were observed and interviewed versus those who were observed and not interviewed.

Theme 1*:* Insurance and Site of Care Frame the Conversations

Payors and the site of care (the inpatient or outpatient setting) framed the conversation around authorizations, reimbursement, and cost. Payors held discretion on approving the use of high-cost pharmaceuticals for their beneficiaries and could determine that certain pharmaceuticals were not medically necessary, delay approvals, or determine that a particular pharmaceutical could only be utilized in either an inpatient or outpatient setting. Regardless of role, all participants emphasized insurance and site of care impact in framing the conversation.

Insurance

Throughout the interviews, participants often referred to the pressure, control, and barriers by insurance companies in authorizing and reimbursing services provided. Participant 1 explained:

> Doctors will definitely talk about the insurance side of things. They feel all the pressure that insurance is giving and just the barriers that they are … trying to influence [the] site of care and the drugs.
>
> … But the insurance companies are tough. They're our biggest headache…. Their first reaction is to deny and then we [the hospital] appeal and which just obviously slows down the process. Many times, they want us to use a different drug and they're influencing clinical care from an office somewhere when our doctors are seeing patients.

Similarly, Participants 1 and 8 explained how insurance would dictate which outpatient oncology biosimilars would reimbursed. Participant 1 commented: "We weren't able to do [what was asked]…. We said, 'We want to use this biosimilar,' but United Healthcare would say, 'We want you to use this one.'" Participant 8 stated:

> They [insurance company] will sometimes just say you have to use the biosimilar … that they have in their payor formulary. A lot of it is driven by that. It's not just what we [the system] carry. It's also what [the insurers] will reimburse.

Participant 3 explained the insurance companies' impact on using drugs that not all insurance companies approve:

> Sometimes a new drug comes out; not all insurances cover it. So then [if] you add it [that drug] to the formulary, you're going to have to base [giving it to a patient] on [whether or not] the person's insurance [covers it]. You don't want to do that.

Participant 11 explained what happens if a drug is not approved by a payor.

> Then we would not bring it in.… Really, that's it, and you know, we depend a lot on the frontline patient access staff to make sure that it's approved, authorized, get that preauthorization.

Site of Care: Inpatient and Outpatient

Participant 1 explained how the different payment methodologies and goals in different sites of care drove listing of drugs on the formulary.

> The gist is that hospitals, which are normally inpatient, are paid under a diagnosis-related grouping [a payment methodology] where the goal should be to minimize cost. So one big bucket is [drug] procurement from an inpatient standpoint where the drivers are reducing cost. And then the other big bucket is outpatient, where the drivers are less based on cost, but what is reimbursed by the patient's insurance. Not as much for the cancer world, but lot of other infusion work. Because they [the insurance companies] want to send it to the lowest cost of care setting.
>
> In an outpatient world where you're paid for what you bill based on fee for service, there still is a lot of pushback from insurance companies about which product to use because the insurance companies are also getting kickbacks from pharma[ceutical companies] to use certain products. So we were not able to just restrict to one product in the outpatient.

Similarly, Participant 11 shared how the payment methodology may influence the formulary and its use in the hospital because one payment is received regardless of how many services are provided: "The less you use, the less cost for treatment for patients who stay in house."

Participant 2 explained what insurance companies say to influence the site of care based on cost:

> They [the insurance companies] are trying to influence site of care and the drugs. They may say: Hey, you don't need to give that in your hospital-based infusion; that could be given at home. Because they want to send it to the lowest cost of care setting. They're very focused, especially more recently, on lowering costs and obviously drugs are a huge cost bucket for them. So they're very focused on slowing down the process of authorization, making it more difficult and even trying to recommend different drugs.

Theme 1 described the insurance companies' reimbursement control and influence on site of care, which contributed to shaping corporate practices and conversations. Observations and policy review did not include any information relevant to this theme.

Theme 2: Corporate Practices Establish Conversational Boundaries

Corporate practices established conversational boundaries through corporate's role, the impact of that role, and access to information. Participants were consistent across roles in describing the role and practice of corporate leadership creating an environment valuing economic factors such as cost avoidance and cost reduction. In addition, corporate practices limited access to information, further creating boundaries on the conversations, as not all participants were able to adequately prepare.

Corporate's Role

Participant 2 described corporate's role as managing the pharmaceutical financial impact, which laid the foundation for corporate practices to frame the conversations on cost: "His [supply chain leadership] charge is to manage and reduce costs across the system and contain spiraling out-of-control pharmaceutical costs."

Participant 6 further described corporate's role and practices during the formulary process.

> They [supply chain] are big on what would be the cost, the cost-effective analysis, cost-benefit analysis, and basically contracts. And is it worth it? How much is the cost? What is the utilization going to be? Those are kind of the numbers they are looking for.

Participant 8 explained corporate's initial response to a formulary: "Often the conversation usually starts off with a no."

Impact of Corporate's Role

Participant 3 explained that there was a hesitation to bring high-cost items to corporate, ultimately limiting which pharmaceuticals may be discussed at corporate P&T.

> I think to be honest right now, cost is a major issue, and insurance coverage is a major issue for products. So, you know, you don't want to bring something to corporate that's going to cost a huge amount of money if it's not going to be beneficial in a certain way. We don't want to add cost without helping benefit the patient's hospitalization. So it's a very complicated issue now to add a product.

Participant 5 described corporate's resistance to a physician drug request, because corporate viewed the drug as being just an additional cost.

> They [supply chain] were against it. Initially they [supply chain] fought back, you know: there's other things that they [hospital physicians] could use, … like drug X would be able to be used…. I think it's the cost, you know. I don't think it's particularly very expensive.

Participant 3 shared how they would talk with corporate to see if corporate thought the formulary request was a good request:

> Sometimes before it gets to the system level [through the formal process], I [the pharmacy director] will talk to corporate. If they [corporate] do not think it's [the formulary request] is a good idea, I would have them [corporate] contact the head of the committee [drug requester] and they could have a discussion [with corporate].

Lastly, Participant 2 provided an example of the corporate practice on reducing costs:

> Immunoglobulin is an example where we were using one product and the reimbursement favored using a different product, and the system was charged with changing to the new product.

Access to Information

Participant 7 described how at times the physician's ability to advocate for a drug was limited because of lack of access to other healthcare organizations' information, which corporate had access to.

> You know, even though you're [the physician] trying to fight to say … we need [the drug] for this and that, … they [corporate] have ammunition. They do

> research. They have ammunition from other systems. "Well, this system doesn't use it. So we don't see [the need]."

Participant 11 echoed Participant 7's description as related to clinical research resources:

> One complaint I have is that we don't have full access to MEDLINE here. I have to Google Scholar and look for free articles. You miss out on a lot of information, unfortunately.

Theme 2 described corporate practices influencing the formulary through corporate's role, the impact on what was considered, and limited access to information. These practices provided a basis for the approval structure and what could be discussed. Meeting observation and policies were void of any information related to Theme 2.

Theme 3: The Approval Structure and Process Limit What Is Discussed

The length of the approval structure and process and related corporate and hospital gatekeepers affected what was discussed. Both the physician and pharmacy leadership shared their frustration with the laborious and arduous process, which ultimately became a barrier for requesters, resulting in limiting of the formulary.

Process Length

Participant 3 described the formulary process as "just slow. It takes time to do those reviews, get on the agenda, and meet once a month." Participant 2 further detailed the process:

> If a physician wants to bring a new drug to the formulary, there's a way to request. They put in a request to our local [hospital] Pharmacy &Therapeutics Committee. Then someone in pharmacy does a writeup, does a review, works with the physician, gets all the pertinent clinical information. They [the pharmacist] submit that documentation to either the local [hospital] P&T or the corporate P&T. At the next meeting, or whenever that agenda item gets put on the

> agenda, which might be 2 months from now if the current one is full, then that doctor is invited to attend and make the presentation.

Participant 11 commented on the impact of meeting frequency: "And we're only required to meet four times. A clinical pharmacist is on leave now. So we put it off [the hospital P&T meeting] as much as possible." Participant 7 added that even if the item was on the agenda, the drug was not discussed unless the physician requester was present.

> The committee meets once a month Tuesday morning, rain or shine is when we have the committee…. If the provider doesn't show to present it, it's not presented. We're not going to talk about it.

Corporate Gatekeepers

Participant 11 referred to the corporate pharmacy supply chain leader: "He does all the prep work of the agenda [for the corporate P&T meetings]…. He's the gatekeeper." Participant 9 explained how corporate at times indicated a desire to change a product yet was not transparent about the reason for the change.

> They [corporate] won't come out usually and say, it's costly and that's why we're going to change it. They're going to say we're looking for a new product or a different product, or this is just as good and we'll try it. And then we find out it is about cost.

Participant 8 explained that although the hospital determined a need for a particular drug, the hospital leadership still needed to convince those in corporate.

> So at the hospital, usually once something is determined that is needed, I don't know what the right word … is petition or meet with the people [corporate] that are in charge of getting those medications for us and try to convince them [corporate] why this new medication is valuable for our department.

Hospital Gatekeepers

Participant 3, a pharmacist, described how they needed to think that the formulary request was 'good' in order to elevate the request to corporate P&T.

> Anesthesia comes to me and they want to add a drug.… They might say, "Listen, there's this new product. Can you talk to the sales representative and see if you're interested? … Maybe we could set up presenting it to corporate?" That's how it starts.… Then I would get back to the physician that approached me. If I think it's a good idea then I would send an email to corporate saying: "I have a physician who wants to present the new product."

Similarly, Participant 13, a pharmacist, described how they would question the formulary request, which may also lead to limiting items discussed at the corporate P&T committee meetings:

> We will look at it first and if there seems to be an issue about duplicative therapy, like if we have something that's similar to it, or we think it's unsafe or extraordinarily expensive, we will question it before it even got there [corporate P&T].

Participant 7, a physician, further described how the hospital P&T review may limit what is discussed at the corporate P&T.

> First it has to be vetted in the sense that they need to bring information why they want this medication, why they need, why is it necessary to utilize this medication.… The [hospital] P&T committee looks at it and decides if the medication has value clinically, and then goes to the administrative end of the [hospital] P&T.… They do the cost analysis to see if it's, you know, is it ridiculous cost or is it reasonable and valuable.

During the hospital P&T meeting observation, facilitated by Participant 4, a cardiac drug was presented for formulary approval. Participant 4 asked the committee members who was opposed to the drug. There was no response by any of the committee members and the drug was approved: "Is there anyone that does not approve of adding this to the formulary? Okay, Perfect."

Although the participants did not mention any additional hospital approvals that were required, the hospital policies had language indicating that the hospital's P&T

committees recommended formulary additions, with the final approval given by the hospital's medical executive committee.

Theme 3 described the burdensome nature of the approval process and the gatekeepers involved in contributing to the limited discussion.

Theme 4: Discussions Are Continuously Characterized in Terms of Financial Implications

The formulary conversations consistently focused on cost and reimbursement, controlling high-cost drugs, and the exceptions. Although across the groups, participants shared conversations primarily related to the financial aspects, when directly asked to list the influences on formulary procurement, participants' responses were overwhelmingly related to clinical factors.

Cost and Reimbursement

Participant 1 described how reimbursement and cost were factors.

> We always used to go, "Let's get the generic that's least expensive, keep the cost down." We've now recently taken it a step further to be a little bit more proactive in looking at the reimbursements [vs cost of the drug], because Medicare reimburses us on average sales price for these drugs.

Participant 4 further described the conversations around saving money and reimbursement.

> We talk about financial implications. If we're saving money, also I would say reimbursement. Obviously, we want to make sure we're getting reimbursed correctly for the drug. You could be saving and the drug can be more expensive, but you can get better reimbursement to other medications…. And [we look at] if there's anything else on formulary that we have that matches up we may get rid of and discontinue and replace it with that item.

Participant 2 added the influence of purchasing power.

> [Approvals] are based on finances. So, the preferred products are based on that magic decision at corporate P&T. That includes what the current reimbursement is, what our purchase power is, and how that's all rolled into the best pricing relative to reimbursement.

Participant 8 described their response to the emerging role of value:

> So, there could be some [chemotherapy drugs] that are more cost-effective and equally effective clinically. There are regimens that are proposed that are based on value, and we are heading that way. It has nothing to do with pharmacy. It is just doing with what is best at using value in our decision making. And so, there's something called pathways that we are incorporating to prescribe a certain chemotherapy regimen. The pathway will present equally effective clinical options but prioritize them based on value. And that's going to be, I think, something helpful for us; that's where we need to go. We need to understand the pharmacoeconomics of what we are doing, especially because what we do is so expensive.

Controlling High-Cost Drugs

Participant 4 described how the system was looking for an alternative for a drug because the cost was out of control:

> It winds up that the doctors started using it more and more widely, which is fine for pain relief. But the cost at this point now is just getting, I would say it's a little bit out of control there. So, we're looking at different items.… So now this [alternative drug], the difference with this is the lower dose, which is 7 mg is $123 compared to $370. And the higher dose is $213 compared to $370.… So there's huge savings there.

The meeting observation supported this statement, as when this drug was discussed the meeting participants referenced replacing this drug because another hospital used over a million dollars of it in a year. They noted, though, that the replacement had begun in some of the hospitals without any physician concerns reported.

Participant 11 described their hesitation to add a high-cost drug because the expense was "crazy":

> It was agreed to bring it [intravenous Tylenol] in. There was a little hesitation just due to the costs and doubtfulness of the efficacy of the drug—saying it's just Tylenol, it's just Tylenol. That seemed to be the recurring theme. And I agree. I mean, to me, it seemed crazy to spend that ton of money.

Participant 13 described another example of difficult conversations:

> They were very tough discussions because the drug is so expensive. It comes in two doses and the lower dose is going to cost about $35,000. And the higher dose is almost $50,000.
>
> … The other hospitals, especially the smaller hospitals in the system, felt that it could put a very high financial burden on their bottom line and they were afraid to bring it in.

Exceptions

Most of the participants' responses characterized the conversations based on financial implications; however, Participant 12 described that the discussion was not always about cost:

> We don't always switch to drugs just because there is a cost savings.… We do our due diligence and our clinical research to be sure that if a drug is a cost savings item, fine. But we want to be sure that there is going to be no harm or ill effect to our patients first. Because certainly our patients do come first. We do want to be sure that they're being taken care of and regardless of whether or not a medication is more expensive or less expensive, our main priority is being sure that our patients are being treated the most safely and effectively as possible.

The participants' stories and examples overwhelmingly depicted conversations tied to financial implications. However, when the participants were directly asked to *list* the top influencers for formulary procurement, the number one reason participants identified did not relate to finances but to clinical implications; the second influencer identified was cost (see Table 4.3). This discrepancy may be a result of the participants' belief that clinical implications should be the most important influencer versus what was actually happening.

Table 4.3

Participants' Descriptions of the Top Influencers on Formulary Decisions

Participant	First influencer	Second influencer	Third influencer
1	Clinical	Cost	
2	Insurance		
3	Product need	Cost	CMO input
4	Product need	Cost	
5	Product need	Cost	
6	Efficacy	Safety	Cost
7	Efficacy	Cost	
8	Quality	Value	
9	-	-	
10	N/A	N/A	
11	Safety	Product need	Cost
12	Efficacy	Safe/effective	Cost
13	Efficacy	Cost	Safe/just as effective

No corporate policies reviewed identified formulary selection criteria. Most of the hospital policies listed formulary selection criteria which included clinical indicators and cost. The selection criteria were not ranked or prioritized.

Theme 4 described the corporate and hospital conversations rooted in financial implications, with most participants' examples describing conversations on cost and reimbursement.

Theme 5: Power Is Dispersed

Within the formulary process, power was diffuse, with different professionals having varying degrees of influence and some ability to exert power. Overall, the participants referenced varying degrees of power and indicated that approvals may occur but with restrictions.

Physicians

Participant 11 explained how power may lie more in some physician specialties than the individual physician.

> Not based, not essentially the individual [physician], but the service line has a lot to do with it. I think cardiology, bariatric surgery, or orthopedics—I mean, you're going to have the ones [the physician specialty] that have the most business, the biggest impact on revenue and patient care.

Participant 8 described how the clinical providers would decide on the biosimilars, and then others would determine which were dispensed:

> Once the clinical folks [physicians] look at it [the drug] and say, okay, these biosimilars have efficacy across them, then the pharmacist has the latitude of which one to dispense.

Participant 13 described the legal implications of drug selection:

> Well, you know, it's an antidote for a life-threatening situation. So if you don't approve it and you use something that's not approved, … the lawsuit, the legal implications could be quite significant. I think [it was approved because] the physicians kept pounding the committee to make a decision.

Corporate

Participant 7 described how the physicians still had input but it was diminished secondary to corporate.

> I think we're [the physicians] on the committee. I am representing the medical board. I think we still have input. I think the input is diminished somewhat because of corporate…. But on the local level, I don't think there's a lot of things that the doctors can do. I think it does go top down more than anything else.

Participant 8 explained how physicians had requested to add a nonnarcotic intravenous pain relief drug to the formulary. Because of the drug cost, compared to other

potential pain medications that could be used, the corporate committee approved it with limited use:

> Years ago, intravenous ibuprofen was being used instead of narcotics. We had been using an oral nonsteroid anti-inflammatory for many years, but from an IV point of view, not so much. We asked for it [intravenous ibuprofen] and we got it. It was working very well. Then unfortunately it seemed like it was very expensive relative to other things that we were using. So, it got special use only.

Similarly, Participant 11 shared drug restrictions put in place for another high-cost drug, intravenous Tylenol, to use only with surgical patients:

> Surgical-only cases and had limitation of the number of doses that were allowed.… Even to this day, it's still an issue because here today it's restricted to still that same restriction, postop for 48 hours.
>
> … We were trying to follow what the restriction in place at the corporate level. Then, Dr. X is looking to present at the next corporate P&T to get that restriction lifted.

Hospital Pharmacy Leadership

In response to a question about the greatest influence on the formulary, Participant 8, a physician, identified the pharmacy department leadership:

> I've never had a problem getting medicines that we thought would be useful approved here. Meaning I think once you bring it to the right people [pharmacy leadership], it seems to get approved pretty fast, so I think the process probably works.

Participant 3 described how they would have to think a formulary request was a good idea prior to bringing the request forward:

> I [pharmacy director] would get back to the physician that approached me. And then if I think it's a good idea, I will say, "Well, we'd have to present it to the corporate P&T."

Participant 3, a pharmacist, explained how they can restrict high-cost drugs even if the drug was approved for the formulary:

> I restricted it [a high-cost drug] for three types of surgeries and basically that's all we use in here. We went over with the different heads of orthopedics, … just saying, "This is what and this is how we're going to use this product in this hospital."

Participant 4 described how the power to make the decision was not one of the clinical committees: "I [pharmacy director] made sure everybody was involved in the conversation…. It wasn't really their decision. I was explaining what the decision was and why."

Theme 5 described how at varying points in the process, different professionals had influence and could exert power. Power lay within revenue-producing physician specialties rather than the individual physician. However, pharmacy leadership had the power to limit which drugs were advanced to corporate. Corporate also exhibited power through agenda control and limiting the use of drugs. With power being diffused among multiple leadership groups, there were numerous points along the process for formulary additions, deletions, or restrictions.

Theme 6: Decisions Are Not Always Final

Decisions may not be final, as across all roles, participants shared varying ways to challenge a formulary decision, including a nonformulary process, hospital autonomy on corporate-approved drugs, and at times additional conversation with executive leadership.

Nonformulary Process

Participant 12 described how if a pharmaceutical did not get approved, the physician might still be able to order the drug through a "nonformulary process" :

> I would say that corporate P&T is the last word. However, there is a caveat to that. Very rarely, I mean, I wouldn't say rarely, but there are times where a medication may go up to corporate P&T for approval and does not get approved. But the physician that requested the approval may still have good reason for wanting to use that medication on a certain subset of patients. If that is the case, we would review what the nonformulary process would be. Because every medication has a formulary process and a nonformulary process. So, by way of making a drug nonformulary, it's a certain way to restrict it, but pharmacies may still stock it if they need it.

Overall, the hospitals' written policies referenced nonformulary use but were inconsistent as to the criteria. One hospital policy indicated that a nonformulary request may be considered if the patient had already been maintained on that particular medication and there were no suitable substitutes; another hospital indicated that it was desirable to use the patient's own medications whenever possible.

Hospital Autonomy

Participant 3 explained that although the system approved a drug addition to the formulary, each of the facilities had autonomy on adding the drug to their hospital's formulary.

> Then [after corporate P&T approval] it [the approved drug] would filter back to the hospitals to get approval. So sometimes a medication will get approved at the system level.… So, we have the option to accept it or decline it after it gets accepted at the system level.

In general, the written policies included language indicating that individual hospitals could consider adding a corporate-approved drug to its formulary.

Executive Recourse

Participant 3 described executive intervention when corporate P&T attempted to replace high-cost drugs with lower-cost drugs:

> We've had a bunch of different high-cost medications that we wanted to switch products and they [the surgeons] didn't like the idea…. They went to corporate to talk about it.
>
> … The surgeons talked to the president and others in executive leadership. There was a lot of discussion about certain things.… One of the products that I was talking about that we wanted to take off formulary, … it was a product we didn't really want because of the high cost. But we ended up adding it because the president got involved.

Similarly, Participant 13 described elevating a different issue to the president for consideration.

> The only recourse I could think of is bringing it to higher administration within the system, like possibly going to the president and the system chief medical officer to express concerns. It did happen within this anticoagulant drug. It reached the highest levels. It finally got to a point where the possible liability for Hospital X not having this drug that they use on a high volume of their clientele was just not a good look.

Theme 6 described corporate decisions that were not final and referenced the nonformulary process, hospital autonomy, and executive intervention.

Consolidated Themes

The participants' descriptions of the formulary process illustrate its complexity with multiple points of discussion between professionals; as Theme 6 illustrated, these decisions may not always be final and may change over time. Many of the participants referenced a recent change in the formulary, replacing a high-cost (HC) pain drug with a lower-cost (LC) pain drug. The participants' descriptions illustrate Themes 2 through 6. Participant 4 described the HC drug:

> We have a drug right now in formulary called "HC Drug." When you give it, it gives pain relief for up to 72 hours. And it gives you pain relief instead of giving opioids. Now there's LC drug that's something similar; it's not injectable, it's actually a topical … and there's a huge cost savings.

High-Cost Drug Added to Corporate Formulary after P&T Rejection (Theme 6)

Participant 3 explained that several years ago this HC drug was first added to the formulary after physicians engaged executive physician leadership when the corporate P&T committee did not approve the drug. “It went above the [corporate P&T] and went to [executive leadership] and we ended up adding it” (Theme 6—executive recourse).

High-Cost Drug Not Added to One of the Hospital’s Formularies (Themes 3, 4, and 5)

Notably, one of the hospitals had never adopted the HC drug. Instead, this hospital continued to use a different, inherently LC pain drug. Participant 13 described that staying with the alternative pain drug was extremely inexpensive:

> About a year and a half ago we worked with our physicians and anesthesia to show that HC pain drug really didn’t do what it was purported to do and no one had expressed interest at this hospital in putting it generally on [our formulary]. We haven’t taken it [the discussion] any further. I mean, if the physicians came to me and asked to use it [HC drug], it probably wouldn’t have been a problem since it’s already approved by corporate. (Theme 3—hospital pharmacist as gatekeeper)

> [We use a different pain drug], a very, very inexpensive product that just cost … like pennies compared to these other drugs [the HC drug]. And, if the right technique is used, it can provide a reasonable analgesic effect. (Theme 4—discussions revolve around cost)

When asked if the physicians were aware of the HC drug and their ability to use it, Participant 13 said:

> I haven’t spoken to them about it…. I’m assuming they’re [the physicians] are aware of the products out there. I’m sure the drug companies have tried to speak to them and they’re pretty up on what they need for their patients to provide safe care, but they’ve never come to me with a request to add it to formulary. (Theme 5—power of hospital pharmacy leadership)

Use of the High-Cost Drug (Themes 4 and 5)

Participants 3 and 4 shared the increasing use and cost of HC drug over time and its restrictions:

> First there was a trial on certain operations, and we tried to keep the cost down. But as time passed, it seemed like more and more it was being used with different surgeries and surgeons and the cost is going through the roof. (Participant 3; Theme 5—power of hospital pharmacy leadership)

> It winds up that the doctors started using it more and more widely, which is fine for pain relief. But the cost, at this point now, is just getting, I would say it's a little bit out of control there. So, we're looking at different items. (Participant 4; Theme 4—financial impact, cost)

> I restricted it [HC drug] to three types of surgeries and basically that's all we use in here for three types of surgeries.… Anything else that's not approved for…. We went over this with the different heads, like orthopedics, just saying: "This is what and this is how we're going to use this product in this hospital." (Participant 3; Theme 5—power of hospital pharmacy leadership)

Introduction of Lower-Cost Drug as a Replacement (Themes 2, 3, and 4)

Participants 4, 11, 12, and 13 shared their recollections of who introduced the LC drug earlier that year and why. Participant 4 identified who initiated the replacement: "the corporate director of pharmacy" (Theme 2—corporate practice, corporate's role).

Participant 11 shared:

> It started with supply chain noting the potential savings of HC pain drug to the LC pain drug.… They had really driven the impetus for it. (Theme 3—corporate as a gatekeeper)

Participant 13 commented:

> Actually, corporate supply chain thought it would be a good alternative and they made the initial push to get it. I think there might have been a couple of orthopedic guys from one of the hospitals that had expressed some interest in it as well. (Theme 2—corporate practice, corporate's role)

Participant 12 described the initial request differently but could not be sure: "[It] came from a drug representative starting at one of the hospitals. You know, it's kind of hard for me to say where it initially originated from."

Participant 4 described how LC pain drug was similar and the cost was much lower:

> So now the LC drug, that's something similar. It does have … a nonsteroidal anti-inflammatory. And what happens with this one, it's not injectable, it's actually a topical. So, when you make the incision for a … procedure, it gets reconstituted and instead of an injection, it's actually a topical like the consistency of honey. And the surgeon will put it deep into the tissue and then sew it closed.… It slowly releases the bupivacaine and meloxicam. So now the difference is the $123 compared to $370 [low dose] and $213 compared to $370 [high dose]. So there's huge savings there. (Theme 4—conversations around cost)

Corporate Approval of Lower-Cost Drug (Theme 5)

The participants shared their recollections of the ensuing conversations after corporate decided to replace the HC drug with the LC drug. Participant 11 described conversations with corporate on the concerns from the surgeon:

> We had conversations with supply chain as the pharmacy directors, noting the hesitation that we were hearing from my understanding, the chief medical officer. Each of the facilities did speak to the surgeons that did speak to supply chain as well. So there was a lot of back and forth. (Theme 5—power of the physician)

Two participants shared that they 'told' the physicians within the hospitals that the drug was being replaced. Participant 4 shared:

> I went to a surgical conference. It was pretty scary, but it was okay with the chair of surgery there. He [surgery chair] was great, very supportive. I talked to the … chief medical officer. And we [the chief medical officer and Participant 4] said, "Listen, this is what we have to do.… We came to a conclusion that we're going to stop using [the HC drug] pretty much almost throughout the hospital."… And on reference, the physicians were a little skeptical, but I told them: "Listen, this is coming off of formulary, the date's going to be." (Theme 5—power of the pharmacy leadership)

Summary of the Findings

This chapter presented the findings on the formulary process to answer the primary research question: *How does a dominant discourse emerge during the procurement of medical resources?* The findings also addressed the two subquestions: *What are the influences on the procurement of medical resources? How do the influences on medical resource procurement occur?*

Six key themes emerged: (1) insurance and site of care frame the conversations; (2) corporate practices establish conversational boundaries; (3) the approval structure and process limit what is discussed; (4) discussions are continuously characterized in terms of financial implications; (5) power is dispersed; and (6) decisions are not always final. The themes illustrate how outside influences create an environment requiring healthcare leadership to structure the formulary process with financial impact in sight. This process is cultivated by corporate roles, limited access to information, and creating limitations on the conversations. Further discussion limitations include a long and arduous approval process prioritizing conversations based on cost and reimbursement. Although overwhelmingly the participants' stories revolved around financial indicators, participants did prioritize clinical indications when asked to list influencers to the formulary. Power to direct the discourse was seen throughout the process and dispersed in a multitude of professionals surfacing at different times throughout the process. Finally, the decisions made may be challenged through the nonformulary process, the hospital's ability not to add an approved drug, or executive override.

Chapter 5, the next and final chapter, presents the interpretation of these findings along with study conclusions and recommendations for theory, practice, and future research.

CHAPTER 5:

INTERPRETATIONS, CONCLUSIONS, AND RECOMMENDATIONS

This study was performed to understand how a dominant discourse emerges during the procurement of medical resources. The research focused on the formulary process and was guided by the primary question: *How does a dominant discourse emerge during the procurement of medical resources?* There were two subquestions: *What are the influences on the procurement of medical resources? How do the influences on medical resource procurement occur?*

This study furthers the healthcare literature on discourse by considering the social and historic processes, power, and knowledge that frame discourse and inform formulary decisions. This chapter presents the interpretations, conclusions, recommendations, and researcher reflections based upon the research findings. This chapter has four sections. Section 1 illustrates the connections of the major themes and interprets the findings guided by the conceptual framework introduced in Chapter 1and the literature presented in Chapter 2. Section 2 presents the study conclusions and modifies the conceptual framework based on the findings and conclusions. Section 3 offers recommendations related to theory, practice, and future research. Lastly, Section 4 concludes with investigator reflections and challenges in performing the research.

Interpretations and Connectedness of the Themes

This section discusses the theme connectedness and interpretations of the findings presented in Chapter 4. The interpretations are based on Foucault's theorization of discourse (1979, 1981) and Hardy and Phillips' (2004) realm of

discourse as depicted in the conceptual frame in Chapter 1 and the literature review in Chapter 2.

Consistent with Kure (2010) and Du-Babcock & Chan (2018), dominant discourse played a role in which drugs were added to the formulary, with decisions based on emerging dominant discourse predicated on practices favoring one group and the silencing of contrasting opinions.

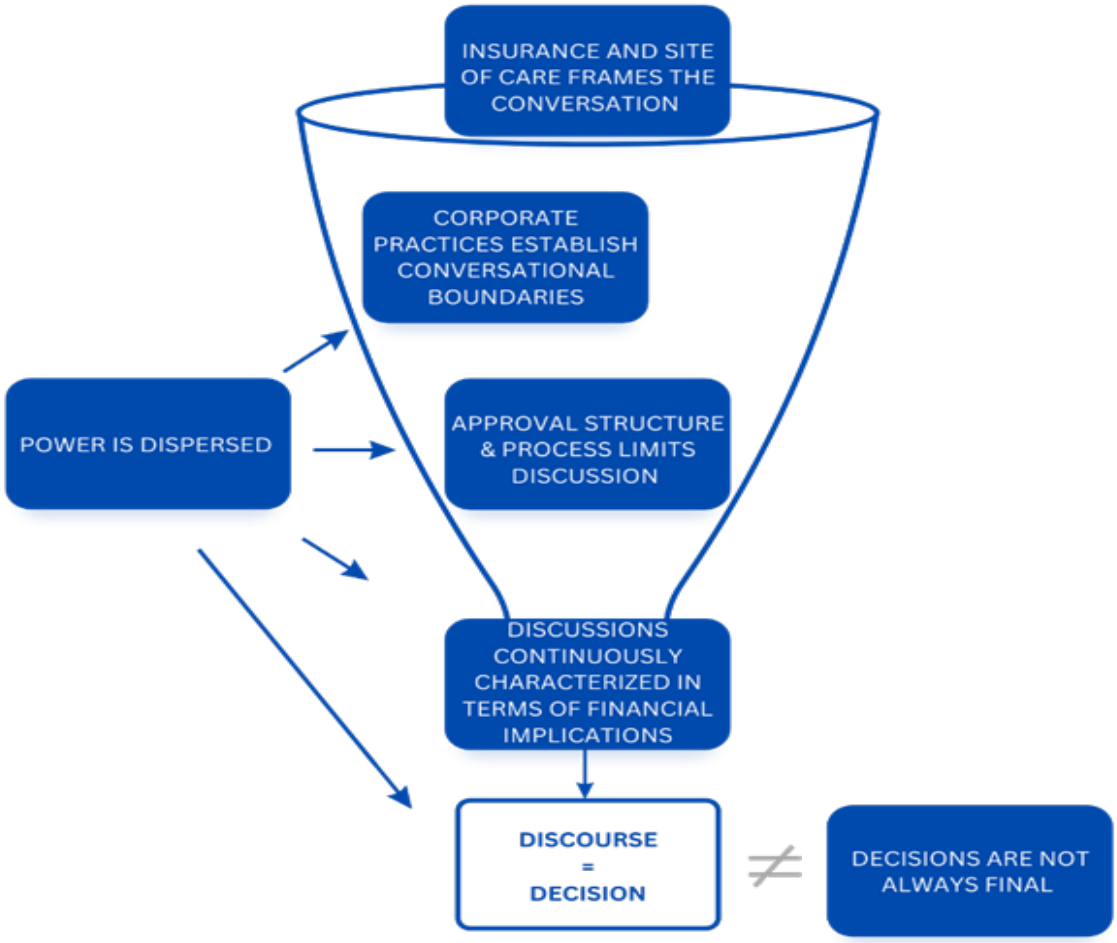
Six major themes emerged during the data analysis in answering the research question and two subquestions:

1. Insurance and site of care frame the conversations
2. Corporate practices establish conversational boundaries
3. The approval structure and process limit what is discussed
4. Discussions are continuously characterized in terms of financial implications
5. Power is dispersed
6. Decisions are not always final.

The funnel diagram in Figure 5.1 illustrates how the first three themes provide a visible and invisible foundation for formulary conversations, with insurance and site of care bearing down on corporate practices and the approval structure influencing the discussions. Power is outside the funnel, being distributed throughout the process, and the decision is not always final.

Figure 5.1

Connectedness of Themes



Interpretation 1

A dominant discourse is cultivated in a recursive manner during the formulary process.

The complexity of the formulary process is inherently nonlinear, with participants describing practices and multidirectional conversations with multiple professionals throughout the process. This recursive nature creates a social context allowing for conversations around financial implications to be guided from previous conversations

that were circulating. Previous practices and conversations related to cost and reimbursement are aligned with Foucault (1980) and the historic nature of conversations, which creates what can be said in the future.

Previous research has shown that texts draw on one another, creating textual chains (Hart, 2014), and texts draw on multiple communications such as books, articles, and announcements (Hardy et al., 2020). Yet previous research has not explored the paths of these texts. This research identified the nature of these texts drawing on each other with a multidirectional flow.

Interpretation 2

The healthcare sector structures the conversations.

The healthcare sector is governed and influenced by a multitude of factors, including insurance providers. The participants clearly identified the insurers' influence related to pharmaceutical authorizations and reimbursement, which heavily frames the conversations around financial factors. With insurers in control of drug authorizations and reimbursement, an environment is created that focuses hospital professionals' conversations on financial aspects. With primacy given to conversations and practices based on economic factors, a clear way to frame the formulary discussion is created. Consistent with Foucault (1979) and Hardy et al. (2020), these formulary conversations privilege certain bodies of knowledge of cost and reimbursement because they are accepted by the relevant professionals and hence help guide meaning making (Hatch, 2018).

Drawing on Hardy and Phillips (2004), people have a subject position from which they act and speak. Along with Hardy and Phillips and Finn (2008), texts converge, with

a professional's subject position playing a substantial role in establishing what should be said and by whom. The pharmacy leadership, physicians, and corporate professionals all have a subject position from which they act and speak. What can be done and said during these discussions is predicated on these professionals' subject position. Hence, those who have subject positions associated with formal power, critical resources, network links, and discursive legitimacy create texts that produce a particular outcome (Hardy & Phillips, 2004). The physicians' subject position is based on their expert power; corporate professionals' and pharmacy directors' subject position may include power related to information or legitimate power, with these different sources of power creating an imbalance.

Previous research by Finn (2008) showed how discursive activities during teamwork reflect and reproduce privileged positions among surgeons and anesthetists over nurses and other operating room practitioners, perpetuating the inequalities between professions. These different professionals drew upon different terms that seek to maintain the status quo. Finn (2008) argued that these terms must be understood within the social context. The corporate professionals and pharmacy directors within their subject position drew upon terms such as cost, expense, usage, and reimbursement, providing legitimacy and importance to the financial impacts.

In addition, participants clearly described practices of physician formulary requests being subjugated. Foucault (1980) identified these subjugated requests as knowledge that has been disqualified and seen as "the historical knowledge of struggles" (p. 83) that need to be emancipated. These requests were quelled by pharmacy or corporate professionals and silenced through an exercise of invisible power prohibiting a

full vetting. Foucault (1980) would argue that these requests (subjugated knowledge) need to be analyzed in terms of power tactics.

Interpretation 3

Power is exercised at different points along the process through corporate practices and by different professionals (Brown et al., 2010).

Miller and Lehoux's (2020) case study identified the procurement office, in this study referred to as corporate, as critical participants shaping what is sought after and provided. Participants' description of the role of corporate as managing and reducing costs is consistent with Schneller and Wilson's (2009) view that increasingly nonphysicians are interjecting issues of cost-effectiveness and reimbursement. Corporate exercise of power to constrain costs creates a practice and hesitation among other professionals not to bring high-cost requests forward. In addition, one of the participants discussed that at times the discussions with corporate were not transparent, which is consistent with previous research by Townley (1993) that the nature of power can be invisible and becomes noticeable when it is exercised.

As the participants' examples illustrated, the professionals engaged in multiple conversations in which challenges arose over which pharmaceuticals should be added to the formulary, along with any usage restrictions. The ability for professionals to challenge is in itself consistent with Foucault (1980) that individual agency must exist to exercise power. As Brown et al. (2012) discussed, power comes into play when professionals disagree. With corporate, pharmacy, and physician members all having different foci, these professionals attempted to influence the outcome in their favor.

These professionals' exercise of power within these discourse exchanges is representative of Foucault's power and social practice (Foucault, 1979; Marshall & Rollinson, 2004) and previous research by Hardy and Maguire (2016) and Day and Patel (2021) that illustrated the display of power by privileging certain bodies of knowledge and expert analysis. Corporate professionals exercised power through their practices with conversations based on financials taking primacy and the ability to control the agenda. Pharmacy directors also exercised power through their gatekeeper status and ability to restrict approved drugs on their hospital's formulary. Physicians had some degree of exercisable power from their knowledge and training.

Interestingly, the concept of a duality of roles surfaced related to the conversations and practices of the pharmacy participants. As Chreim et al. (2013) described, there are tribes in healthcare, the clinical vs. the nonclinical, and although all the formulary participants were professionals, their subject positions offered a dichotomy between clinical and nonclinical professional status. In this study, the pharmacy professionals were considered part of the clinical domain yet their responses around cost and restricting drug usage aligned with those of the nonclinical professionals. This departure may be explained by pharmacy professionals being considered "too far away from patient care," with their role essentially similar to a nonclinical professional.

Conclusions

The formulary process is complex and wrought with professionals using discourse as a crucial way to exercise power (Leclercq-Vandelannoitte, 2011). From this study, three conclusion were drawn. First, Foucault's theorization on discourse and Hardy and Phillips' (2004) realm of discourse model explain the formulary process, but the

conceptual framework should be modified to illustrate the significant influence exerted by the insurers and discourse's recursive nature. Second, the critical approach provides an effectual way to understand how a dominant discourse is predicated on power relations and normalizing conversations. Third, hegemony of executive leadership can alter decision outcomes.

Conclusion 1

> *Foucault's theorization on discourse and Hardy and Phillips' (2004) realm of discourse model explain the formulary process, but the conceptual framework should be modified to illustrate the significant influence exerted by the insurers and discourse's recursive nature.*

The conceptual framework depicts how the formulary process is influenced by the healthcare sector and the realm of discourse elements (Foucault, 1979; Hardy & Phillips, 2004). Foucault's (1979) theorization establishes discourse as a way of seeing and thinking about a topic. In this study, the insurance companies provided a way of seeing and thinking about pharmaceuticals on a financial foundation. Financial impact is given meaning, influencing the conversations by healthcare systems professionals. Similar to Hardy and Maguire's (2016) study that illustrated discourse constructing the social world, with certain texts accepted as truth by giving the phenomenon meaning, economics provided a meaning.

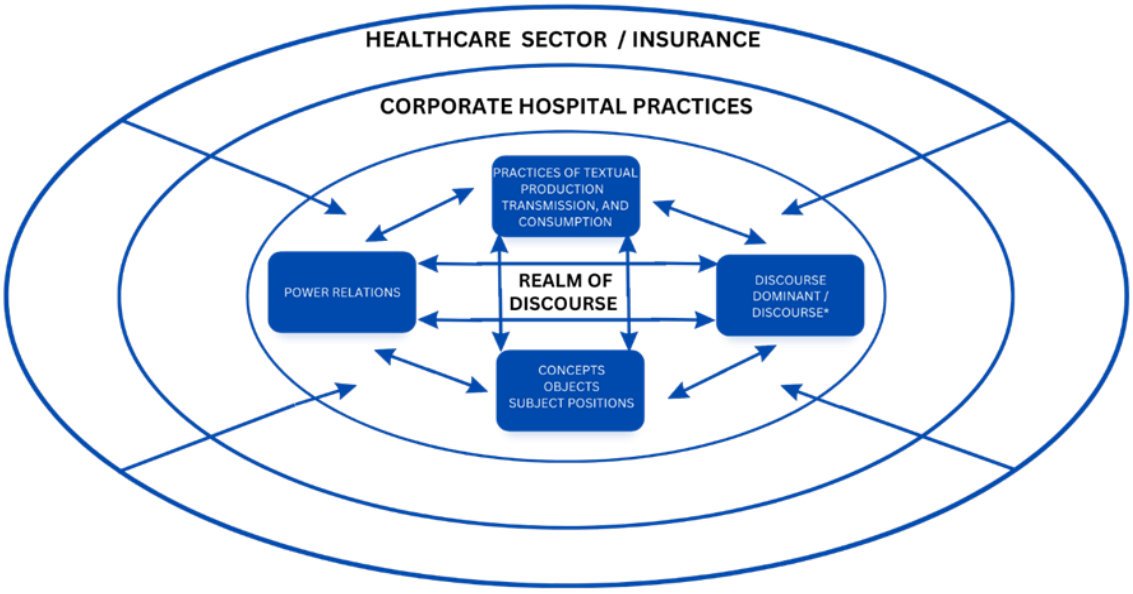
Previous literature supports the realm of discourse holding in place certain meanings through concepts, objects, and subject positions, shaping power relations and constituting the social context. Similarly, some of the formulary process professionals were in subject positions creating text and practices revolving around the concept of

economics. Hart (2014) argued that a dominant discourse emerges from competing discourse through the discourse of powerful speakers. Aligned with Hart (2014), in this study, a dominant discourse emerged through the text and social practices given legitimacy from professionals in powerful subject positions.

The conceptual model in Chapter 1 was revised to reflect the findings and conclusions of this study in Figure 5.2. There were four changes to the original conceptual framework. The first change was to the outermost shell description, where "healthcare system" was changed to "healthcare sector," consistent with the literature in Chapter 2 reflecting the external environment and adding insurance to highlight its significance.

Figure 5.2

Revised Conceptual Framework of Dominant Discourse During the Procurement of Medical Resources



Note. Based on Foucault (1979) and Hardy and Phillips (2004).

The second change was to the middle shell description, which was updated from "procurement of medical resources" to "corporate and hospital practices" to identify the practices occurring. The third change extended the shell arrows to breach the innermost shell, reflecting how the healthcare sector and corporate and hospital practices bear down on the realm of discourse. For the fourth and final change, the realm of discourse arrows were updated to illustrate the recursive nature of the process.

Conclusion 2

The critical approach provides an effectual way to understand how a dominant discourse is predicated on power relations and normalizing conversations.

The critical approach, as presented in Chapter 3, asserts that all thought is mediated through power relations (Kincheloe et al., 2011), emphasizing the role of language as a power resource (Willig, 2014) and supporting subjugated knowledge (Sayer, 2009). Applying the critical approach in this research to explain the formulary process is effectual and appropriate. This critical approach effectively portrays the formulary process, illustrating the opaqueness of power relations and the exercise of information in influencing decisions and marginalizing and silencing information.

As described by Mullet (2018), the critical approach literature also sees language as purposeful, analyzing power and what is hidden as manifested through language. The conversations the professionals engaged in were in pursuit of a specific outcome, utilizing language to disguise their bases and forms of power. In addition, as Hart (2014) contended and this study illustrated, discourse is produced, consumed, and reproduced as it enters textual chains to be normalized as a dominant discourse through further comments or to be recontextualized. Power is hidden through the language of economics

with its organizational impact, with recursive conversations around financial information becoming so taken for granted it becomes normalized and dominant.

Other critical research espouses the practical relevance of critical discourse studies (Wodak & Meyer, 2016). Given the material need of pharmaceuticals to a hospital, this study provides a contribution to understanding how formulary decisions may be based on favoring professionals and privileging information through a dominant discourse and not predicated on all knowledge through logical and rational dialogue or practices.

Conclusion 3

Hegemony of executive leadership can alter decision outcomes.

Although formulary decisions are predicated on a dominant discourse, this study illustrated that sometimes the decision can be challenged and altered. Physicians challenged and elevated a nonfavoring formulary outcome to the executive leadership, who in turn engaged and altered the decision. Potentially, this could be explained through executive leadership's legitimate power (Raven, 1993) and dominance within the organization. In this study, examples of challenging unfavorable outcomes were given by the physicians. It is unknown if the intervention by executive leadership was due to the physician's knowledge or the hegemony of executive leadership substantiating their ability to overturn challenged outcomes.

Executive leadership intervention is tangential to the research of Day and Patel (2021), who found that a higher court maintained yet acknowledged and extended expert knowledge. Day and Patel illustrated that although problems and solutions are articulated differently, a dominant discourse can be altered. In a conflict around the removal of

nonindigenous pine trees, a higher court upheld a lower court's ruling siding with the discourse of amenity of nature over the science of nature. However, the higher court also ruled that those favoring the science of nature discourse were deprived of their right to be heard and ruled that the proponents of the science of nature had to agree to timing of the removal.

Recommendations

This section presents this study's recommendations related to theory, practice, and future research. These recommendations take into consideration the theories and concepts from the literature informing this study and the research findings, interpretations, and conclusions.

Recommendations Related to Theory

The findings and conclusions inform three recommendations related to theory: (1) expand the realm of discourse to consider different types of environments; (2) consider developing a framework of how different types of power are exercised during discourse; and (3) extend dominant discourse theory to include the influence of hegemony.

Recommendation 1: The realm of discourse would benefit by taking into consideration different types of environments, such as social, political, and economic sectors, in the development of a dominant discourse. The realm of discourse focuses on power relations, the practices of textual productions, transmission and consumption, the concepts, objects, and subjects, and the discourse without consideration of environmental influences. The sociopolitical macro environment strongly influences organizations, individuals, conversations, and decision-making (Chitescu & Lixandru,

2016). Whether consciously or unconsciously, individuals may be impacted by different environments that bear down on the formulary process, impacting the discourse and hence the outcome. Expanding discourse theories to unambiguously consider the environmental context during discourse would provide greater insight and the ability to impart practical implications.

Recommendation 2: Theory should include the types of power and how it is exercised. Broadly, there is a wealth of literature related to power. This study included previous literature related to the exercise of power through discourse (Ezzamel & Willmott, 2008; Foucault, 1979; Hardy & Thomas, 2014, 2015; Knights & Morgan, 1991). In addition, the literature has identified different types of power as expert, referent, reward, legitimate, and coercive (French & Raven, 1959; Raven, 1993), with subsequent literature including a sixth form of power, informational (Raven, 1993). Although the realm of discourse includes power relations, it is lacking in understanding how different types of power impact these relations and discourse. Understanding the complexity of different types of power and its effects on discourse would broaden theory and provide tangible practical interventions.

Recommendation 3*:* Foucault's theorization of discourse should be extended to address how dominant discourse outcomes can be modified through hegemony. Overall, discourse theories are effectual in understanding the power related to discursive practices during the formulary process. Foucault and discourse theories in general focus on the discursive practices of what can be said or excluded within a body of knowledge managing power. The inclusion of hegemony, leadership or dominance over others, demonstrates a sometimes overt dominance to achieve an end. Expanding theory and

drawing on the role of hegemony broadens the field to consider contexts when a dominant discourse is modified through executive leadership.

Recommendations Related to Practice

The literature, findings, interpretations, and conclusions suggest five recommendations for structuring the formulary process to reduce a dominant discourse emerging based on power: (1) a process that is comprehensive, expediated, and agile; (2) the ability for all professionals to impart knowledge; (3) a collaborative approach; (4) transparent practices that reduce subjugated knowledge; and (5) an appeals process that is well delineated, communicated, and understood.

Recommendation 1: Overall, a formulary process should be comprehensive, expediated, and agile. With the rapid pace of pharmaceutical innovation and development, healthcare systems must utilize a workflow that can quickly yet comprehensively identify and vet new drugs for their formulary. New and replacement formulary requests should be grounded in evidence-based literature and value, with all professionals having access to resources that support their pharmaceutical research. The process should be expediated with a faster throughput and a regular meeting cadence, with the output of these meetings documented and shared.

Recommendation 2: All stakeholders should be able to impart knowledge and be included in the conversations. Professionals have different ways of seeing and thinking about pharmaceuticals with an inherent professional language. Practices and conversations should be established with the expectation that all the professionals involved will impart knowledge into the process through open dialogue.

Recommendation 3: Leaders should be cognizant of conversations intended to privilege one's goals and establish boundaries to ensure a collaborative approach. Essential to ensuring a robust formulary is the need to have all requests and information visible to all professionals involved in the formulary process. It is recommended that leaders impart boundaries on those who normally dominate the conversations to allow for an open dialogue. In addition, leaders should create a practice that expects all the professionals involved with the formulary process to offer evidence-based information.

Recommendation 4: Leaders should ensure that information is not subjugated by having transparent conversations. All requests should be documented, delineated, and brought to the formulary committee for consideration. Requestors should have the opportunity to either provide a written document outlining the need and value of a pharmaceutical or attend the meeting to speak to the reason for the request. Requests that are barred from reaching the hospital or corporate committees result in subjugated pharmaceuticals.

Recommendation 5: A formal appeals process should be well documented and delineated. This study's findings indicate that a formal appeals process is either not well delineated or not communicated or is not followed with physicians, evoking the hegemony of executive leadership to intervene. The establishment of a well-documented, communicated, and understood appeals process will allow for all stakeholders to pursue appeals consistently and not just those who have access to executives**.**

Recommendations Related to Future Research

The literature review, findings, and conclusions of this study suggest four recommendations for future research: (1) expand how a dominant discourse emerges

during the procurement of other medical resources or areas; (2) consider how a nonclinical discourse impacts patient care; (3) explore how formulary spending impacts a hospital's quality metrics; and (4) explore how a dominant discourse emerges in different settings.

Recommendation 1: Expand on how a dominant discourse emerges during the procurement of other medical resources such as supplies and implants and in areas such as operating rooms. Healthcare entities, being large and complex, procure numerous types of medical resources in addition to pharmaceuticals. Medical supplies are needed for daily patient care, with some very high-dollar supplies and implants utilized in areas such as the operating rooms and cardiovascular suites. Further research in understanding how a dominant discourse emerges for these types of medical resources or in specialized areas will allow for improved practical effectiveness.

Recommendation 2: Consider how a nonclinical professional's discourse impacts patient care overall. Overall, there is an abundance of healthcare literature related to communication between clinical professionals, with a dearth of research related to discourse. Nonclinical professionals occupy material roles throughout a healthcare system without visibility into knowing if their discourse affects patient care. Understanding their texts, subject positions, and power may provide insight into how nonclinical professionals' discourse shapes patient care.

Recommendation 3: Explore how formulary spending impacts a hospital's quality metrics. As healthcare continues to move towards being consumer-centric and transparent, patient outcomes and third-party hospital quality ratings gain more relevance. Extending beyond how a dominant discourse emerges during the formulary process to

understanding how formulary expenses relate to patient outcomes will provide a level of insight not available currently. This level of insight will provide knowledge that may guide policy makers and hospital leadership to different economic decisions.

Recommendation 4: Explore how a dominant discourse emerges in different settings. The findings and conclusions also suggest a need to better understand how a dominant discourse emerges in various hospital operations such as marketing, planning and development, or facilities management and consider whether it forms in the same way. In addition, it would be useful to understand how dominant discourse emerges across different areas of management, different leadership styles, and in different organizational cultures and subcultures.

Investigator Reflections and Challenges Conducting the Research Study

The purpose of this study was to understand how a dominant discourse emerges during the procurement of medical resources, with this research focusing on the formulary process. As I reflect on my journey during this research, I find three material ruminations: (1) the challenge in participant recruitment, (2) the potential bias of participants, and (3) the overall importance in understanding how the practice of discourse impacts daily decisions and activities.

I was surprised to encounter difficulty in recruiting participants for this study. While this study did take place during the declared COVID-19 public health emergency and was conducted at a healthcare provider site, I expected participant recruitment to be uncomplicated and less challenging. The difficulties in recruiting participants could have stemmed from general healthcare worker burnout due to the overall demands of the pandemic or could have been unique to this site.

Corporate participants were the most difficult to secure, with some participants agreeing to participate yet continually cancelling scheduled interviews and/or not responding to various communications. Additionally, many of the participants appeared hesitant to discuss the formulary process freely, often sharing a situation and then qualifying the situation with verbiage deemed more politically acceptable. After the interview, a few of the participants made references to the challenges with corporate overall. I felt these references represented the need for some of the participants to restrict transparency.

Given my experience with healthcare finance, I made every effort to ensure that the research questions and probing did not influence the participants in any particular way. However, given my background, there may have been participant bias to respond to the questions from a financial perspective. This potential bias must be considered when reading this study.

I believe the most pertinent and significant reflection of this study is how the practice of discourse in daily decisions and activities guides meaning making. The literature review as well as the findings, interpretations, and conclusions have provided an eye-opening experience on how discourse allows for a way of looking and thinking that impacts all activities and decisions within an organization.

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APPENDIX A:

RECRUITMENT MESSAGE FOR PARTICIPATION IN A RESEARCH STUDY

Dear Mr./Ms._____,

I am writing to you today to invite you to participate in my dissertation research study on discourse and medical resource procurement (further described on the attached page). I am a doctoral candidate at The George Washington University's Graduate School of Education and Human Development in the Human and Organizational Learning Program, and this research is being performed as a part of the program's requirement.

As part of my study, I plan to conduct 60- to 90-minute interviews with members of the organization who are involved in the procurement of medical resources and attend meetings when these medical resources are discussed. You were identified as a potential participant for this study because of your role in the procurement of medical resources such as supplies, devices, implants, and/or pharmaceuticals. The findings of this study will contribute to the organizational literature related to how conversations are influenced using language, context, and social practices.

Please contact me via email at **mdykstra@gwu.edu** or by phone at (xxx) xxx-xxxx if you would like to obtain additional information or are willing to participate in this study.

Appreciate your consideration,
Michele Dykstra

Research Study Overview

Study Title:	A Critical Discourse Study: Dominant Discourse and Medical Resource Procurement
Purpose of the Study:	The purpose of this case study is to explore and understand healthcare professionals' conversations and practices during the procurement process that results in the decision to purchase.
Problem:	A significant portion of a healthcare system's operating budget relates to medical resources. Professionals have different foci and perspectives on which medical resources to procure. Professionals engage in talk and practices that may influence the medical resource procurement.
Significance of the Study:	Healthcare studies usually revolve around communication, the exchange of information, and do not always consider the use of language or social practices. From a practical perspective, understanding the influences around medical resource procurement can provide a foundation on how healthcare systems devise conversations related to procurement.
Study Participants:	Clinical and nonclinical professionals who are directly involved in identifying and procuring of medical resources are the desired participants for this study. Data collection will include semi-structured interviews, observations, and document review. Interview participants will be asked to engage in either in-person or virtual sessions which will be audio recorded. After the interview, the audio recording will be transcribed and returned to the participant for verification of accuracy. Participants will be identified by numbers with a code link identifying the participant to the participant number. The code link will be secured and only the researcher will have access. Transcripts will have real names deleted. Names of study participants will not be shared; no one except the researcher will know that you took part in this study. All data collected in this study will be presented in aggregate form (all together). Every effort to maintain and protect confidentiality will be made.

APPENDIX B:

INFORMED CONSENT FOR PARTICIPATION IN A RESEARCH STUDY

Title of Research Study:	A Critical Discourse Study: Dominant Discourse and Medical Resource Procurement
Principal Investigator:	Ellen Goldman, Ed.D. Email egoldman@gwu.edu Telephone (XXX) XXX-XXXX
Co-Investigator:	Michele Dykstra Email mdykstra14@gwu.edu Telephone (XXX) XXX-XXXX

Introduction

You are invited to participate in a research study under the direction of Dr. Ellen Goldman of the Department of Human and Organizational Learning at the George Washington University (GWU). The purpose of this study is to explore and understand healthcare professionals' conversations and practices during the procurement process that result in the decision to purchase. Involvement in this research is solely voluntary. If you choose to participate, you may withdraw at any time. Further information regarding this study may be obtained by contacting Michele Dykstra, GWU doctoral candidate researcher, at xxx-xxx-xxxx.

The Study

If you agree to participate in this study, you may be asked to:

1. Share your experiences related to resource procurement in a 60- to 90-minute interview. The interview will be conducted either in person at a location of your choosing or virtually through a Go to Meeting, Skype, or Facetime.
2. You will be provided with a participant number at the time of the interview. A code link will be used so that your name does not appear directly on the interview responses. Any mention of real names will be deleted and replaced with participant numbers.
3. The interview will be recorded with your permission and the audio-recording will be transcribed. The transcript will solely be used for data analysis. You will be requested to review the interview transcript and provide any clarification on comments made during the interview.
4. Should additional information be needed, you may be requested to participate in a second one-to-one, face-to-face or virtual interview which will also not last more than 60 minutes. The interview session will be audio-recorded with your permission and transcribed. You will be asked to review the interview transcript and provide any clarification on comments made during the interview.

5. At the end of the interview, you will be asked for recommendations on organization-specific documents or names of others who are involved in the procurement process. Providing this information is voluntary and at your sole discretion.
6. Observations will take place during selection and decision meetings on purchasing of supplies, implants, devices, or pharmaceuticals that would occur during your normal course of business.

Please note you may stop participating in this study at any time and choose not to answer any of the questions. Participation in this study may benefit your healthcare organization as well as other healthcare organizations in understanding how resources are procured.

Risk and Confidentiality

The risks and discomforts associated with participation in this study are not expected to be greater than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.

The potential risks of participating in this study are minimal. One possible risk or discomfort you could experience during this study and through your participation in the interviews are persons outside of the research team may find out that you have participated in the study and may be able to connect you with the information you provided. Every effort will be made to keep your information confidential. In order to reduce these risks, the following steps are being taken:

- You will be provided with a participant number at the time of the interview. All interview and observation meeting information, including audio recordings and transcripts, will identify you only through this participant number (i.e., Participant #1). A code link will be used so that your name does not appear directly on the interview responses. Your name will not be mentioned in any transcripts and will not be included in any reports, publications, or presentations as a result of this study. Names of study participants will not be shared; no one except the researcher will know that you took part in this study.
- The corresponding participant name to participant identification number will be stored separately in a paper format in a locked cabinet. Only the researchers associated with this study will have access to any information that is personally identifiable.
- All data collected will be presented in aggregate form, in other words, combining all the data together.
- The audiotape files will be password protected and saved on a password-protected computer. Any and all handwritten notes will be kept in a locked cabinet that only I have access to. All the files and notes will be permanently removed from my files or computer and destroyed after six months following the completion of this study.
- To ensure confidentiality, your signature is not required. Your willingness to participate in this study is implied if you proceed and continue to participate.

Note: You will be asked whether you would like documentation linking you with this research; the participant's wish will govern.

Benefits to Taking Part in This Study

The findings of this study will not benefit you directly, but participating in this study will aid in understanding how resource procurement occurs, informing organizational processes.

Cost and Compensation

There are no costs to participate in this study. You will not receive any compensation for participating.

Problems or Concerns

Research-specific questions should be addressed to Dr. Ellen Goldman at **egoldman@gwu.edu** or telephone number (xxx) xxx-xxxx.

This research is being overseen by GWU's Institutional Review Board ("IRB"). You may talk to them at 202-994-2715 or via email at **ohrirb@gwu.edu** if:

- You have questions, concerns, or complaints that are not being answered by the research team or if you wish to talk to someone independent of the research team.
- You have questions about your rights as a research subject.

If you agree to take part in this study, please sign below. After you sign this consent form, I will provide you with a copy.

Participant Signature: _____Date: _____

Participant Name: _____

APPENDIX C:

TRANSCRIBER'S AND REVIEWER'S LETTER OF CONFIDENTIALITY

I have been asked to listen to, transcribe, or review the content of interviews for research related to a doctoral dissertation. I agree to maintain confidentiality regarding the identity of those interviewed and the contents of the discussions.

I understand that to maintain confidentiality means to protect all personal information, keeping the study participants' identity confidential, not sharing their identity with anyone, and keep their recordings safe while in my possession.

In preparing documents or manuscripts, I will not identify anyone by name and only use the designated aliases or codes.

I agree that I will not make any copies of the audio recordings that I have transcribed or transcripts that I may have reviewed. I will return all materials to the researcher.

Transcriber/Reviewer Name: _____

Signature: _____

Date: _____

APPENDIX D:

INTERVIEW GUIDE

Thank you for agreeing to participate in this research study on discourse and medical resource procurement. I am pursuing my doctoral degree at The George Washington University, and this study is being completed as part of my dissertation and requirements for graduation.

You were selected to take part in this interview because of your role in deciding which supplies, devices, implants, or pharmaceuticals should be purchased. Since we know each other professionally *(use as applicable),* the interview itself is not anonymous; however, your responses will be held as confidential.

For this study, I am focused on understanding the conversations amongst clinical and nonclinical professionals during identifying and deciding which supplies, devices, implants, or pharmaceuticals should be purchased. I want to hear your perspective on the conversations or writings that take place during the process to buy supplies, devices, implants, or pharmaceuticals. My goal is to understand what happens during these conversations which contribute to how supplies, devices, implants, and pharmaceuticals are selected for purchasing.

May we proceed?

Permission to Record: Do I have your permission to audio record this discussion? The audio recording will be transcribed to assist with data analysis.

To confirm with you, your responses will be reported anonymously, and your name will not be associated with your responses. So please feel free to share your thoughts and reflections openly and honestly. Feel free to not answer any question.

Any questions before we begin?

Participant Interview Questions

1. Please tell me about how long you have worked for the organization.
    a. Can you describe your current role? [Subject Position, Power Relations]
    b. Have you held other roles? If yes, please describe. [Subject Position, Power Relations]
2. How does someone start the process of procuring a supply, implant, or pharmaceutical?
    a. Can anyone start the process? [Subject Position, Power Relations, Practices of Textual Practices Production, Transmission, Consumption]
    b. How is the process of supply procurement structured? [Power Relation, Concept, Object, Subject Position]

c. Can you describe if there is any paperwork or request forms that need to be completed? [Practices of Textual Production, Transmission, and Consumption, Power Relations]

3. How would you describe your role in procuring supplies, implants, or pharmaceuticals being considered for purchasing within the [insert interviewee's department]? [Subject Position, Power Relation]
    a. How long have you been involved in procurement? [Subject Position, Power Relation]
    b. Were there any changes in your role?
4. Can you take me through the specific process of a supply, device, implant, or pharmaceutical [use designation as appropriate] that is currently (or recently) being considered and discussed for procurement?
    a. Can you describe how the conversations unfolded? Who was involved? What was said, by whom? [Subject Position, Practices of Textual Production, Transmission, and Consumption]
    b. Was there anyone that you thought should be involved in the conversations but was not? [Subject Position, Power Relations]
    c. Was there anyone involved in the process that you thought should not have been? [Subject Position, Power Relations]
    d. Was there anybody who did not want the supply, implant, or pharmaceutical? [Subject Position, Power Relations, Consumption]
    e. Was anything discussed or said about an alternative to this product? [Concept, Object, Practices of Textual Production, Transmission, and Consumption]
    f. Did you feel that your input was appreciated or was not appreciated? [Power Relations]
    g. What indicated that to you? [Subject Position, Power Relations]
    h. Did you feel that all who were involved in the conversations were able to speak up about the product? What indicated that to you? [Subject Position, Concept, Object, Power Relations]
    i. What was the outcome of these discussions? [Discourse/Dominant Discourse]
    j. If the decision to buy was made, did all participants in the process agree on the decision? If not all involved in the conversations agreed, who did not agree and why? [Subject, Object, Subject Position, Power Relations]
    k. If the decision to buy was not made, do you have an idea when the decision will be made? May I contact you in xx weeks [depending on answer] by telephone to discuss the outcome?
    l. How did you feel about your role in this procurement?
    m. Were there any problems or issues with this procurement?
    n. If you are creating a picture of this process, what would it look like?

o. Why did you create it that way? What are you trying to depict?

p. What should it look like?

5. Was the process of this procurement of [insert resource procured] different from other procurements?
    a. If yes, can you describe how this procurement was different?
    b. Why do you think this procurement was different?
    c. Was this procurement harder or easier? If so, what made it harder or easier?
    d. Could you share the outcome of the previous [insert product being procured] and what was said after the outcome?
    e. Use probing questions from Q3.
6. Overall, how would you describe the process of deciding which supplies, devices, implants, or pharmaceuticals [use appropriate designation based on interviewee] should be purchased?
    a. What may influence which products to procure?
    b. Could you describe any problems you think the process of procurement has?
    c. Could you describe what is being said about the process of procurement?

Closing: Do you have any questions for me at this point?

Thank you for your participation. I appreciate your willingness to participate and your insights. If you do have any questions or further insights, please contact me via my email at **mdykstra@gwu.edu** or call me at 631-872-2675.

APPENDIX E:

NONPARTICIPATORY OBSERVATION GUIDE

Date: _____ **Start Time:** _____

Observation Event: _____ **End Time:** _____

Participants: _____

Setting Attributes (in person, virtual, space, lighting, table arrangements, naming convention if virtual)
Participants (Who is present, their roles and titles, who is not present, their roles and titles, any standing members of this meeting and/or invited guests)
Topic of discussion What area, department, hospital is the supply, device, implant, pharmaceutical for? What type of supply, device, implant, pharmaceutical? Cost discussed? Reimbursement discussed? Conversation to influencers? (Name dropping etc.)
Observations What was said and by whom? Who received what was said? Did all participants contribute? Did participants spontaneously contribute or spoke only when spoken to? Did any one person talk more (or less) than another? Who provided the information about the topic? Was any evidence-based information provided? Who was silent during the interactions? What questions were asked? Were those questioned responded to, who answered, and what was said? What was the outcome? Did the outcome appear to be agreed upon by all participants? If yes, why? If no, why? Will another meeting be scheduled? Was additional information requested?

Researchers Behavior
What were my thoughts during this time?
Was I able to stay focused?
What was my role, and do I think that my presence had any impact on the process?