Name : Mayank Kumar
Roll No: 1402003

Information Technology in Healthcare:
A Practice-based Empirical Examination in India *Abstract*

The success of Information Technology (IT) implementation hinges on its inevitable interaction with the broader social order in which the actors engage with it through their work practices. To examine this interaction, literature has noted the significance of practice-based approach, which proposes that social order *lies* in the micro level human activities; social world is recurrently reproduced through actors' daily practices. This theoretical perspective enables examination of IT and social order interaction, and its associated challenges, by examining the daily human practices in which actors need to engage with IT. On the basis of this premise, current research has adopted practice-based approach and studied actors' practices for explaining two critical challenges associated with the interaction of healthcare IT (HIT) and the social order of healthcare.

The first problem focused in this research is doctors' resistance to HIT. While there is abundance of literature on IT resistance across various organizational and social contexts, doctor's resistance has become a critical *contextual* challenge in its entanglement with the unique power structure of healthcare. Doctors' resistance has been identified to be the result of freedom granted to them by larger society in the form of professional autonomy, which is a socially and historically rooted power; doctors' resist upon perceiving HIT use as a threat to their powerful status. While the extant literature consistently reports the criticality of doctors' perceived threat to powerful status in their resistance, here is a significant void with regard to scrutinizing *how* the threat to power is created. Considering this theoretical void and building on the premise that social world is recurrently reproduced through its micro level activities, an ethnographic enquiry extending over two years has been conducted to examine the interaction of HIT with doctors' power by examining the daily reproduction of Doctor-Patient-Interaction (D-P-I) practices at a large corporate hospital in India.

The findings of this study revealed that doctors' resisted HIT because of perceived threat in the reproduction of symbolic value of their embodied emotional capital through which they were reproducing their domination. Emotional capital, in its symbolic recognition, was allowing the doctors in better manifestation of clinical capital and building social capital in the form of long-term doctor-patient relationship. However, as an embodied capital, it existed as a trans-situational resource in tandem with doctors' habitus. Doctors perceived that while using HIT, they could not practice their habitus that was essential for the reproduction of the symbolic value of emotional capital. Therefore, doctors being the dominant actors, striving to regularly reproduce their domination, adopted conservation strategy to resist HIT.

However, resistance refers to a challenge that results from the actors' evaluation of HIT in their practice, and it emerges only when HIT has become a part of actors' reflexivity. Reflexivity refers to the ability of actors to carefully evaluate their immediate social context, which includes material IT artifact, and consider how the structure of that context is implicated to their practices. Reflexivity holds key implications for the change or reproduction of the social order.

The second study of this research focuses on the challenge resulting from the actors' *lack of* reflexivity. The challenge faced while implementing HIT for patient empowerment in Diabetes Care Management (DCM) practice is one such unique context of healthcare. Amidst the growing realization of patient empowerment in the effective management of diabetes, the

significance of HIT has been noted. However, one of the critical challenges in achieving patient empowerment is the deeply rooted structure of acute care model in the actors' daily doings of DCM practice. Literature has reported that this deeply rooted structure constraints actors' reflexivity in their practices, which is nevertheless essential for moving toward the structure of empowerment model of DCM practice. However, there is limited understanding about the interaction of HIT with this structure of DCM practice and the challenges this interaction poses in creating actors' reflexivity. An ethnographic examination of an unsuccessful case of HIT implementation at a sugar clinic in India has been conducted to reveal the challenges faced by the HIT in creating actors' reflexivity and being part of their consideration in the practice.

The findings from this study demonstrated that the failure of HIT in creating actors' reflexivity was a result of existing collective habitus that was defined around the acute care model. Because of its daily reproduction, the collective habitus had created a non-reflexive relationship between the structure of acute care model and the actors' daily doings of DCM practice. Aspects such as actors' roles and responsibilities, and control in the practice, around which that structure was defined, had reached in the universe of Doxa. The accomplishment of patient empowerment required creation of actors' reflexivity toward those aspects by bringing them in the universe of opinion, which essentially required *creating* an objective crisis—misfit between the habitus (embodied structure of acute care model) and the newer structure embedded in the practice. But as HIT traditionally was not a part of that structure, its successful implementation met with a challenge of being unable to create that crisis on its own; a concomitant change in the structure of practice was required.

Together both the studies reveal crucial theoretical insight about the role of actors' *habitus,* which in embodying the social order creates challenge on the actors' engagement with (H)IT in their practices either in form of resistance as a result of perceived threat on habitus (findings of study 1) or by creating sense of limits to the actors (findings of study 2). Social order of healthcare is instilled in healthcare professionals' habitus during their clinical education, which subsequently becomes significant in their engagement with HIT as they practice that habitus in their practices.

Along with these theoretical insights, the findings have significant practical implications as well for the healthcare providers and policy makers. While the first study has stated about the need of making HIT as part of doctors' early education where the habitus is built, the second study informs about the need of concomitant change in the structure of practice by making HIT a part of that structure during its implementation. However, at the same time, doing any change in that structure may result in their resistance. Thus, the larger implication deduced from this research is to make HIT a part of healthcare professionals' medical education where their habitus is primarily built, which will gradually become the habitual and dominant way of performing the practice.

Keywords: Healthcare Information Technology, Resistance, Empowerment, Practice Theory, Bourdieu, Healthcare, Chronic Care Management.