Turning theory and empirical research into reflective practice

Catherine Settle
Centre for Health Stewardship
The Australian National University
Hi everyone, thanks for coming

This is my plan for today, and I will be moving reasonably quickly through my first few slides as I situate my research within the overarching ARC Linkage project so that I have enough time to discuss my research methodology.
This is the title of the collaborative ARC Linkage project I have been working within

And when I mention it again throughout this presentation I’ll refer to it as the Citizen Engagement project.
These are the people and institutions involved in the Citizen engagement project

A defining feature of ARC Linkage projects is that they have industry partners, with the aim of creating - as the name implies - linkages between academia and industry.

In our case the industry partners have been 3 health policy departments, represented by the policy departments of ACT, Q, and SA Health
This has been the aim of the Citizen Engagement Project

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Citizen Engagement Project

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- March 2012: ACT Health Directorate: World Café and Open Space: ACT Chronic Disease Strategy
- July 2012: Qld Health: 21st Century Dialogue: Community Priorities in regard to Chronic Disease

And these are the various health policy issues and types of deliberative techniques that the jurisdictional health policy partners engaged with their citizens
So, having know situated my research within the Citizen Engagement project, the research data that I will be drawing on for the remainder of this presentation is derived from my fieldwork in these two jurisdictions.

The notion, citizen engagement, refers to the involvement of members of the public in the planning, development and evaluation of policies and services.

And deliberative means of policy development were chosen as the type of citizen engagement techniques for the Citizen Engagement Project.

Deliberative means of policy development are collectively known as deliberative mini-publics or often simply referred to as mini-publics, and these engagement techniques form part of a growing international, participatory-turn in policy making.

Mini-publics emphasis a democratically-deliberative process of public reasoning. Whereby, citizens are given opportunity to discuss, question, listen to others, reflect, and think critically with an open mind and a willingness to respectfully justify their arguments in terms that others
can accept.

Viewed holistically, these procedural features mirror certain democratically-deliberative standards which are now widely viewed as comprising the normative theory and principles which democratically legitimate the process and outcomes from a mini-public.
I have argued in my research, however, that although mini-publics are heralded as more democratic and meaningful forms of citizen engagement, the transferability of these democratically-deliberative norms to Australian health policy settings cannot be taken for granted, because citizens’ experiences of these public fora have received very little attention; even less in Australian health policy settings, where mini-publics are still fledgling means of policy development.

For instance, we have not known what genuine opportunities exist within these democratic innovations for citizens to effectively participate, let alone, participate on an equal-footing, and have their voices heard and valued.

These are important considerations because health policy is notoriously political and deeply contested. And problematising just how little is actually known of citizens’ experiences when mini-publics are applied in Australian health policy settings gave rise to these two key questions to concentrate my research inquiry.

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**Research questions**

Guided by 2 key questions:

- What are the citizens’ experiences of deliberating and exchanging knowledge - the epistemic practices - when mini-publics are used in health policy settings and how might these experiences be accounted for?
- What do these citizens’ experiences imply for the theory and practice of mini-publics in health policy settings?
Although there has been very little in the literature relating to citizens’ experiences in mini-publics when used for health policy, a recurring theme throughout the literature on citizen engagement is power.

Reflecting on relationships of power steered my attention towards one of the key sociological debates: that is, regarding agency and structure.

Essentially, the agency-structure debate refers to attempts made to understand the extent to which human behaviour is determined by social structure.

Many contending arguments have formed this sociological debate, though few contemporary social theorists contest the notion that social structures are the accumulated outcomes of the actions of many actors enacting their own intentions. Such intentions are, often, uncoordinated with others, and the confluence of actions on the part of participating agents can have intended and unintended consequences.

Of course, various manifestations of power are what form that bond between agency and structure and because power can manifest in so

### Power and the agency-structure debate

- Power is found everywhere in social life and its many forms and permutations vary depending upon whether we are dealing with individuals, social interactions, social settings, or wider social contexts.
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- Many contending arguments have formed this sociological debate, though few contemporary social theorists contest the notion that social structures are the accumulated outcomes of the actions of many actors enacting their own intentions; such intentions are, often, uncoordinated with others, and the confluence of actions on the part of participating agents can have intended and unintended consequences.
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many different ways, to be clear, my research has worked from the premise that power directly relates to our capacity to act and that that capacity can be enabled or disabled.
Faced with the challenge of how to explain what was ‘really happening’ within the relevant agency-structural factors sparked a foray into several, diverse epistemological territories and many different methodological approaches.

Ultimately, I adopted a critical realist perspective as the ‘best-fit’ for me and this piece of research.

Staking-out a realist epistemological approach does not, necessarily, mean that I adhere to the positivist notion that ‘the facts’ lie waiting to be revealed as a purely, objectively-understood, universal truth-for-all time.

Instead, the broad-church of approaches to realism vary; not least because adhering to a realist position does not entail any particular ontological or epistemological commitments. And a realist perspective soon appeared as most consistent with my view that social life is composed of both subjective and objective elements, which can be unpredictable and are ‘constituted by the actions of meaning-conferring humans’.

My research

Adopted a critical realist perspective for this qualitative and broadly, cross-disciplinary research:

- 28 semi-structured, in-depth interviews
- Participant-observations
- Document analysis
- Metaphor analysis
- Layder's Adaptive theory: deductive, inductive and abductive forms of reasoning
- Layder’s Theory of Social Domains: illuminates different facets of a common social reality. Provides ontological depth by displaying the objective, inter-subjective, and subjective factors
- Case studies
Working within the critical realist paradigm does, however, mean that I aimed to apply social research methodologies and strategies designed to increase knowledge, and to understand and trace the mechanisms and effects of the deeply intertwined behavioural and structural factors.

This included examining the way that these factors mutually influence each other, and involved a process of drawing upon different types of theory and evidence in a way that sought to determine the validity of certain propositions or claims.

Through this process ‘definitive accounts of actions, practices or institutions are possible’, yet inherent to such a claim is an important caveat: that such definitive accounts can later be challenged in light of new theoretical or empirical evidence which can overturn prevailing accepted beliefs.

And of particular value to my inquiry into the exchange of knowledge is the way that a realist approach goes beyond the sensory limitations inherent to the human experience, in its attempts to understand the objective nature of the social relations inherent to the social systems of our lives.

As you can see, my research has been a broadly cross-disciplinary piece of work and I have utilised several research methods in a qualitative way.

The analytic framework chosen for my critical realist approach drew upon two closely-linked theories: Adaptive theory and the Theory of social domains – each theorised and empirically validated by Derek Layder.
And for this presentation today, I will be emphasising these two components of my methodology.

Adaptive Theory originated in Layder’s concern about the gap between general social theory and research, and entails a process of a ‘two-way borrowing - from general theory to empirical research and from empirical research to general theory’; effectively, comprising deductive, inductive and abductive forms of reasoning.

So, although my research sits firmly in existing theory and my deductive perceptions of that, for any new theory to emerge, I also stayed open to the unexpected and inductively, emergent findings.

This was not a linear process but an iterative one of moving back-and-forth with each phase informing and refining the logical underpinnings of my abductive interpretations with the ultimate aim of generating theory that would contribute to relevant practice and existing bodies of knowledge.
Consistent with an adaptive theory approach, initial insights derived from the literature, and my past experiences and observations of mini-publics, were used as ‘orienting concepts’ to focus the drafting of my interview-schedule. For instance, the processes of exchanging knowledge, in particular, the epistemic practices that occur when mini-publics are used in health policy settings became a key orienting concept, and I used a variety of approaches in my line of questioning to tap into my interviewees’ thoughts, opinions and feelings on these things.

For those of you unfamiliar with the term, epistemic practices, essentially, it refers to the credibility given to someone when they are conveying information or, alternatively, when they are trying to understand information that has been conveyed to them.

With my interviewees’ consent, I recorded their interviews, and these conversations were then transcribed and entered into NVivo, from within which I coded my data.

The first-stage of analysis was done through the lens of the orienting concepts with which I had used to focus my interview-questions. During
this deductive phase, I developed coding in relation to how my interviewees’ responses related to my research questions and any other pre-existing theoretical constructs I was working with at the time.

This phase of analysis captured, for instance, the epistemic practices, and the metaphorical responses I had requested from each interviewee to describe certain experiences at their respective mini-public.

This coding process helped to gather all relevant material together, of which I was able to readily retrieve through searches enabled by NVivo, allowing me to easily develop more nuanced coding as my analysis progressed beyond the initial broad categories.

With the deductive findings clearly defined, it became easier to then identify and differentiate the emergent, inductive themes as I worked through my data again. For instance, emerging themes pointed to ‘participation frustrations’, the ‘opportunity lost’; ‘feeling safe’ was important to many; and the ‘emotional nature of health deliberations’ was also identified.

This inductive phase of analysis involved reading through the coding and listening to the recorded-interviews, repeatedly - this process remained a constant feature throughout my analysis and subsequent writing-up of my research into case studies, and helped to ensure that my interpretations stayed true to my data.
With all data analysed this way and with a view to theory development, I then worked through the data to differentiate behavioural from systemic concepts. From an adaptive theory perspective, behavioural concepts refer to certain features of human behaviour and social interaction; whereas systemic concepts are used to denote the key research problem derived from within the social setting and the broader contextual factors.

As such, systemic and behavioural concepts complement, and are closely intertwined within, each other. One example of how this process unfolded is with what began as a code labelled, ‘deliberative constraints’. These constraints had been identified in the citizens’ experiences at various points in relation to the respective mini-publics. Many factors were isolated; some lying at the behavioural level: with individual differences in ‘deliberative capacity’ becoming prominent.

But systemic concepts/factors were also deeply implicated. For instance, the way that the forum-questions were worded and the lack of time provided for effective deliberation soon became dominant systemic themes as it was evident that these factors were the direct result of the structure these citizens were required to deliberate within.
These concepts effectively became another way for me to bring order to the large amount of research data I had accumulated; with the point being that it would also help to identify the agency-structural factors within.
Although the agency/structural factors had become apparent working with behavioural and systemic concepts, I could not yet see a definitive pattern in my data which would prove resilient and consistent enough to lead to theory development. The process of analysis thus continued as I looked for ‘bridging concepts’ to help me find such a pattern in my data.

In adaptive theory bridging concepts depict ‘a fairly balanced, synthetic... connection between behavioural and systemic phenomena’ and represent the ‘combined effects of the objective world of “systemic” phenomena and the subjective and intersubjective world of “behavioural” phenomena’. In this sense, the validity of a bridging concept is inherent to its capacity to reference the duality of the concept.

There are three broad types of phenomena which bridging concepts represent or upon which may focus our attention as researchers: **firstly**, the agency/structure linkages as mentioned above;

**secondly**, bridging concepts may portray the ‘fact that certain kinds of social actors occupy strategic positions of control in social life’ and that those individuals ‘holding positions of authority or influence’ in
organisations and other social settings tend to be involved in relevant agency/structure situations.

The decision-making power held by certain health policy administrators represents the most pertinent example of this bridging phenomenon in relation to this research. In addition, the cross-disciplinary approach I had pursued enabled me to strengthen the conceptual bridges I was building by adding highly-nuanced, theoretical insight into the decision-making power on display.

And the third way a bridging concept can be used is to characterise the ‘nature of social relations that are significantly influenced by systemic features but which also express the nature of people’s involvements and their motivations’.

Examples of this type of bridging concept appeared in the form of the notion of intentionality and the intended and unintended consequences of health policy administrators’ decision-making and communicative actions.

For instance, by comparing and contrasting what the relevant health policy administrators in both the ACT and SA jurisdictions said they would be doing with what they did do, and how the citizens experienced those actions, I was able interpret the ensuing consequences as either intentional or unintentional with disabling or enabling outcomes.

The next and final phase in this process was comprised of tracing the various bridges thus displayed into a conceptual model, of which I will soon demonstrate. I then used that conceptual model as a template to reconfigure my earlier coded data within the trajectories defined. This process was analogous to a theory-testing and further theory-building phase.
To complement insights derived through the process of working as an adaptive theorist, I incorporated Layder’s Theory of social domains as a heuristic to guide my research analysis and in the composition of the qualitative case studies used to portray my empirical findings.

Viewing social reality through the lens of these four social domains illuminated different facets of the common social reality I was exploring and provided ontological depth to my analysis by explicating objective, intersubjective and subjective features.

In this research, the social setting domain represents the respective, policy jurisdictions;

The domain of situated activity marks the arrival and departure of the citizens from their respective mini-public;

And I have portrayed the social domain of psychobiography with my interviewees’ narratives, and boxed-entries called Participant portraits, which I compiled from information my interviewees gave of themselves, as well as, drawing on the metaphors they provided.

**Layder’s Theory of Social Domains (2006)**

Views social reality through the filter of four domains:

- **Contextual Resources**: outermost social domain. Focuses attention on the distribution of material resources and the historical accumulation of cultural resources, such as knowledge, social mores and values;

- **Social Settings**: this domain mediates between subjective and objective elements of social reality and displays aggregations of reproduced social relations, positions and practice which embody systemic [structural] aspects of social life;

- **Situated Activity**: distinguished by the arrival and departure of people in face-to-face interactions and their social [intersubjective] exchanges. This domain has a formative influence on meaning-making - given that meaning is also created and influenced by contextual factors and psychobiography;

- **Psychobiography**: this domain reflects an individual's unique self-identity in the context of their life experiences and social connections. It also identifies an individual's passage through time and space in the social world demonstrating how they have responded to the tensions of the dialectic of separateness and relatedness of all social life.
This brief overview of the theory of social domains is not intended to imply that phenomena can be isolated and fully-compartmentalised within any one of the four stated domains.

On the contrary, these social domains were shown to be intimately interlinked and to comprise a complex and multi-dimensional whole, with the nuanced and holistic view of social reality thus obtained, revealing the combined effects of the different manifestations of power expressed within the various social domains. Doing this, enabled the conceptual overview of findings displayed here.

Specifically, this conceptual model focuses attention on the pathway between contextual factors and decisions taken by certain health policy administrators at critical points of tension management, and the intentional and/or unintentional, enabling and/or disabling consequences for the citizens’ experiences of deliberating and exchanging knowledge.

Viewed from the vantage-point obtained by these citizens’ experiences, I describe the decision-making power expressed within the critical points
of tension management identified, as manifestations of either structurally reproductive agency: where the recreation of existing structures, including bodies of knowledge, was apparent and the status quo far more likely to be maintained; or as structurally transformative agency: where the opportunity for making a structural difference, including to bodies of knowledge, was enabled.
And as it transpired, the predominant path taken by the health policy administrators examined in this research was that of the ‘unintentional’ trajectory with ‘disabling outcomes’ for the citizens’ experiences of exchanging knowledge and expressing their deliberative capacities, of which I have interpreted as expressions of ‘structurally reproductive agency’.

With the confluence of these, and other research findings, casting doubt upon the validity of any claims that can be made of the democratic authenticity and legitimacy of mini-publics when applied in health policy settings, under such circumstances.
Investigating what ‘really happens’ regarding any particular phenomenon - when working as a critical realist - does not simply need to be about explanation, however; it can also ‘aid meritorious conduct’.

Indeed, the purpose of my conceptual model is not simply to direct attention to the decision-making outcomes from critical points of tension management - as important as doing that is. It is also designed to encourage critical reflection on the contextual factors that contribute to relevant decision-making within these inherently opaque decision-making processes, as well as, the ethical and political dimensions associated with the intended and unintended consequences of certain decision-making when mini-publics are applied in health policy settings.

With these points in mind, and by way of concluding this presentation, I will simply highlight here how the critical edge to my realist position encouraged me to transform certain unintentionally disabling factors found – essentially, using them in an inversely-instructive way - to formulate five propositions.

Time prevents an elaboration of these propositions but I will explain that
they are designed to promote an intentionally enabling approach to the use of mini-publics in health policy settings by creating a more democratically-deliberative environment whereby epistemic justice and deliberative capacity can flourish.

**Proposition One: Expanding the view of health policy administrators’ responsibilities**
An explicit and expanded understanding of what health policy administrators’ responsibilities entail is required when mini-publics are applied to health policy settings. This includes a requirement that health policy administrators take active steps towards understanding and exercising their epistemic responsibilities in relation to the norms of democratic deliberation, so that these norms become their critical guide when operationalising mini-publics.

**Proposition Two: Develop a communicatively rational approach**
An explicit communicative rationality is required when health policy administrators apply mini-publics. This requires the development of an intersubjective approach to their communicative competence to facilitate an understanding of the ways that communicative irrationality can disable the democratically deliberative nature of a mini-public. This communicative rationality is to have epistemic justice at its core, with structures in place to help correct any epistemic injustices identified.

**Proposition Three: Substantive equality to be used as a guiding deliberative norm**
That the principle of substantive equality is used to guide development of the requisite and more equitable opportunities that enable citizens to exchange knowledge and deliberate when mini-publics are used in health policy settings.

**Proposition Four: Mini-publics are a public service**
To counter the prevailing product-dominant logic an active reframing of the way health policy administrators approach mini-publics is required so that their approach to mini-publics is more akin to it being a public ‘service’ than a ‘product’.

**Proposition Five: Mini-publics warrant further research and development**
That a structured process of longitudinal research into the use of mini-publics on matters related to health and wellbeing is established.
So, thank you for listening.

This presentation complements my article published in the Conference proceedings and if you would like more details on my research you may like to refer to that paper, where you will also find my references for today’s presentation. Alternatively, please feel welcome to direct your questions to me at this e-address.