Instilling and Distilling a Reputation for Institutional Excellence: a critical Reflection on Organising Practice

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Declaration

I declare that this thesis has been composed by myself and the research reported in it is my own work.

Signed:

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2nd October 2001

Abstract

In this ethnographic investigation of a general hospital, I critically analyse a much lauded corporate culture. Rather than accepting the managerial and academic claims concerning the mobilisation of corporate culture at face value, in this study I build upon a labour process analysis and take a close look at how it actually seems to work. By means of a six month field study of day-to-day life in the hospital's nursing division I explore and describe how executive managers seek to design and impose corporate culture change and how it affects the nursing employees of this organisation. The results lend little support to the official claims that if managerial objectives are realised, they are achieved through some combination of shared values and employee participation. The evidence lends more support to the critical view in labour process writing that modern cultural strategies lead to increased corporate control, greater employee subjection and extensive effort intensification. The contradiction this brings into the working lives of the employees leads to the conclusion that the rhetoric of corporate culture change does not affect the pre-existing attitudes and value orientations of nursing employees. However, there were considerable variations in how employees received the managerial message and thus affecting, by their degree of misbehaviour and adaptation, the organisation itself as well as using the cultural rhetoric against the management for their own ends.

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Introduction and Overview of the Study

How it all began...

This doctoral thesis began with the question of how institutional excellence is facilitated and constrained by everyday management practices. This question has persistently attracted extensive attention in the health care sector and the often repeated maxim today is to '[f]ocus on those who are succeeding!' So said Marlene Kramer and Claudia Schmalenberg in the abstract of the article *Magnet Hospitals: Institutions of Excellence* (Kramer and Schmalenberg, 1988a, p. 13). That is what Kramer and Schmalenberg's report does. But that is also what other people's reports do. The idea of mobilising corporate cultures is being heralded in these reports as a way of replacing rigid bureaucracies and unclear communication lines with more task-centred, decentralised, human-based organisations involving cultural ideologies of co-ordinating productive or service-oriented activities. The particular merit of this approach has been strongly advocated by influential management thinkers of excellence (e.g. Peters and Waterman, 1982) and corporate culture (e.g. Deal and Kennedy, 1982) as well as by advocates of total quality (e.g. Crosby, 1979) and human resource management (e.g. Legge, 1989, 1995). Academics have identified moves toward a change of culture as a prominent feature of a broader trend in the direction of more humanistic and flexible organisations that allegedly facilitate a continuous improvement of production and service delivery processes and, in turn, contribute to sustained quality performance, claiming it is the most popular form of corporate change (e.g. Kanter, 1985; Schein, 1985, 1991, 1992, 1996; Handy, 1986). The mobilisation of corporate culture forms part of a broader movement to develop specific behavioural and normative innovations and a heavily involved workforce in which managerial control is allegedly replaced by internal commitment and shared understanding. Even those who question the substance of claimed shifts away from traditional, modernist forms of working arrangements have concluded that cultural management is unlikely to disappear from the workplace because it is part of a modern trend in changing day-to-day practices at work (Thompson and Findlay, 1999).

In a recent literature review, Thompson and Findlay (1999) have noted the diversity of traditions in which corporate culture has been featured, including high trust work relations (e.g. Peters and Austin, 1985; Peters, 1988b, 1992), empowerment (e.g. Kanter, 1985, Foy, 1994), innovative teamworking (e.g. Peters, 1988a; Drucker, 1992b) organisational learning (e.g. Senge, 1990, 1992; Reich, 1993) and transformational leadership (e.g. Burns, 1978; Kets de Vries, 1989, 1990). Conspicuously present in this review are highly critical conceptions of management and organisation and some references to case studies conducted within a labour process research tradition (e.g. Ogbonna and Wilkinson, 1990; O'Donnell, 1996; Harris and Ogbonna, 1999). These studies have shown how, especially when combined with participatory and skill-enhancing schemes, the project of changing the culture of an organisation can discourage employees or encourage their resistance by strengthening managerial control and increasing effort intensification in the name of progressive organisational development and the more effective management of human resources. Others have voiced concerns about the discursive and potentially totalitarian features of the mobilisation of corporate culture and claim that the fundamental rules underlying the approaches of excellence, empowerment, total quality and human resource management are effective by means of cultural ideologies and discursive practices (e.g. Rose, 1990; Willmott, 1993; Casey, 1995). Ironically, even critical commentators, who perceive the idea of changing the culture of a corporation as a mode of attaining 'total' control and a new form of effort intensification (e.g. Sewell and Wilkinson, 1992a-b; Sosteric, 1996; Ezzy, 1997), also tend to subscribe to conceptions of disciplinary power in terms of agency and responsibility.

The purpose of this thesis is to contribute to a small number of critical, in-depth studies of the mobilisation of corporate culture by building upon, and explicating, a labour process analysis in which the rationality or effectiveness of the managerial or post-structural conceptualisation of corporate culture is neither taken for granted nor presumed. Nonetheless, while the labour process perspective displays an awareness of the degree and intensity of management control and highlights areas of conflict

and employee resistance, it also exhibits some theoretical limitations. In particular, in its wish to provide a more critical account of the labour process in manufacturing and service industries, it does not hold the view that managerial control over workplace relations works differently in the health care sector where the traditions of professional autonomy and an ethic of service are shared by the employed occupational groups. In this thesis I share the labour process desire to analyse the importance of organisational politics and the wider context of power but, in my case, not for the purpose of illustrating the commercial motivations and market pressures that characterise the control and organisation of contemporary work in the private sector. Even if I support a labour process theory of capitalist and other class-divided forms of work organisation in the health care sector, I would be sceptical of any attempts to apply them because of the different mode of rationality that derives from the health care sector professionals' labour process (O'Connor, 1973; Habermas, 1976a-b; Offe, 1975a-b, 1976a-b). However, it is neither insensitive nor wrong to promote a labour process analysis in the health care sector where the conceptions for the practical realisation of corporate goals are generally the same as in the production industries or commercial service sectors.

Moreover, managerial or post-structural supporters of the concept of culture in the health care sector rarely support their claims regarding the search for institutional excellence with detailed historical and empirical analyses. In this thesis, I combine a critique of the managerial and academic claims about changing the culture of an organisation with a critical realist ethnography of its introduction[1] (Bhaskar, 1977, 1989, 1998). This includes the use of documentary material to justify and control the everyday cultural practices as a way of contributing to an improvement of service quality and corporate effectiveness with a minimum of human and financial resources. The aim of the present study is, therefore, to explore and describe the

[1] The study is not principally directed at answering a research question in the usual sense. The idea of mobilising corporate cultures is developed in the present study as a rhetorical and practical mechanism of improving managerial effectiveness and organisational success. I have also examined the impact of this upon the organisation's people and their work. Furthermore, I have investigated the so-called socio-political and historical context and take a wider view of ideologies and practices to examine the day-to-day practices in the study.

nature of the contemporary forms of cultural initiatives within the wider organisational context and to consider the extent to which management intends, and is effective in changing the people.

The analysis I present here of corporate culture change at Jo-care – a pseudonym for a successful hospital in Germany[2] - broadly confirms the assessment of those who have appreciated cultural initiatives as means of improving effectiveness and competitiveness. The mobilisation of corporate culture appealed to Jo-care's authority when the commissioned report from management consultants indicated that these change agents could provide a cost-effective, continuously improving way of enhancing service quality by responding more rapidly to shifting health care demands, competitive pressures and business opportunities. Like analysts of other accounts of excellence, empowerment, total quality control and human resource management, I also pay attention to cultural-ideological dimensions and social confines. But instead of viewing the concept of corporate culture as an 'adaptive-regulating mechanism' that promises 'to serve human biological and psychological needs' and 'to effect system stability' (Legge, 1995, p. 186), I show how its introduction in Jo-care was embedded in a socio-political and historical context of work organisation. While appearing to bring forth a general advantage for the hospital's people, the project of changing its corporate culture can obscure otherwise clear features of re-organisation at the workplace (e.g. Webster and Robins, 1993; Smith and Thompson, 1998; Ackroyd and Thompson, 1999). These features include representing the utilisation of employee's knowledge as participation and staff development (e.g. Jacques, 1996; Milkman, 1998, Warhust and Thompson, 1998a-b) and the concealing of enhanced management control in the rhetoric[3] of high trust work relations (e.g. Whitston and Edwards, 1990; Kunda, 1992; Reed, 1995). While it is accepted that cultural programmes can provide managerially wanted, cost-effective and innovative outcomes, as it did in Jo-care, I question the claim of those

[2] A full explanation of this pseudonym, and other terms used throughout this thesis, can be found in the Glossary (see Appendix One).

[3] In contemporary critical discussions on management theorising the word rhetoric is used as a form of 'consciously persuasive communication' in which rhetorical elements are central to managerial purpose and existence (Thompson and O'Connell Davidson, 1995, p. 17).

organisational analysts who have noted that the "optimism of the management writers and others is better supported (...) than the pessimism of the control school" (Rosenthal, Hill and Peccei, 1997, p. 497). I extend this critique in the following empirical and theoretical ways: firstly, I highlight the broader social and organisational context, and the pre-dispositions and power resources of people inside and outside the hospital's labour process in justifying the introduction of a new cultural politics and supporting its day-to-day practice; an issue generally 'underplayed or ignored' by organisational sociologists (Thompson and Findlay, 1999, p. 177). Secondly, my examination of the deployment of two rhetorics on culture contributes to a small but growing body of research undertaken by labour process analysts that explores and describes how the use of bureaucratic and normative control is implicated in processes of organisational change. Thirdly, I take care to address the disparity between the claims of the cultural rhetoric and the reality of its day-to-day practice and then add an understanding of how nurses' common sense of identity and values as well as their working conditions make them more or less responsive to moves in the direction of corporate culture change.

Issues and Themes

In the chapter which follows this introduction an attempt is made to provide a comprehensive literature review, which forms the background for the detailed account of the design, management and experience of one corporate culture and its relation to control as it is manifested in the day-to-day life of one hospital and its people. Thus, in Chapter One I look in greater detail at the managerial and academic claims concerning the mobilisation of corporate culture and go on to emphasise the impact which the literature of corporate culture management has had on individuals and organisations. Here, I also highlight the restrictions of the applied research approaches and argue that this literature is limited in that its conceptualisation of corporate culture change is incomplete. The same chapter also emphasises how many works concerning the mobilisation of corporate culture adopt a post-structural perspective, thereby neglecting much of the conflict and contradictions which occur as part of the labour process. The focus switches then to a range of literature which

has been used to study organisational change with a labour process perspective and explains why an approach based upon the study of the disparity between the cultural rhetoric and the day-to-day practices as well as of how people experience and respond to that disparity is to be preferred. While the disparity and people's experiences are important, what is also needed is a critical review of the political economy of the 1990s and the wider organisational context that has been evident in order to secure change within the health care sector. In Chapter Two I gain substance from a variety of viewpoints in order to discover a suitable way of putting the matter of interest into context. Drawing on the analytical framework of the sector model, which differentiates in the economy between private and state production sectors, it is possible to distinguish the different modes of rationality governing each sector. As a basis for further contextualisation, the powerful and privileged positions of health care professionals and the distinctive character of their employment relationship are considered. Building on this comprehensive, multidimensional framework, and as a response to the practical and ideological implications of cultural initiatives, I then introduce an ethnographic approach for labour process analysis. Here, the methodology used, and some of the concerns and potential personal and cultural biases that may have influenced the way in which the overall argument was put together, are discussed. In Chapter Three I offer a personal and subjective account of the time I have spent, and space I have occupied in the ethnographic field. How I negotiated access to the hospital as well as the methodological and analytical procedures applied in this research work are accounted for as well. Furthermore, I tackle the questions of informed consent and my own conduct as an ethnographic researcher in everyday practice. In Chapter Four I address the complex issues of how the German health care system and its recent reforms are structured. In this chapter I look at the fundamental principles and policies by which the German health care system is organised and discuss some of the impacts of the recent health care reforms and practices on the hospital sector[4]. This provides a view of the broader external and societal context as required for labour process analysis. In Chapter Five I give a

[4] The following discussion is limited in its reference to policy areas outside the health care sector and to welfare policy developments in countries other than Germany.

general overview of the health care organisation and its nursing division where the ethnographic research was carried out. The description of the formal hospital setting provides a basis for readers to familiarise themselves with the general, architectural and personnel background picture. The particular reason for this chapter is that it provides insight into structural forms and their relations within the comprehensive, multidimensional framework of labour process analysis. In Chapter Six I describe the development of the hospital and its nursing division, its history, employee population and some of the relevant practices and policies that represent its cultural life. The complexity of the hospital's reorganisation becomes visible within this socio-political and historical analysis of the labour process as I describe the development of chief executive management and as I present the substance and form of the new management approach; an approach which means that a consciously persuasive rhetoric has been introduced that clearly reflects a belief in the mobilisation of corporate culture. In Chapter Seven I explore the actual language and day-to-day practices through which the new culture seems to be brought to life. The scenes and inter-/actions where the rhetorical elements and the day-to-day practice (do not) meet are further explored and outlined. The analysis focuses on the following themes: service-orientation towards people and people's needs, the generation and utilisation of knowledge, people's awareness of expenditure and the implications, and public relations and the marketing of services. In Chapters Eight and Nine I examine and describe the complexity of the day-to-day practice and the employee responses that are provided under the managerial rhetoric. The analysis focuses on the following questions: Who are the agents of corporate culture change? And who are the subjects? How is the cultural rhetoric transmitted? What happens in the day-to-day practice? What is the nature and impact of the cultural rhetoric? How do people experience and respond to the cultural rhetoric in day-to-day life? In short, what has the cultural rhetoric done to the organisation's people and what have the organisation's people done to the hospital, its management and their patient clientele[5]? The concluding discussion and reflection outlined in Chapter Ten gives

[5] Instead of using the often repeated misnomer of the patient as the customer, I will use the term *patient clientele* to refer to all people who seek the advice of health care professionals and who are under the protection of the hospital.

an overview of the main findings and summarises this research. Despite the winds of change in economic and political respects, the health care ethos of the nursing division, the hospital's labour process and social life are shown to be the most influential factors to its purposeful corporate system.

Chapter One

Theorising Culture: Institutional Excellence and Control

Introduction

The managerial and academic literature concerning the mobilisation of corporate culture is very diverse and could lead in various research directions. For the purpose of brevity the aims of the literature review in this doctoral thesis are firstly, to discover which work has been conducted relating directly and indirectly to the research interests; secondly, to refer to a number of studies that are thought to be related to this piece of work from other related areas; thirdly, to analyse the literature in detail and find interrelationships between previous research results; fourthly, to examine and review the written material in terms of content, method and theoretical perspectives and finally, to learn from the past in order to challenge the future and to increase the body of knowledge in the social science domain.

This review, of course, does not cover all the literature which could be placed under the 'culture banner' (Thompson and Findlay, 1999, p. 164). For instance, I am not concerned with influences upon culture that are beyond the control of managers and the identity formation and self-organisation of employees. Thus, influences upon culture in terms of ethnicity, nationality, gender and age have nothing to do with this particular case. It does, however, concentrate on selected considerations which affect hospital organisations and sets limits as to how far their cultures can be changed. Some of these considerations also provide empirical evidence to highlight the changing nature of culture over different periods of time.

This chapter has five sections and begins with an overview of how the idea of changing the culture of an organisation has been conceptualised. This is then followed by a section which aims to briefly re-trace the steps of how the culture concept developed in the management and academic literature. The third section in turn presents the theoretical and analytical underpinnings of the discourse of corporate culture change within the social science domain. It documents a critique of

the functionalist and interpretative perspective and argues that such perspectives of organisations are flawed in that their conceptualisations of corporate culture and change are incomplete. The next section illuminates the dark side of the project to change the culture of an organisation, by drawing attention to the subjugating implications of its excellence prescriptions. It displays principle areas which are either ignored or insufficiently addressed by the extant culture literature and subjects case studies concerned with the structuring of meaning and the subjection of employees to critical scrutiny. Finally, in the fifth section, an attempt is made to put the human subject back into organisational analysis and to review the major contributions to management and organisation studies, from labour process orthodoxy to structuralist labour process theory. The contemporary analyses give important insights into how control of the labour process is never complete and show that attempts to change the culture of an organisation only serve to create conflicts and contradictions as people resist and struggle to come to terms with the demands made of them. It is then suggested how the concept of corporate culture, widely researched as an aspect of management, can be understood to be constituted differently in health care organisations where the traditions of professional autonomy and an ethic of service are shared by the employed occupational groups. The result of this review of the literature is that most of the existing organisational analyses have little to say about the relationship between cultural change and the work of managers and nursing professionals within the health care sector.

In Search of Excellence

During the early 1980s a central theme around the culture of organisations emerged when Peters and Waterman (1982) began to search for the most excellent organisations which were assumed to have magical qualities. These highly regarded American corporations described in *In Search of Excellence* were essentially employee and customer oriented as well as innovative and productive organisations. What sparked off the enormous public interest was the assumption that the culture of an organisation could actually be managed towards achieving greater effectiveness and a model of eight key criteria, found in the most successful business enterprises,

was identified which could be used as an instrument for obtaining competitive advantage and organisational success. For example, both authors were captivated by the managerial approach carried out by the executives of Hewlett-Packard (HP) who had established a corporate culture famed for strong team commitment coupled with a philosophy of innovation through people. Although something like the procedures of HP were linked to a set of shared values, beliefs and meanings, often drawn from the heroic stories of Bill Hewlett and Dave Packard, it was always obvious that these founding leaders reinforced their business strategy through an appropriate control and support system. This *HP Way* created a collective identity and sustained corporate objectives that were aimed at providing guiding principles for all decision making by people and an organisational climate in which high employee satisfaction, commitment and productivity could occur. If this distinctive route is taken as an example of the pursuit of excellence, then it reveals that organisational culture and organisational performance are 'close bedfellows', since one was thought to be inextricably linked with the other (Wilson, 1992, p. 73).

The excellence tradition, which emerged following the publication of Peters and Waterman's book in 1982, was to promote the concept of culture in a way unprecedented in management theory and practice. Strengthening the culture of an organisation was seen to engage directly with people's sense of self, securing 'an exchange that is more than economic' (Kunda, 1992, p. 209). What is important to note is that the management of people's self is working in mutual consistent ways; i.e. the promotion of the values of self-actualisation, freedom and 'respect for the individual' influence human resource policies and quality management (Rosenthal *et al.* 1997, p. 483). Here, as Thompson and Findlay (1999) note, people "are acted on, but they also have to pick up the cultural cues and construct an organisational self" (p. 163). Anyone who reads Kramer and Schmalenberg's investigation of life in 16 *Magnet Hospitals* (1988a-b) is able to discern the plausible story of how the notions of excellence began to permeate the everyday perceptions and language of

employees. In their intensive, on-site, follow-up study[1], they followed the eight attributes described in Peters and Waterman's book and searched for what it takes to achieve and sustain an *Institution of Excellence*. The results were manifold, and in terms of job satisfaction and nurse turnover, Kramer and Schmalenberg (1988a) stress that these hospitals "may be dealing effectively with the nursing shortage by creating organisational conditions conducive to eliminating internal nursing shortage" (p. 13). They concluded by revealing that these *Magnet Hospitals* possess the same characteristics that Peters and Waterman (1982) found to be characteristic of the best-run American corporations:

> They are infused with values of quality care, nurse autonomy, informal, nonrigid verbal communication, innovation, bringing out the best of each individual, value of education, respect and caring for the individual, and striving for excellence. They are lead by nurse leaders and managers who are zealots in holding and promulgating these values. Many of the basic principles of the excellent companies are clearly present in the magnet hospitals (Kramer and Schmalenberg, 1988b, p. 17).

As the popularity of the approach spread, more organisations joined the bandwagon of excellence, trying to emulate IBM, Disney, McDonald's and other examples of institutional excellence (e.g. Kramer and Schmalenberg, 1993; Buchan, 1993, 1994, 1999; Fuszard, Green, Kujala and Talley, 1994a-b). Yet approximately two years after the publication of Peters and Waterman's book (1982), *Business Week* (1984) provided empirical evidence that a number of these highly regarded American corporations in the face of change were experiencing severe problems and may not be so excellent. That is, the subsequent business performance of the cultures of excellence named by Peters and Waterman (1982) was no better than the performance of other organisations selected at random[2].

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[1] In 1982 the American Nurses' Association sponsored the original magnet hospital study, which resulted in the designation of 41 hospitals across the US as *Magnet Hospitals*; i.e. hospitals that had been particularly successful in attracting and retaining well qualified nursing staff and had reputations as being good places to work and as giving good nursing care (McClure, Poulin, Sovie and Wandelt, 1983). See Buchan (1999) for a short review of the research base for *Magnet Hospitals*.

[2] Further criticism that has been levelled at the concept of achieving change towards a model of excellence was the virtual omission of key business sectors and the poor sampling among the case studies (e.g. Silver, 1987; Wilson, 1992; Guest, 1992).

What many researchers have also discovered concerning the reality of these corporations was an attempt by them to undertake a generalised change programme, wrapped up in new language and practices (e.g. Silver, 1987; Delamarter, 1986; Thompson and McHugh, 1990, 1995; Guest, 1992; Trapp, 1993; Willmott, 1993; Newton and Harte, 1997). For example, Silver's (1987) analysis of McDonald's 'no-boss structure' and its organisational performance is very different from that of Peters and Waterman (1982). He interprets this lively, 'people-oriented' culture as one of 'speeded-up Taylorised work', where de-skilled and monotonous part-time jobs are the order, backed up by a ready supply of cheap young labour which is not unionised (p. 110). Similarly, Delamarter's interpretation (1986) of IBM's success lies largely in its monopoly position in the market rather than in any superior product, managerial style or organisational culture. In the IBM case, he states that

> IBM's success is the result of a sophisticated strategy for exploiting its substantial power - power that its competition cannot match. As a result of its power, IBM's competitors cannot win. If they ever get close, IBM changes the rules in its own favor (pp. xvi-xvii).

However, in other empirical studies the links between organisational culture and organisational performance appear to be rather conclusive. For example, it is interesting that Kramer (1990) re-visited the *Institutions of Excellence* and she is careful to show that the *Magnet Hospitals* used an innovative and challenging programme to change corporate structures and processes with a value-oriented message:

> The most frequently mentioned new activities in the 14 hospitals were: 1) redesigning or further developing new nursing care delivery systems (n = 13); 2) designing, expanding, or differentiating nurse roles (n = 12); 3) developing programs and activities to enable or to empower staff (n = 12); 4) strengthening collaborative practice (n = 11); 5) flattening the organisational structure (n = 10); 6) strengthening computerisation programs, particularly those for documentation (n = 5) (p. 43).

Kramer's follow-up study of 16 *Magnet Hospitals* was drawn from a sample of 14 individual respondents; i.e. the chief nursing executives of these hospitals. The research data from telephone interviews and statistical and demographic figures

indicate that the trends and patterns, many of which were just becoming evident in the first investigation, were found to be well established in the second. That is, a variety of innovative and challenging programmes appeared to be positively related to creative and successful solutions to problems of that time, especially where they were a consistent aspect of organisational culture. Therefore, it might be argued that promoting cultural change towards this end would be worthwhile in the pursuit of better organisational performance. The research data raise even more questions about the concept of organisational culture and its performance because Kramer (1990) reveals that these 16 *Magnet Hospital* appear to focus strongly on 'doing the ordinary things extraordinarily well' (p. 43).

Paying attention to employees, not working conditions *per se*, the excellently managed organisations have been mainly associated with specific normative and behavioural programmes, such as the continuous improvement of production and service delivery processes (e.g. Heskett, Earl Sasser and Hart, 1990; Schlesinger and Heskett, 1991; Fitzsimmons and Fitzsimmons, 1994; Büssing, 1997; Meurer and Riegel, 1997; Reschke, 1997; Aschè, 1998; Amelung, Aschè and Bender, 1998; Büssing, Barkhausen and Glaser, 1998; Müller-Bellingrodt, 1998; Hildebrand, 1998, 1999; Schmidt and Visse, 1998). On a related matter, the route to service quality is also seen through the attitudes and value orientations of employees and is linked to the development of a culture of total quality among all organisational people (e.g. von Reibnitz and Güntert, 1996; Hill, 1995; Dickens, 1994; Kaltenbach, 1993; Watzka and Watzka, 1992a-b; Kellnhauser, 1991a-b, 1992; Riegl, 1992; Wilde, 1991; Günthert and Horisberger, 1991). As noted in Crosby's *Art of Making Quality Certain* (1979) "[q]uality is an achievable, measurable, profitable entity that can be installed once you have commitment and understanding and are prepared for hard work" (p. 291). Thus, the rhetoric of quality management is aimed at bringing about a variety of creative and successful day-to-day practices and responsibilities at work. The same rhetoric is also found in the ideas of the human resource management literature, that managers should place an emphasis on recruitment, reward and retention strategies which increase employee motivation and flexibility in place of

command and centralised control (e.g. Legge, 1989, 1995; Pfützner, 1988; Sisson, 1989; Storey and Sisson, 1989; Storey, 1989, 1992; Purcell, 1989; Torrington, 1989; Sprenger, 1991; Gowler, Legge and Clegg, 1993; Borsi and Schröck, 1995; Eichhorn and Schmidt-Rettig, 1995; Nientiedt and Dobat, 1998).

All these ideas seem logical enough but they do raise a considerable problem. How can managers initiate and sustain this kind of commitment and shared understanding? As a response to this question Peters and Waterman (1982) stress that people's greatest need is to find meaning in their working lives and the main managerial task is to create meaning. They refer to the use of stories, slogans, symbols, rituals, legends and myths which together convey the values, beliefs and meanings that are shared among organisational people:

> [A] set of shared values and rules about discipline, details and execution can provide the framework in which practical autonomy takes place routinely. (...) By offering meaning as well as money, they give their employees a mission as well as a sense of feeling great.. Every man [sic] becomes a pioneer, an experimenter, a leader. The institution provides guiding belief and creates a sense of excitement, as sense of being a part of the best, a sense of producing something of quality that is generally valued. And in this sense it draws out the best (pp. 322-3).

Thus, the excellent organisations are the way they are because they are organised to obtain extraordinary effort from 'ordinary human beings' (Peters and Waterman, 1982, p. 81). With ordinary human beings they refer to the 'transforming leaders' of organisations who have to engage in an unusual effort to do their job with great passion in order to engender enthusiasm and commitment among employees (p. 82) (e.g. Burns, 1978; Deluga, 1988; Peters 1988b; Kets de Vries, 1989, 1990; Müri, 1989; Darcy and Kleiner, 1991; Deluga and Souza, 1991; Wey and Krause, 1991; Pestalozzi, 1991; Dienemann and Shaffer, 1992; Zaleznik, 1992; Gray, Bebbington and Walters, 1993; Dillard, 1993; Jackson-Frankl, 1993; Rowsell and Berry, 1993; Ryan, 1993; Preston and Saunders, 1994; Ogger, 1995). Transforming leadership thus provides the key to excellence:

> The manager who attempts to change the organisational culture must assume, in effect, the role of a missionary. If the manager is successful in converting key

> personnel to the new set of values, then appropriate symbolic change should follow. (...) As with any new proselyte, organisations which are converting their cultures can be helped in this process by institutionalising new rituals, symbols, languages, and heroes. Considerable efforts at socialising people in the new value system will be required. This will take the form of memos and directives from top management, discussions among members, circulation of stories which emphasise the new values, and reward systems which praise those who serve the new values (Ulrich, 1984, p. 126).

This dissemination of values, beliefs and meanings may be strengthened by a more formal programme to train new and existing employees, for example in terms of service-expectations, as well as a specific cross-departmental conference and meeting structure to imply the necessity for identifying and distributing the new values (e.g. Hart, Heskett and Earl Sasser, 1990; Höhler, 1991; Gerken, 1993; Warnecke, 1993; Rashford and Coghlan, 1994; Young, 1995; Rahmstorf, 1996; Bleses, 1997; Mühlbauer, 1999). Alternatively, the emphasis may be placed upon the creation of mission statements or an organisational philosophy to enable employees to identify themselves with the organisation and to perform in wider functions within the corporate work place (e.g. Hildebrand, 1999; Bleses, 1997; Schank, Weis and Ancona, 1996; Uys and Smit, 1994; Gärtner, 1994; Curtin, 1993; El-Namaki, 1992, Thomson, 1992). For such commentators, the economic, political and social advantages and implications were immense and such emphases were applicable to all re-organisation in the world, both to those in the private or public sectors, and to those within the service or production industries. Up to the present time, however, there are only few publicised accounts of organisations claiming to have succeeded in changing their organisational culture.

The Career of the Culture Concept

The extent of Peters and Waterman's (1982) model of excellence was considerable because 'it reminded managers what they were supposed to be doing' (Colville, Waterman and Weick, 1999, p. 131). The other three key accounts of this period - Deal and Kennedy's *Corporate Cultures*[3] (1982), Pascale and Athos' *The Art of Japanese Management* (1982) and Ouchi's *Theory Z* (1982) - were also influential in

[3] Terrence Deal and Allan Kennedy (1982) acknowledge Tom Peters as 'the intellectual and spiritual godfather' of their book, *Corporate Cultures* (p. iii).

helping to lay the foundation of the organisational culture concept[4]. All four books became best-sellers and, as Parker (1998) notes, made it almost an obligation in the following years that "humanistic writings on management and organisations should contain a textual nod in the direction of culture" (p. 3). In fact, the very wide claims made for the success of cultural change have led to an enormous level of interest in which it has been praised as one of 'the most significant advances in the history of organisational studies' and as 'the herald of a new renaissance in management' (Anthony, 1994, p. 4). That is, a new school of thought developed, emphasising the human role in organisations and the importance of employee commitment and shared understanding for successful organisational change[5]. As Colville *et al.* (1999) so eloquently put it:

> If it was reminding managers via the excellent companies what they ought to be doing, then it was also saying to academics that not have you been focusing on the wrong things but your research methods also need to change if you are to engage in the type of theorising that can account for what it is the excellent companies were doing (p. 132).

Even though the majority of the writers had not been familiar with the procedures of promoting culture as a social and normative glue and source of increased productivity, they engaged with the reproduction of the 'strong' cultural claims (for illustrative nursing accounts see, for example, Magers, 1993; Van Ess Coeling and Simms, 1993; Cavanagh, 1996; Hewison, 1996; Kerres, 1999). Either they strictly applied the existing cultural practices of U.S. organisations and that of large Japanese corporations, or they developed 'a parallel reading' through which culture could be positioned as an integral feature of a new form of competitiveness and success

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[4] All of them except Ouchi were connected to McKinsey - a large consultancy company in U.S. which thus made its day-to-day living from America's best-run companies (Silver, 1987; Guest, 1992). Moreover, Pascale and Athos collaborated with Peters and Waterman on developing the seven 's' framework of measuring a company for excellence. The hard 's' factors were 'strategy, and structure' and the soft ones were 'style, systems, staff (people), skills, and shared values' (Peters and Waterman, 1982, p. 11).

[5] According to Trapp (1993) the boom was fostered by the immense growth in Master of Business Administration programmes, which promoted a deeper self-awareness among young business people of what they were doing as managers. It was an era dominated by increasingly large mergers and acquisitions that caused unprecedented management uncertainty. It is no coincidence that this period also saw the rise of such strategy based management consultancies such as McKinsey, Bain & Co and the Boston Consulting Group.

(Thompson and Findlay, 1999, p. 165). For example, the comparison between rural and urban *Magnet Hospitals* conducted by Fuszard *et al.* (1994a-b) revealed not only an identification of shared qualities of institutional excellence but also characteristics unique to *Rural Magnet Hospitals of Excellence*:

> The Rural Magnet Hospitals appeared more active in their own communities, seeking to meet local, rather than regional needs, toward which the urban hospitals are directed. Close bonding was found between local communities and their hospitals, and many examples of response to special community needs were found. Creativity and patient care skills were both seen as characteristics of the rural nursing directors, who constantly face uncertainties and financial constraints. Staff nurses were found to be highly involved in decision-making within their hospitals, and in direct lines of open communication (1994b, p. 41).

As the interest and practice expanded, the concept of achieving change towards a model of excellence became central to contemporary management discourse. If the dissemination of values and specific behavioural and normative programmes were the themes of the early 1980s, then surely their position had been usurped in the late 1980s by high trust employment relationships (e.g. Peters and Austin, 1985; Peters, 1988b, 1992; Höhler, 1991; Gerken, 1993; Kinchen-Singleton and Nail-Hall, 1995) and high skilled, empowered employees (e.g. Kanter, 1989; Peters 1988a, 1992; Hart *et al.*, 1990; Slater and Bennis, 1990; Foy, 1994). That is, management periodicals and textbooks published since the mid-1980s are replete with references to the capacity of high trust work relations and employee empowerment to maximise the potential of employees and organisations and thus to contribute to organisational competitiveness and success. Advocates of both concepts promoted them with considerable fervour, claiming that they have the potential to generate the kind of effects which are beloved of all employed people; i.e. while improving the organisational performance and strengthening the corporate culture, both concepts simultaneously lead to improvements in the experience of work for managers and employees.

This futuristic concern was reinforced by the emphasis on more creative and people-focused forms of activity in which the co-ordination of '"knowledge" workers' could be horizontal, collegiate and cultural (Drucker, 1986, p. 780). Such *Learning*

Organisations are not an impediment to continuous change because they create an environment that facilitates employee learning and then change by learning from knowledgeable and committed employees (e.g. Chandler, 1962; Senge, 1990, 1992; Peters 1992; Drucker, 1992a-b, Borsi, 1994). Reich (1993) has further argued that getting employees to become committed to attaining knowledge in a highly motivated fashion requires the development of an understanding on the part of management that the workplace is no longer a pyramid or a bureaucracy but a 'web of enterprise' (p. 87). At the same time, management writers promoted the idea that as organisations become more complex, domain-specific and esoteric, employees must participate in co-ordinated decision-making so that the old tension between professional autonomy and bureaucratic control will diminish (e.g. Simms, 1991; Lynch, 1993; Cavanagh, 1996; Joslyn, 1997). On a related terrain, Dickinson and Svensen (2000) consider style and design as a benign influence and as a powerful force reshaping organisations and lives:

> Corporate style is about individuality and personality. All the best companies have it. Style is not neutral; it is a great motivator of people. Whatever you buy in business is just a promise, but if that promise has style to it, that style makes it powerful (p. 30).

What is to be concluded from such complex cultural ideas? They are being taken seriously - not only by famous consultants, chief executive officers and management writers but also by a number of academics - as management theories (e.g. Kanter, 1985, Handy, 1986, Schein, 1985, 1991, 1992, 1996). For example, Handy's structural distinction (1986) between role culture, task culture, power culture and person culture meant that there is a linkage between cultural taxonomy in organisation and its performance. He pointed out in addition that these cultural types are usually tied to particular kinds of organisational structures and strategies. Initially, Kanter (1985) also dealt with cultural changes, in particular the implementation of change and the complex organisational and cultural processes that go with it. She noted, for example, the paradox implicit in linking organisational culture with organisational change, and was more concerned than others with the problematic aspects of culture. Whereas writers such as Peters and Waterman (1982)

and Deal and Kennedy (1982) dismissed alternative values as 'weak cultures', Kanter (1985) has taken full account of these complexities; i.e. she identified a number of cultural types such as the 'cultures of inferiority' and the 'cultures of success' which are diametrically opposed (p. 92). Another interesting set of cultural types are what she calls the cultures of 'age versus youth' (p. 392). However, all these classification schemes of organisational cultures had relatively a limited impact on the workplace and the world of academe.

Notwithstanding, the concept of achieving change towards a model of excellence had truly entered upon a career and is responsible for a list of concepts[6] such as total quality management, just-in-time, business process re-engineering, empowerment, innovative teamworking, organisational learning, transformational leadership or high trust work relations (e.g. Trapp, 1993; Willmott, 1994b; Thompson and Wallace, 1996; Blair, Taylor and Randle, 1998; Valentin and Knights, 1998; Thompson and Findlay, 1999). For the moment, the preceding review of the literature suggests that corporate cultures can be explicitly created and modified to bring about market success for organisations and career success for the individuals. In this way the idea of changing the culture of an organisation gained many friends and promoters, if for no other reason than that noted by Wilson (1992), "what really mattered was having an organisational culture which placed people first on the managerial agenda" (p. 72). As a reminder, however, the examples of the rural and urban *Magnet Hospitals* enable whoever reads them again to attribute causes other than organisational culture to both success and failure. That is, the success of these *Institutions of Excellence* lies largely in a variety of innovative and challenging programmes to change corporate structures and processes rather than in any managerial style or cultural approach. A similar point has been made by Thompson and Findlay (1999) who note the deployment of two rhetorics on culture as they refer to their own research (see Marks, Hine, Findlay and Thompson, 1997) on change programmes:

[6] There are considerable conceptual links between these concepts such as the 'culture break that is required for each to be successful' (Blair, Taylor and Randle, 1998, p. 119).

> In the first, culture signified creating a vision or set of shared values that would guide the change process generally. On the other hand culture was also used to signify an inherited tradition or set of practices, normally identified as in need of transformation (p. 164).

The purpose of quoting here is not to defend the *Institutions of Excellence* but to illustrate that one part of the cultural idea is, both practically and theoretically, strongly related to internalised commitment and shared understanding which require an acceptance and endorsement of values generated by the new corporate culture. The other part is used to signify a set of day-to-day practices which embody where the organisation is now and where it wants to be in the future. This latter usage does not require that people are tied into the local values of particular corporate cultures and may provide an answer to the perennial question of what accounts for business success. This should be borne in mind and will be discussed further in subsequent sections and chapters.

Concepts of Culture and Organisational Analysis

So far I have introduced the concept of achieving change in order to become a model of excellence. However, I have also shown in the preceding review of the literature that diverse and contradictory considerations exist in respect of the concept of corporate culture and its management. Prior to the mid-1990s the focus of academics in this area was on the deconstruction of the concept of corporate culture. This means that the literature is full of analyses seeking to criticise the limited conceptualisation and superficial ways of changing cultures via corporate stories, myths, heroes, sagas, legends, folk tales, symbols, slogans and mottoes (e.g. Silver, 1987; Delamarter, 1986; Thompson and McHugh, 1990, 1995; Guest, 1992; Wilson, 1992; Willmott, 1993; Newton and Harte, 1997). An important point was being made here and in other social science writings on culture; namely that there were two fundamentally different stances in the field which nonetheless met each other in places (e.g. Smircich, 1983a-b, 1985; Morgan, 1986, 1990; Smircich and Calás, 1987; Alvesson, 1990; Alvesson and Berg, 1992; Czarniawska-Joerges, 1992; Meek, 1992; Wilson and Rosenfeld, 1992; Ogbonna, 1992, 1992/1993; Anthony, 1994; Wright, 1994).

For example, Smircich (1983a) demonstrates how organisations can be understood *as* cultures and how the term culture has been redefined in the process of its appropriation from anthropology. She refers to Burrell and Morgan's (1979) pathfinding framework and argues that the first of these conceptions can be identified as the assertion that culture is something an organisation *is*, as opposed to the second conception which is that culture is something an organisation *has* (p. 347)[7]. What is fundamental about this distinction is that the first stance holds that culture is a mental state that has to be tolerated since it is incapable of being changed by management or anyone else for that matter; i.e. where culture *is* the organisation, any change would result in a metamorphosis of the organisation itself. The second stance asserts that culture is an objective reality that can be measured and changed by management like any other organisational variable. It is exactly this latter outlook which is often recognised as corporate culture change and one of the easiest ways of appreciating it is simply to see a neutral link between organisational culture and leadership style, irrespective of historical and social conditions.

It all comes from People: the functionalist Perspective

Following the pragmatic view, which indicates that corporate culture change may occur, has led the writers of the 'excellence' tradition (which followed the publication of Peters and Waterman's book in 1982) and others to identify culture as a powerful organisational tool which "shapes behaviour, gives employees a sense of identity and establishes recognised and accepted premises for decision-making" (Ogbonna, 1992/1993, p. 42). If cross-cultural researchers borrowed the concept of culture from anthropology in order to assemble and integrate various aspects of organisational life, Peters and Waterman (1982) and their followers decided to use

[7] In an effort to address the same issue Anthony (1994) draws a clear distinction between the espoused version of culture and the real, between the proposed and the descriptive, between what should be and what is. To aid clarity he suggests that the espoused version be referred to as 'corporate culture' and the real as 'organisational culture' (p. 3). Meek (1992) also argues that the various theories on corporate culture fall into one of two groups. In one, corporate culture is seen as something an organisation possesses; in the other, culture is embedded in the organisation's history and its cultural relationships. Similarly, Wilson and Rosenfeld (1992) distinguish an analytic from the applicable cultural school and argue that culture, the scholarly concern of the anthropologist, has become "one of the key concepts from organisational behaviour to be translated so readily in the world of the practising manager" (p. 238).

the whole set of anthropological concepts as a 'colourful metaphor' in order to produce an attractive rhetoric and to replace traditional concepts such as 'authority, incentive systems, information systems and so on'. (Czarniawska-Joerges, 1992, p. 168). Culture is relevant here because

> whenever you have what appears to be successful decentralisation, if you look more closely, you will discover that it was always preceded by a period of intense centralisation where a set of core values were hammered out and socialised into people before the people were turned loose to go their own "independent", "autonomous" ways (Weick, 1987, p. 124).

'Cultural pragmatists' see an organisation culture as the key to employee commitment and shared understanding and enthusiastically embrace the lessons of the *Holy Grail* of organisational productivity and profitability (Martin, 1985, p. 95). In this respect culture is seen as a unifying and regulatory mechanism which is directly manageable and as the 'social or normative glue' that holds a potentially diverse group of organisational members together (Smircich, 1983a, p. 344). This view emphasises social cohesion and integration and suggests that it is defined functionally, as 'an instrument serving human biological and psychological needs', and as 'an adaptive-regulating mechanism that effects system stability' (Legge, 1995, p. 186). The same perspective holds that the 'head' of an organisation has a directive role in developing the collective consciousness by changing artefacts and espoused values, and that the 'healthy' culture is both reflective of and active in organisational adaptation and growth (Legge, 1995, 186).

Organisational analysts generally look for anything that is shared by organisational members and concentrate on common language, shared values and agreed on, appropriate, behaviours. As a research strategy this approach is very practical and Martin (1992) argues that there are four essential features of this dominant perspective: 'organisation-wide consensus' amongst cultural members, 'consistency' across cultural manifestations, 'clarity' of interpretations and meaning, and a focus on 'leaders' as cultural creators (p. 61). It holds that these features will contribute to the overall systemic balance and effectiveness of an organisation through greater

employee commitment and control, as measured by productivity and profitability. Referring to work being undertaken within this perspective, Smircich (1983a) writes:

> This stream of research acknowledges that subjective interpretative processes that may influence adaptability occur in organised settings, and it seeks to describe and predict the ways they are related to other outcomes such as turnover, absenteeism and commitment (p. 345).

Several studies have been produced with the express intention of helping senior managers in the health care sector to replace worn-out and dry traditional concepts with highly visible, consciously designed and regularly occurring events and activities, which provide opportunities for employees to acquire the organisational values, beliefs and norms. For example, Meyer (1981) revealed how managerial ideologies and organisational stories in hospitals served a structuring function; McClure *et al.* (1983), Kramer and Schmalenberg (1988a-b, 1993), Kramer (1990), Fuszard *et al.* (1994a-b) and Buchan (1993, 1994, 1999) identified and re-examined the core characteristics of 'magneticism' in the *Institutions of Excellence*; a nation-wide study on the impact of shared values on staff nurses' job satisfaction and perceived productivity was done by Kramer and Hafner (1989) in 24 hospitals under different auspices, some of which were also *Magnet Hospitals*; Shortell, Rousseau, Gillies, Devers and Simons (1991) investigated organisational culture, leadership, communication, co-ordination, problem-solving / conflict management and team cohesiveness as key managerial practices and processes affecting organisational performance; in the study reported by Chandler (1991) staff nurses identified support, information and opportunity as important empowerment factors affecting their work effectiveness; Kitching (1993) explored the role of nursing leadership in relation to the management of care delivery and concludes that the profession must move away from its traditional power base and refocus on clinical practice and the management of nursing rather than the management of nurses; Bourmans and Landeweerd (1993) found out that social leadership contributes positively towards nurses' job satisfaction and experienced meaningfulness while reducing negatives such as absenteeism and health complaints; Van Ess Coeling and Simms (1993) present a five-step cultural innovation process which can be used by creative nursing unit

managers to implement a variety of practice patterns to help the health care organisation remain competitive and increase the quality of its nursing care; Klakovich (1996) and Morrison, Jones and Fuller (1997) discovered a positive correlation between transformational leadership and job satisfaction on the one hand, and empowerment on the other; Hewison (1997) examined the significance of language and its relevance to nurse managers; and Wilson and Laschinger (1994) and Laschinger, Sabiston and Kutszcher (1997) conclude that nursing administrators can empower their staff and improve organisational commitment by manipulating the structures in the work environment to allow greater access to the power and opportunity structures that Kanter [1993] maintains are important for overall work effectiveness. These cultural pragmatists, and many others, argue that cultural artefacts, and even the art of management itself, are powerful symbolic means which can be used to build "organisational commitment, convey a philosophy of management, rationalise and legitimate action, motivate personnel, and facilitate socialisation" (Smircich, 1983a, p. 345).

One of the implications of such a view is that economic success and competitive advantage can be explained largely in terms of specialist factors internal to the organisation. For example, it is suggested that an ineffective organisation can be made more effective and flexible if a 'weak' culture can be supplanted by a 'strong' and cohesive one (Deal and Kennedy, 1982). As Guest (1992) and others (e.g. Thompson and McHugh, 1990; Pettigrew and Whipp, 1991; Wilson, 1992; Casson, 1993) have noted, this fails to take account of the external environment that is independently given, including various forms of 'protective legislation, market dominance, access to supplies and possibly an advantageous geographical location' (p. 10). Even within organisations little attention is being paid to the hard 's' factors such as 'strategy and structure' because culture proponents explain the necessity for a shift in emphasis from the traditional focus to the soft 's' factors of 'style, systems, staff (people), skills and shared values' (Peters and Waterman, 1982, p. 11). These factors, which must be properly directed, are widely cited in the literature as being crucial to managing cultural change and include leadership style, information and

communication systems, performance and reward systems, organisational policies and procedures, training and orientation seminars, results orientation, etc. However, the failure to take sufficient account of the external environment as a re-/source and the variety of domestic affairs such as the division of labour, the unity of command, the centralisation of authority, the remuneration of people and the subjugation of employee interests to the general interests flies in the face of contingency theory that provides a general basis for much organisational analysis[8]. Guest (1992) argues that this 'disregard for variations in context is reflected in the advocacy of the universalistic application of the body of writing' devoted to the issue of corporate culture change in all organisations - *Institutions of Excellence* and others (p. 10). Along similar lines, Ezzamel and Willmott (1998) argue that

> [s]uch diagnoses simply omit, or refuse to acknowledge, that the business of organising employees in ways that yield a surplus from their productive activity is inherently problematical for social and political, and not just technical or functional, reasons (p. 362).

A rather different pitfall in the advocacy of the conception of corporate culture, is its similarity to much earlier themes in organisation theory, particularly those concerning operational performance and its presumed increase under different working conditions. As Peters and Waterman (1982) acknowledge at the start of their book and as a number of writers have noted (e.g. Silver, 1987; Thompson and McHugh, 1990; Barley and Kunda, 1992; Anthony, 1994; Guest, 1992; Willmott, 1993; Newton and Harte, 1997), both the organisational development literature and that of excellence draw on neo-/human relations discourse, such as Elton Mayo's (1933) ideas concerning worker motivation following the Hawthorne experiments; Maslow's (1954) hierarchy of needs as an account of human needs; Herzberg's

[8] Research which deals with organisation-environment congruence is based on a 'system theory framework' and is concerned with articulating patterns of contingent relationships among collections of variables that figure in organisational survival (Smircich, 1985, p. 59). Perhaps the most influential academic writers identified with this research tradition have been Burns and Stalker (1961), Woodward (1965), Lawrence and Lorsch (1967) and Mintzberg (1983) who looked at the relationship between the management systems and the organisational tasks and how this affected the technology of the manufacturing process or the organisational survival in different environments. For example, Burns and Stalker (1961) identified the fact that stable environments can be handled by 'mechanistic' structures such as bureaucracies, whereas an environment which is unpredictable requires an 'organic' structure that is flexible in its responses to changing circumstances.

(1966) hygiene and motivation factors along with concepts of job enrichment and McGregor's (1960) theory X and Y approaches to management. Despite the dismissive criticism from a number of academics (e.g. Carey, 1967)[9], Peters and Waterman (1982) and their followers found the neo-/human relations school useful because of its capacity to present 'a coherent, positive and optimistic philosophy about management' (Guest, 1992, p. 17). Given the less-than-hoped-for outcomes of the rational model - its dominant use as the standard by which managing was defined, rationality being seen as the pathway to gain competitive advantage and the prevailing fiction that people could anticipate the future - the idea of changing the culture of an organisation resulted in the reception of new ideas, indicating new solutions to old corporate problems. Employees are now human resources and talents potentially responsible and dedicated while sharing, caring managers remove the impediments from the natural consensus of values that exist among people and employ a unitary rhetoric which creates an underlying consensus of interest within organisations. Although literature such as this is *in vogue*, Willmott (1993) shows that it effects a subtle but notable twist to this kind of argument:

> Instead of assuming a consensus of values (as theory Y does), corporate culturism aspires to build or manufacture consensus by managing the content and valency of employee values. Rejecting the view that non-rational aspects of human organisation must be eliminated (e.g. scientific management) or patronised (e.g. human relations), it is argued that these aspects can be legitimately and effectively *colonised* (p. 525).

Characterising these developments as 'a *re*turn to familiar themes in new languages', Thompson and Findlay (1999) notice how the rhetoric of 'commitment and human capital' has largely replaced that of old-style 'loyalty' (p. 172). Yet it is one thing to recognise the connection between employee loyalty and the security provided by an organisation; it is quite another to accept that the cultural rhetoric provides a favourable medium for the practical realisation of corporate goals such as efficiency, effectiveness, profitability or value for money. Changing the corporate culture can then be understood as a managerial discourse which builds upon 'something active and internalisable to values and feelings' rather than something passive (Thompson

[9] See Barely and Kunda (1992) for a short review of the literature.

and Findlay, 1999, p. 172). As Ezzamel and Willmott (1998) commented about seemingly neutral corporate values and objective accounting techniques such as performance measurement and budgeting:

> The objective of these methods is not simply to improve the coordination of productive effort but, more fundamentally, to induce and discipline employees to work at a pace or in ways that are intended to increase or at least maintain profitability (p. 362).

Apart from the pro-managerial bias that this aspect of the culture literature suggests, the very concept of it and its causal relationship with employee commitment and performance can easily be viewed as over-simplified and highly functional. Relationships between organisational people are tacitly assumed to express only a single set of values, beliefs and meanings, which unite all people, groups and functions around common objectives. By recognising only those values that are shared and cultural manifestations that are consistent with each other, however, this view of corporate culture ignores evidence of dissent among people and makes little reference to ambiguity in the workplace. In particular the assumption of cultural change fails to take on board the traditional literature on social action in which the critical importance of human autonomy may constrain or at least influence attempts by managers to introduce notions of excellence, empowerment, teamworking, total quality and human resource management developed in one organisation into another.

Another aspect that has to be considered is that the popular culture literature tends to provide 'a plausible way of going beyond technique and putting it into perspective' (Guest, 1992, p. 10). It is perhaps not surprising to discover that some of them place a great deal of emphasis on the question of 'how to' put the principles of excellence, empowerment, total quality and human resource management into practice[10]. Nor is

[10] What is important to note is that this style of cultural writing adopts a tone which is highly evangelical and seeks to persuade readers of its compatibility with righteousness and positive reinforcement. For example, there is a predominant influence of words like 'managers *should* become masters of change', 'managers *must* change towards...' or 'championing *must*...'. From this point of view, it is seen by some as being the *only* perspective on organisational change. What Newton and Harte (1997) have argued in relation to the books by the new 'gurus' is equally applicable to this discussion; namely, that the culture literature has a 'missionary zeal' to convert rather than to explain what happens or how is it when corporate culture change is applied (p. 77).

it surprising to find that the demand for excellence in an unstable environment and the predicted conditions of managerial control call for an interest in transformational leadership and an advance to the very frontiers of corporate culture. Even in the more academic literature, proponents claim that corporate culture can be deliberately influenced and changed. In some respects, leadership and the management of culture are synonymous:

> Organisational cultures are created by leaders and one of the most decisive functions of leadership may well be the creation, the management and - if and when they may become necessary - the destruction of culture. Culture and leadership, when one examines them closely, are two sides of the same coin, and neither can really be understood by itself (Schein, 1985, p. 2).

In Schein's view (1985, 1991, 1992, 1996) there is an observable and potentially manageable relationship between cultural outcomes and the behaviour of managers, change agents or consultants as the creators, transformers and transmitters of a vision. The question here is not which are the right or wrong innovative techniques by which to achieve organisational ends; e.g. participative decision-making, informal practices like Management by Walking About and the use of rituals such as training courses and award ceremonies. Rather, the point is that managers became the 'new systematisers' who know how objectives can or should be met in organisations (Barely and Kunda, 1992, p. 377). Through employing the images of the excellence literature, they have a new instrument which authorises them to monitor, measure and manage the values of their employees but within an apolitical rhetoric that still appears dedicated to empowering and enabling the autonomous and creative employee (Miller and Rose, 1990). Peters (1988a) makes the case with disarming directness when, referring to the use of values to govern people's behaviour, he claims that "*[t]hese devices - vision, symbolic action, recognition - are a control system, in the truest sense of the term.* The manager's task is to conceive of them as such, and to consciously use them" (p. 486). Anthony (1990) reflects this concern when he identifies an inexorable trend in the evolution of managerial ideology and practice toward forms of consensual, normative control:

> In the discussion of the management of culture it is assumed that the boundaries extend to the organisation that is managed, that it is the culture of the managed organisation, the official culture, that requires adoption or adaptation in the belief systems and values of subordinate groups. But, from the perspective of these groups, colonies within the empire, the right to manage the meaning of events, the imperial culture, may seem like the sophisticated disguise of economic power (...). Performance is measured, not by reputation among peers, but by financial results; bureaucratic controls are introduced to count the number of published papers rather than attempting to assess their worth. One must surely conclude that, contrary to what we are so often advised, the achievement of strong culture and the methods to be employed in its creation, is not the end in view. The chief concern is with the values that the culture exhibits; if they are strongly established but deemed unsuitable, then that culture will have to be destroyed (pp. 5-6).

Overall, a major problem associated with the idea of culture concerns its tendency to focus upon its features without giving much attention to the way that they are selectively adopted and mobilised in the politics of management theory and practice. As Thompson and McHugh (1990) have ruefully observed, in most literature on culture management, considerations on 'many deep-rooted features of organisational life - inequality, conflict, domination and subordination, manipulation' are neglected in favour of 'behavioural questions associated with efficiency or motivation' (p. 28). Meek (1992) makes a parallel statement in critiquing this general orientation, arguing that "[c]ulture, if it is to have any meaning, needs to be related to the total organisation, not regarded as phenomena solely vested in the hands of management" (p. 197). All too often, as Alvesson and Willmott (1996) have pointed out, ideas presented as radical and revolutionary (e.g. the causal link between storytelling and corporate culture change) are based on narrow conceptualisations and are actually preoccupied with preserving established priorities and privileges (e.g. organisational growth or managerial prerogative).

Although recent theory and research have embraced culture as a valuable re-/source, it sees an organisation as a natural, logical and functional structure or system which affects the inter-/actions of its people but remains unaffected by them. From this point of view it appreciates the presence of people's inter-/actions to improve organisational effectiveness but pays no attention to the ability of people to inter-/actively construct the world around them. In this wave of theorising, a full and

complete understanding of an organisation is highly unlikely without the insightful analysis of how its culture and the meaning of life at work has been accomplished.

Looking for Clues: the interpretative Perspective

Alternatively, and as noted above, the second or interpretative stance states that organisations *are* cultures and conceptualises culture as "a pattern of symbolic relationships and meanings sustained through the continued processes of human interaction" (Smircich, 1983a, p. 353). This frame of reference has been used for social analysis for some time (e.g. Goffman, 1955, 1957, 1959, 1964, 1972; Berger and Luckman, 1966; Silverman, 1970; Schutz, 1972) and traces its roots to German idealism, particularly to Immanuel Kant's belief (1724-1804) that social reality exists in spirit or idea rather than in concrete facts (Burrell and Morgan, 1979). In addition to this meaning-centred focus it shares general assumptions about "the nature of reality and social order, the role of knowledge in social action, and the relationship between human beings and their environment" (Putnam, 1983, p. 32). The major schools of sociology that follow this perspective, namely, social action theory, hermeneutics, phenomenology, symbolic interactionism and ethnomethodology say that organisations may be regarded as

> a system of shared cognitions, of knowledge and beliefs, or as a system of shared symbols and meanings, or even as a projection of the mind's universal unconscious infrastructure. It is both produced and reproduced through the negotiating and sharing of symbols and meanings - it is both the shaper of human action and the outcome of a process of social creation and reproduction (Legge, 1995, p. 186).

This inspirational view directly challenges the preoccupation with certainty and linearity that characterises the positive perspective of organisational culture and organisational change. It sees culture as existing in, and through, the social inter-/actions of people and recognises the possible existence of heterogeneous sub-cultures within a single organisation; e.g. between different departments or functions. The same perspective recognises the cultural values, attitudes and meanings of occupational or non-managerial groups and those espoused by cultural managers. As Morgan (1986) has put it: "different professional groups may each have a different

view of the world and of the nature of their organisation's business" (p. 127). For example, nurses may subscribe to one kind of world view and medical doctors to another; the frame of reference guiding executive managers may be different from that of members of the occupational divisions.

For this group of writers and researchers, the fundamental nature of culture is inseparable from organisation and this concept is drawn from cognitive, symbolic, and to a lesser extent, structural anthropology. The use of culture as a 'root metaphor' differs from conceptualisations of organisational cultures as variables that adapt to their turbulent environments (Smircich, 1983a, p. 347). What is important to understand here is the meaning and significance of the 'social-constructed web of symbolic relationships' within a single organisation, and how it exists as such (Morgan, 1990, p. 18). This standpoint does have many inter-linked implications for understanding organisations because it is understood and analysed not in 'economic or materialistic terms', but as 'expressive, ideational and symbolic processes' (Smircich and Calás, 1987, p. 233). Along similar lines, Morgan (1986) argues that

> [t]he slogans, evocative language, symbols, stories, myths, ceremonies, rituals and patterns of tribal behaviour that decorate the surface of organisational life, merely give clues to the existence of a much deeper and all-pervasive system of meaning. The challenge in understanding organisations as cultures is to understand how this system, in its mundane as well as its more dramatic aspects, is created and sustained (p. 133).

This perspective offers attractive insights into the depth and plurality of culture and organisational symbolism, and relies on very different analytical and methodological views on how sense may be made of an organisational culture. Characterised very broadly, an analysis includes a concentration on social inter-/actions rather than causal explanations as well as a tendency to explore an organisational culture with reference to the inter-/subjective processes of communication and meanings which influence its continuous construction, re-production and transformation. From an interpretative perspective, such a methodology requires

> a close involvement with those who are being researched in order to discover how the meaning of concepts are actually formulated and interpreted by different

> members of an organisation, and how this meaning is negotiated and changed over time (Alvesson and Willmott, 1996, p. 53).

'Cultural purists' have widely endorsed Smircich's distinction (1983a) between managerial and anthropological orientations to the study of organisational culture and symbolism (Martin, 1985, p. 95). According to Willmott (1993) purists regard "corporate culturism as a superficial, commercial and theoretical impoverished enterprise unworthy of serious examination" (p. 520). The point being made by them is that no matter how hard managers try, they cannot change the values, beliefs and meanings which guide people's thoughts and behaviour (e.g. Krefting and Frost, 1985; Bourn and Ezzamel, 1986; Weick, 1987, 1995; Young, 1989; Alvesson, 1990; Turner, 1990; Alvesson and Berg, 1992; West and Anderson, 1992; Hassard, 1990; Wright, 1994; Procter, Currie and Orme, 1999). This view is exemplified by Ackroyd and Crowdy (1990) who have studied the slaughtering teams in an English abattoir:

> [E]ven if we regard this management "managing culture" at its surface level, it cannot account for the taken-for-granted understandings observed. Such control systems do not explain why the discipline was effective, why the members of the groups submitted to its discipline with such readiness, accepting the need to work fast and hard (p. 10).

The same point of view is expressed by Currie (1996) who has analysed the incomplete closure of managerialism in the health service:

> Many organisational changes, which lie outside the control of the programme facilitators, mean that the programme's potential as a powerful socialising ritual is not being achieved. The sphere of influence of this development programme lies mainly with facilitating improvement in the technical competence of participants as it relates to general management. However, even this is ineffective due to many of the assumptions which underlie the programme's design and its perceived lack of application to context (p. 18).

It is the conception of the organisation-culture relationship which is not shared by these authors because organisations are treated as being sets of values and axiomatic assumptions which cannot be imported into the organisation through managerial means. This ahistorical-hermeneutic view and criticism is rooted in social action and ethnomethodological studies of organisations where the nature of culture can be

found in social norms and customs and where individuals' definitions of the situation are given pre-eminence over other methods of data collection (e.g. Dalton, 1961; Strauss, Schatzman, Ehrlich, Bucher and Sabshin, 1963; Bittner, 1965; Garfinkel, 1967, 1968; Sudnow, 1967a-b; Cicourel, 1968, 1982; Turner, 1974; Wieder, 1974; Clegg, 1975). Like Garfinkel and his colleagues, who are guided by the heuristic to treat social facts as accomplishments, cultural purists stress the pro-active role that different organisational groups play in creating their day-to-day world. However, from the inside, they favour an anthropological-informed approach in which culture - as a single set of meanings which is continually re-made in everyday inter-/actions - simply exists and cannot be invoked, created, controlled, changed or managed by the dictate of management. As Parker (2000) argues, they employ the methods that characterise the interpretative perspective and use culture as a 'resource to make reflexive and retrospective sense of their experiences' (p. 50). In general, as Willmott (1993) argues, "the attitude of 'purists' seems to be that because the culture literature is theoretically deficient, it is academically unrespectable, and *therefore unworthy* of serious examination" (p. 520). In pursuing this subjective/micro-level approach, however, cultural purists have apparently taken less notice of labour process writings on the idea of changing the corporate culture of an organisation, or Smircich's argument (1983a) that

> [a] cultural framework for analysis allows us to see that an important role for both those who study and manage organisation is not to celebrate organisations as a value, but to question the ends it serves (p. 355).

If this is so, cultural purists dismiss the feasibility of corporate change because they are conceptualising social disorder and change as only occurring at the fundamental level of altering values, beliefs and systems of meaning. Unfortunately, as Alvesson and Willmott (1996) argue, change appears then to have been reduced to a 'temporary and necessary means of re-establishing equilibrium', which cannot be analysed from the point of view that social relations within organisations are conditioned more by 'contradictory pressures for transformation' than by 'forces of continuity and integration' (p. 55). This leaves the interpretative perspective open to the same criticism as the functionalist perspective because it restricts the view of day-

to-day life within organisations. Whereas the organisational analysts following the functionalist perspective tend to pay too much attention to the cultural artefacts of an organisation, and even the art of management itself, those who follow the interpretative perspective overvalue the inter-/active and symbolic side of organisational life by presenting the human subject as creating their own realities within a restricted scope.

For the above reasons, a more critical perspective to the reading of cultural change must be adopted. However, from an analytical and methodological viewpoint, it is inappropriate to separate approaches into either a functionalist or an interpretative perspective because, as Wilson (1992) argues, "[t]he two are at work simultaneously and both have to be considered as key factors in explaining both the processes and the outcomes of change" (p. 84). For example, it is not just the actions of people, the interactions between social actors, the micro-elements of organisational life and the perception of individuals which need to be taken into account. The macro-contextual milieu in which an organisation operates, the existence of an official rhetoric that attempts to structure and influence people's inter-/actions, the conflicts between interest groups and the contradictory responses to the cultural projects of management also cast their influence over both aspects. By implication, case studies that seek to combine both 'the diversity of assumptions guiding analysis *and* the ways in which they may be combined' may be taken into consideration (Willmott, 1990, p. 49). In doing so, the researcher questions the strength and actual 'necessity of the normative framework' that is taken for granted by the pragmatic management writers and challenges the 'adequacy' of empirical accounts of cultural purists who separate symbolic artefacts from the political and economic conditions of their emergence and reproduction (Willmott, 1993, p. 522).

Governing the Soul: the post-structural Perspective

However, not all intellectual culture researchers followed the same lines of thought. Recent years have seen a resurgence of interest in the potential contribution of corporate culture to management and organisational studies. Most recently,

Thompson and Finday (1999) argue that one strand running through the work of those interested in corporate culture change is based upon the following subject matter: "If culture *could* be managed, even partially, then it needed to be analysed as part of management's armoury of control" (p. 167). This view goes back to Ray (1986) who distinguishes between different types of management control in history. She refers to the regulative and integrative sociology of Emile Durkheim (1858-1917) and notes that the organisation is 'the appropriate site for moral order' (p. 287). She then argues that the attempted management of an organisation's culture is simply an addition to bureaucratic and humanistic forms of control which organisations have tried to implement.

Briefly, bureaucratic control focuses on external, overt control of people through a systematic division of labour, the imposition of formal rules and procedures and through administrative staff who are separated from ownership of the means of production, make decisions and formulate rules, select candidates for office on the basis of technical qualifications and remunerate office holders with fixed salaries. For example, Frederick W. Taylor (1856-1915), Henry Ford (1863-1947), Max Weber (1864-1920) and Henri Fayol (1841-1925)[11] discuss this rationalist approach to directing the behaviour of employees towards organisational goals. However, it is claimed that bureaucratic control is expensive in terms of supervisory staff required, frequently causes resentment and elicits grudging compliance from employees. Alternatively, humanistic or normative control seeks to satisfy people's needs by providing an ergonomic and satisfying work and work place, or a healthy and pleasant working life within a small work group or team to promote internal control. Promoted by Elton Mayo (1933) and other neo-/human relations theorists such as Roethlisberger and Dickson (1939), Maslow (1954), Herzberg (1966), McGregor (1960), the social and co-operative prospect is that employees willingly meet corporate goals by meeting their own individual ones. In other words, the

[11] Whereas Weber defines his 'ideal' type of bureaucracy as just that, an ideal that may rarely if ever be realised (Bittner, 1965), Frederick W. Taylor [1911], Henry Ford [1924] and Henri Fayol [1916] actually set out in the belief that industrial or service "organisations can run just as effectively as machines, following a set of explicitly formulated principles which any manager could apply" (Bolton, 1999, p. 43).

humanising concern of these advocates has been to increase co-operation and compliance by enabling people to derive a sense of meaning and esteem, as well as financial reward, by directing their creative energies towards the realisation of organisational objectives. This kind of humanistic control, however, fails, as does bureaucratic control, because it remains 'externalised' rather than becoming 'internalised' by the human subject and is unable to generate 'sentiment or emotion' (Ray, 1986, p. 293, p. 294).

Ray (1986), then, suggests that Peters and Waterman (1982) and other management writers created the possibility of using a more effective form of management control; i.e. the 'manipulation of corporate culture' (p. 294). The tendency in corporate culture, she goes on to explain, is to subjugate the individual to the collective because people are viewed as 'emotional, symbol-loving, and needing to belong to a superior entity' (p. 295). In the long term, Ray (1986) argues, this form of ideological control could be cheaper, avoid resentment, and build employee commitment to the organisation and its goals. Within this frame of reference is the nucleus of an organisational analysis which explores "*how, as a medium of domination, the scope and penetration of management control is, in principle, considerable extended by corporate culturism*" (Willmott, 1993, p. 522). Noting the affinity between the corporate culture vocabulary and the self-regulating capacities of the individual, Miller and Rose (1990) remark:

> The 'autonomous' subjectivity of the productive individual has become a central economic resource; such programmes promise to turn autonomy into an ally of economic success and not an obstacle to be controlled and disciplined (p. 26).

By promoting this form of devotion, the change of corporate culture was suddenly not just another managerial strategy but the supreme form of managerial and individualised control. What is new about the concept of corporate culture is according to Willmott (1993) "the *systematising* and *legitimising* of a mode of control that purposefully seeks to shape and regulate the practical consciousness and arguably, the unconscious strivings, of employees" (p. 523). Here, the task of managers is no longer restricted to bureaucratic and humanistic forms of control but

determines and manufactures how employees should think and feel about what they do in their day-to-day practice at work. Or, as Willmott (1993) goes on to argue, employees are concurrently required "to recognise and *take responsibility for* the relationship between the security of their employment and their contribution to the competitiveness of the goods and services that they produce" (p. 520). In this way, the productive person is systematically invited, and legitimately induced, to become 'tied to his [sic] own identity by a conscience or self-knowledge' (Foucault, 1982a, p. 781). As previously quoted, the central argument is clearly articulated by Peters and Waterman (1982):

> [A] set of shared values and rules about discipline, details, and execution *can provide the framework in which practical autonomy takes place routinely.* (...) The institution provides guiding beliefs and creates a sense of excitement, a sense of being part of the best, a sense of producing something of quality that is generally valued (pp. 322-3, emphasis added).

Here is the basic departure of the concept of corporate culture change from humanistic management theories even though both share the understanding that 'self-determination' is the basis both of 'labour power' and also the characteristic nature of 'human action' (Willmott, 1993, p. 525). The realisation of this mutual understanding makes it clear that an organisation's performance can only be optimised by not only exploiting this, but also by respecting it. Unlike the neo-/human relations discourse which holds that the needs of the individual and the organisation are fully integrated, and, indeed share the same identity, the concept of culture encourages the development of a mechanism of control which harnesses the forces of personal independence and self-determination for the purpose of realising the desired values. Reviewing Ray's analysis (1986), however, Thompson and Findlay (1999) remind the reader how circumspect she was with the argument about cultural control:

> She made clear that all this was *potential.* It may not work, it may not be generalizable outside the USA, it was riven with contradictions, existed alongside other controls and workers could well resist it (p. 167).

It is no coincidence that Ray's circumspection was swept away by social theorists and researchers who have embraced post-structuralist concepts and language drawn from a reading of post-modern analyses. Those who took up and extended the argument saw it as a much wider transformation of society and how it should be viewed. In other words, the perspective of corporate culture change is now something in which post-strucutralists have also their say (e.g. Dandeker, 1990; Donzelot, 1991; Knights and Morgan, 1991; Mumby and Stohl, 1991; Kerfoot and Knights, 1993, 1995; Newton, 1994, Law, 1994; 1996b; Knights, 1997).

Basically, the post-structuralist position accepts and takes for granted much of the structuralist understanding of organisations such as the subordination of labour or the emphasis upon labour as a collective activity, with the important exception that the dynamic of the labour process has to be adequately analysed without a theory of subjectivity (O'Doherty and Willmott, 1998). In doing so, these organisational studies on new language and practices introduced vastly complex ideas and concepts drawn from the writings of authors such as Jacques Derrida (1976, 1978, 1979, 1982, 1994), Bruno Latour (1986, 1987, 1993) and Michel Foucault (1970, 1971, 1973, 1977a-g, 1977/78, 1979a-b, 1981a-b, 1982a-d, 1983a-h, 1984a-b). On the surface, the exceptional work of these post-modern theorists appears immediately congruent with the qualitative developments in the labour process which point to a move from

> rule-based, bureaucratic forms, to the new flexibility of contemporary patterns of accumulation and post-bureaucratic organisation where people follow values rather than rules (Thompson and Findlay, 1999, p. 167).

For instance, in his book *Discipline and Punish* Michel Foucault (1926-1984) (1977a) spends some time illuminating his ideas about the role of surveillance in the external control of human activity. He refers to the work of Jeremy Bentham (1748-1843), an English social reformer, whose conceptualisation of an architectonic machine called a *Panopticon* serves as a technology of surveillance:

> The principle was this. A perimeter building in the form of a ring. At the centre of this, a tower, pierced by large windows opening on to the inner face of the ring. The outer building is divided into cells each of which transverses the whole

> thickness of the building. The cells have two windows, one opening on to the inside, facing the windows of the central tower, the other, outer one allowing daylight to pass through the whole cell. All that what is then needed is to put an overseer in the tower and place in each of the cells a lunatic, a patient, a convict, a worker or a schoolboy. The back lightening enables one to pick out from the central tower the little captive silhouettes in the ring of the cells. In short, the principle of the dungeon is reserved; daylight and the overseer's gaze capture the inmate more effectively than darkness, which afforded after all a sort of protection (Foucault, 1977b, p. 147).

The basic idea here is that people can be seen but cannot see, while the observers who reside in the tower see everything but cannot be seen by the incarcerated individual. By this conscious and permanent visibility, even if discontinuous in its action, the individuals begin to discipline themselves to become, in Foucault's words (1977a), 'docile' and useful bodies (p. 135). Such micro-techniques of disciplinary power were developed and refined in religious institutions, prisons, asylums, and work houses and were concerned with evaluating, recording and observing individuals in a detailed manner and later spread to other institutions. In other words, a series of heterogeneous micro practices were developed, refined and employed within pre-societal institutions in which power was conceptualised as a commodity and led to them becoming an object of scientific investigations and systematic articulations. On the issue of location, there is no single locus of power such as individuals, groups or functions. Rather power is 'capillary' in nature, being dispersed among the practices and discourses of day-to-day life (1977g, p. 39).

In a sense this aspect is not post-modern at all because the functional mechanism that improves the exercise of power was already part of the Weberian tradition to emphasise indirect and rational forms of bureaucratic control. That is, Weber was concerned with 'the iron cage of bureaucracy' and with modern forms of calculation that submerged all natural and localised human relations (e.g. DiMaggio and Powell, 1983; Dandecker, 1990; Webster and Robins, 1993; Clegg, 1994a). But with Foucault (1977a) one is able to see a much broader disclosure of these ideas and disciplinary power is identified as the basis of modern forms of stratification:

> The movement from one project to the other, from a schema of exceptional discipline to one of a generalised surveillance, rests on a historical

> transformation: the gradual extension of the mechanisms of discipline throughout the seventeenth and eighteenth centuries, their spread throughout the whole social body, the formation of what might be called in general the disciplinary society (p. 209).

The principles of disciplinary power are those of the enclosure of people within functioning sites such as modern organisations, the partitioning of behaviour and the control of activity with systems such as time tables. These power relations can be elaborated in many locations and according to Foucault may be unlocked within any enclosed area of activity. Other instruments of disciplinary power in which he was interested include procedures like the examination, the investigation and systematic training. These constrain human motivation into 'collectively useful aptitudes' and they contribute to what Foucault (1977a) calls the 'normalising judgement' (p. 162, p. 177). He states that the process of normalisation is one of the great instruments of power in modern society because it involves the establishment of limits of accepted behaviour; standards to be achieved. Those who follow the standards or routine may be rewarded, but anyone falling outside is automatically defined as deviant and these technologies of control will by their very nature exclude some people.

From this perspective, Foucault (1982a) is not concerned with the subject of knowledge or personal bonds of obligation but rather with the visibility of the person and the construction of identity. For example, disciplinary power resides in a network of relationships which are systematically interconnected, and does not come from outside the organisation, but is built into the very process of the pyramidal structure of organisations (Donzelot, 1991). A key aspect here is the control of deviancy within organisations and people's subjectivity is an effect of power which derives from the refinement of techniques of surveillance and the structuring of meaning and identity. However, there is more to this than just the monitoring of activity or the disciplining of people because in Foucault's analysis (1977a) knowledge is inseparable from power:

> We should admit rather that power produces knowledge (and not simply by encouraging it because it serves power or by applying it because it is useful); that power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge

> that does not presuppose and constitute at the same time power relations. These 'power-knowledge relations' are to be analysed, therefore, not on the basis of a subject of knowledge who is or is not free in relation to the power system, but, on the contrary, the subject who knows, the objects to be known and the modalities of knowledge must be regarded as so many effects of these fundamental implications of power-knowledge and their historical transformations (pp. 27-8).

Of central importance here is the emphasis on the primacy of discourse and this refers to a specific 'disciplinary' language; e.g. the medical technical jargon or the development of 'immature sciences' which continuously form that which they speak. For example, if a medical doctor diagnoses a person as sick, the attachment of the name of the disease will empower this health care professional with control over the patient as regards incarceration and treatment. However, the central object of knowledge (i.e. the person is sick) and the classification itself (i.e. the person's disease) were constructed by the discourse of the medical discipline in the first place. With this point of view, Foucault (1970, 1973) displaces the subject and consciousness from the centre of theoretical concern and human beings appear in his writings as mere objects of knowledge.

Whether Foucault's 'archaeological and genealogical analyses' are correct or his methodology adequate is not beyond the scope of this doctoral thesis but at this particular moment the potential *Foucault Reader* simply has to accept him on his own terms (Rabinow, 1984). Applied to the relationship between employers and employees or the divisions of labour in organisations the position of Foucault becomes particularly influential in stimulating a deeper analysis of subjectivity and social control because the concern is with developing and structuring the identity of employees. The central issue with these kinds of studies within organisations is not managerial coercion or economic exploitation but the domination of behaviour or the *Governing* [of] *the Soul* (Rose, 1990):

> The image of the citizen as a choosing self entails a new image of the productive subject. The worker is portrayed neither as an economic actor, rationally pursuing financial advantage, nor as a social creature seeking satisfaction of needs for solidarity and security. The worker is an individual in search of meaning, responsibility, a sense of personal achievement, a maximised 'quality of life', and hence of work. Thus the individual is not to be emancipated *from* work, perceived as merely a task or a means to an end, but to be fulfilled *in* work,

> now construed as an activity through which we produce, discover, and experience our selves (pp. 102-3).

The cultural power of corporations is best illustrated by Willmott (1993) who demonstrates that there is something alarming about the effective mechanisms that no one owns. Initially, he follows the standpoint of the previously quoted ethnomethodological researchers in order to make a powerful critique of cultural programmes as they create "monocultures in which conditions for the development of value-rational action, where individuals struggle to assess the meaning and worth of a range of competing value-standpoints, is systematically eroded" (p. 518). Here, like other post-structural organisation theorists (e.g. Cooper and Burrell, 1988; Burrell, 1988, 1992; Cooper, 1989; Miller and Rose, 1990; Rose, 1990; Calás and Smircich, 1991; Rose and Miller, 1992; Hassard, 1993, 1994; Hassard and Parker, 1993; Jeffcutt, 1993, 1994; Chia, 1995), he seeks to replace the rhetoric of control and coercion by that of 'leadership' or 'seduction' (Calás and Smircich, 1991).

In this seductive search of excellence, modern corporations construct what Casey (1995) labels 'designer cultures' and 'designer employees' through the production of self strategies and discursive practices of corporate culture (p. 5). In her case study Casey (1995) illustrates at length that the moulding of meaning, language and personal identity arises from an increase in discretion and employee involvement which leads people to identify totally with the objectives of their employer's interests. Although Casey (1995) mentions that "corporate colonisation of the self takes place with varying degrees of resistance and struggles" (p. 161) she uses her individualistic, psycho-analytic conceptual framework, which is clearly influenced by Foucault, to argue that the "new Hephaestus employee becomes somebody in his [sic] association with the reified company and through performance of his team-family work" (p. 189). According to Casey (1995) the complex process of corporate colonisation generated three psychic strategies or self-styles - *defence, collusion and capitulation* (p. 163). Unfortunately, cynical views or latent narcissism are the only responses which occasionally appear to disturb the total dedication and identification of people. When re-read in this light, her study does not clearly illustrate the activity

of those under disciplinary power and discourages the emergence of counter-strategies to cope with it. But whatever the source of new processes, Casey (1995) goes on to claim that

> the conditions for such alternative production are increasingly less conducive to employee initiative. The possibilities of action are reduced as employees' previously semi-autonomous loci of solidarity and protection are taken over by the totalizing corporate culture (p. 192).

It appears strange that Casey (1995) hardly appears to consider the possibility that her observation completely re-frames her arguments concerning the tremendous significance of corporate culture change. Furthermore, the significance of cultural change is prevalent in her arguments, and it appears that it will remain prevalent regardless of what contrary argument or data might suggest. As Newton (1998) reviews in a different analytical context, even if empirical investigations suggested that 'entrepreneurial norms were excluded, subverted, or even *perhaps just ignored* ', the rhetoric of corporate culture change 'would still be judged to be salient to people's lives' (p. 424).

Similar conflict-free themes emerge throughout the post-structural analyses which present a Foucauldian inspired account of the totalising impact of sophisticated cultural discourses and practices. However, it is interesting to note that corporate culture as such is not the only focus. That is, the familiar theme of managerial intervention into people's soul and the construction of self-disciplining, productive selves also emerges from the critique of contemporary information technologies and somewhat different elements of technique, particularly just-in-time, total quality and human resource management methods (e.g. Zuboff, 1988; Sewell and Wilkinson, 1992a-b; Grey, 1994; Newton, 1994; Newton and Findlay, 1996; Sosteric, 1996; Ezzy, 1997; Sewell, 1998).

Drawing on their case study of *Just-in-Time* (JIT) and *Total Quality Control* (TQC) regimes in Kay electronics, Sewell and Wilkinson (1992a-b) argue that with TQC there is the extension of autonomy to groups of people who monitor their own

activities and the activities of others. With this there is an active reporting system feeding information on activities into the information system. In contrast, they claim that JIT production monitors and controls the flow of goods and materials. From this productive scheme emerges another flow of data, which is particularly transparent. Sewell and Wilkinson (1992a) then extend their argument to its post-structural conclusion by claiming that the 'electronic panopticon' can also be produced socially from within the manufacturing cell or quality circle in a horizontal process which operates directly on the subjectivity of individuals (p. 271 [sic] Robins and Webster, 1989, p. 216). They suggest that both JIT and TQC mechanisms 'create and demand systems of surveillance' and thereby produce the responsible worker whose subjectivity is constructed by informational data and then internalised as self-discipline (p. 277). By means of knowledge engineering, managers are thus able to observe and analyse potential information or complex activities in terms of money flows and evaluate business performance.

Another example is Zuboff's analysis of different sites (1988) in which she discusses 'the psychology of visibility' (p. 342) and examines the methods of resistance to and coping with indirect surveillance and 'panoptic power' within information systems designed to control employee behaviour and to increase managerial certainty (p. 324). However, she recognises that the development of superior flows of informational data, which communication and information technologies produce and transmit in abundance, has in-built constraints and limitations which cannot be overcome or erased by even further refinement of their design or functioning. This heightened awareness enables Zuboff (1988) to demonstrate the real effects of new technology on the managerial capacity to control organisations:

> Unilateral techniques of control tend to evoke techniques of defence from subordinates who resent their own involuntary display. (...) [T]his battle of techniques of control versus techniques of defence signals the erosion of reciprocal relations as information becomes the field on which latent antagonisms are let loose. (...) The electronic text can so insulate managers from the felt realities of their workplaces that they will no longer have available the means with which to rekindle reciprocities if they should want to. (...) Thus insulated managers often collude in ignoring the ever more slender relationship between their data and the organisational realities they are meant to reflect (p. 361).

There are some sincere disagreements about the likely feasibility of these arguments in which information is assumed to be directly available to managers with disciplinary intentions (e.g. Webster and Robins, 1993; Reed, 1995; Thompson, 1990, 1993; Thompson and Ackroyd, 1995; Newton, 1996a 1998; Smith and Thompson, 1998; Ackroyd and Thompson, 1999; Thompson and Findlay, 1999). Recognising the dis-aggregation of complex productive processes and the development of superior flows of data, Webster and Robins (1993) connect the various kinds of corporate development envisaged by Sewell and Wilkinson's study (1992a-b) with very much more general processes of structural reorganisation in corporations. In their view, the new communication and information technologies both "allow managers to individuate labour processes, thereby increasing control while apparently delegating responsibilities", but this has to be seen as "part of a more general neo-Fordist (...) strategy which increases the flexibility of corporations in a wide range of their activities: production, design, marketing and distribution" (p. 246). It can thus be argued that the post-structural researchers pursue the same fallacy as the prescriptive management writers in that they maintain a belief in the effectiveness of structural deterministic managerial schemes to secure control over labour and to ignore the presence of overt conflict and forms of misbehaviour. The difference, according to Knights and McCabe (1998a), is that "the prescriptive literature welcomes, whereas the [post-structural] critics demonise the effectiveness of management control" (p. 434).

Indeed, as Ackroyd and Thompson's analysis (1999) indicates, the endemic optimism and determinism of new forms of organisation is belied by their highly partial and imperfect practical realisation. In their commentary, the significance of these new systems is that they produce informational data which can be used for managerial innovation and enhanced corporate control. However, the same authors go on to argue that one has to be 'careful not to confuse the technological potential of such devices with the extent of their use' (p. 157). It follows from this that the development of new information and communication technologies does not necessarily stop employee resentment and resistance towards recording and

enforcement of scripted behaviour. The inherent nature of restructuring initiatives associated with JIT / TQC and other schemes implies therefore that conflicts between different interest groups, or collective forms of resistance from below, should not be overlooked or played down.

Writers like Thompson and Findlay (1999) who have taken the perspective on corporate culture change a large step forward, have also argued that many of those writings mentioned previously simply infer local effects on employee subjectivity from processes of organisational re-structuring without even presenting their 'subjective inputs or responses to the transformation of work' (p. 169). This response to the analysis of corporate culture can be further elucidated by reference to Thompson and Ackroyd's framework of organisational misbehaviour (1995). They note that 'no actual accounts of resistance can normally be found in such studies' (p. 624) because post-structural research work usually neglects resistance, and replaces a concern with the employed subject with a concern with identity needs to the extent that 'the labour process is just part of the scenery'[12] (p. 627). Further, Thompson and Findlay (1999) argue that even where qualitative data is collected in case studies, they are often simply linked to the 'respondent's concerns with identity' such as individual needs which are seen as different and incoherent with traditional fields of management and work (p. 173). Consequently, the nature and significance of this collective engagement often remains unexamined in the post-structural research literature which means that the employed subjects simply disappear from view. As Thompson and Findlay (1999) have put it:

> In the cultural turn and the search for subjectivity, *labour* as a subject has gone missing. Management has become the central actor, the author of new initiatives and disciplinary practices which labour is subject *to*, or subjects *itself* to. There is, in other words, far too much emphasis on discourses and practices which operate *on* the subjectivity of labour, without labour as an alternative voice, with its own distinctive 'themes', 'accents' and meanings being centred (p. 174).

[12] According to Newton (1998), Thompson and Ackroyd (1995) mistakenly attribute human agency to Foucauldian analysis of local power relations; e.g. they note how post-structural researchers present an image of power-knowledge discourses controlled by management and the academics in human resource management, accounting and consultancy. Newton (1998) goes on to argue that they also present a false dichotomy between individual 'struggle' and collective workplace-based 'struggle' (pp. 431-2).

Foucauldian perspectives are also proven as a means of re-framing the theoretical developments and understandings in the sociology of work. This strand, while recognising the potential for surveillance, also raises questions of identities and, hence, of resistance and misbehaviour. It is part of attempts to theorise subjectivity in the cultural sphere, though influences, such as Giddens (1984), are wider than Foucault (e.g. Knights and Willmott, 1989; O'Doherty and Willmott, 1998, 2001)[13].

Given this evidence from a number of perspectives and methodologies, one is uncompromisingly led to the inference that 'some theorists are seeing what they want to see' (Ackroyd and Thompson, 1999, p. 157). Many of those promoting a post-structural organisation theory of power should not have a real problem in relation to the Foucauldian account of power. Thus, before going on with a more labour process-oriented perspective, I examine Foucaullt's own theoretisation of power, as articulated in his clearest treatment of the issue in *The Subject and Power* (1982a). The first thing to note is that his thesis is novel on a number of counts and according to Munro (1993) '[t]heorising about power should be conducted in the context of the whole corpus of his text'[14] (p. 249):

First, the subject in Foucault's writings (1982a) becomes apparent *a priori* from power and he stresses that "while the human subject is placed in relations of production and signification, he [sic] is equally placed in power relations which are very complex" (p. 778). This power brings into play 'relationships between partners' and by that he thinks of 'an ensemble of actions which induce others and follow from

[13] Another concrete example is shown by Latimer (1994) who is concerned with the examination of nursing assessment as a component of the nursing process. Even though she relies initially on a Foucauldian analysis of power, she neglects the image of a disciplined and recalcitrant subject within the later stages of her research. In following this line of thought Latimer (1994) is able to reflect a more ethnographic concern while recognising the potential for surveillance: "*As discussed in relation to Foucault's work in Chapter Two, social actors are disciplined in particular ways. In the present study individuals count as knowledgeable, experiencing selves but their experience and their knowledge are taken to be socially constructed*" (p. 69, emphasis added). Clearly, the dualistic mode of human subjects has not been challenged and Latimer's analysis seems to imply that human subjects have to be seen as 'if the mind is assumed to act independently of the body' (Willmott, 1994a, p. 119).

[14] For earlier accounts on Foucault's framework see Dews (1984), Giddens (1984, 1987, 1993), Rabinow (1984), Frow (1985) Cousins and Hussain (1986), O'Neill (1986), Kritzman (1988), Martin, Gutman and Hutton (1988), Ball (1990), Habermas (1990), Morgan (1990), Burchell, Gordon and

one another' (p. 786). That is, power is 'a way in which certain actions modify others' (p. 788) and to exercise power means 'to structure the possible field of actions of others' (p. 790). In this context power exists only when it is put into action even if it is integrated into 'a disparate field of possibilities' brought to bear upon permanent structures (p. 788). What defines a relationship of power is that it 'is a mode of action which does not act directly and immediately on others' (p.789). Instead, 'it acts upon their actions: an action upon an action' (p. 789). Therefore, "speaking of power presupposes that, were it not for the action of the power holder, the power subject would or could have acted otherwise" (Kusch, 1991, pp. 123-4). Nevertheless, as Foucault (1982a) explains, it is always a way of acting upon an acting subject because 'it is a total structure of actions brought upon possible actions' (p. 789).

Second, Foucault (1982a) stresses that 'a power relationship can only be articulated on the basis of two elements which are indispensable' (p. 789). That means that the power subject is 'thoroughly recognised and maintained' by the power holder that s/he is someone who acts, and that the power holder tries to get the other person to act or to abstain from acting (p. 789). Even though Foucault (1982a) characterises power as part of the process of inter-/action in which 'consensus and violence are the instruments or the results', he notes that power is 'only exercised over free subjects, and only insofar as they are free' (p. 790); i.e. 'slavery is not a power relationship when [a] man is in chains'[15] (p. 790). That is to say that the power subject is involved as an actor and not just as a body which means that the power subject is able, and has the possibility, to disobey. As Foucault (1981a) has put it: 'Where there is power, there is resistance' (p. 95). Thus, passivity of those under power is not assumed because power is productive of and generates resistance. Since

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Miller (1991), Kusch (1991), Norris (1992), Munro (1993), Best (1994), Clegg (1994b), Dickens and Fontana (1994), Hoskin (1994), Lacombe (1996), Flyvbjerg (1998), Fox (1998).

[15] According to Kusch (1991), Foucault distances himself from Jean-Paul Satre (1905-1980) when he claims 'the slave is no longer free' because Satre [1969] stated once that "the radical freedom of the human beings extends even to the slave in chains, in so far as the latter still has to decide what his chains means to him" (p. 124). Instead, Foucault (1983a-h) suggests that "a power relationship demands the possibility of 'refusal or revolt', even when the latter might consist only in preferring death over submitting" (Kusch, 1991, p. 124).

resistance, struggle and change cannot be seen and understood as dichotomous to and outside of power it reflects a limitation of Foucault's analysis in terms of the social. As Newton (1996a) notes 'the subject is potentially in danger of appearing as largely a by-product of discourse' (p. 138). This tendency is revealed in Casey's study (1995), which I discussed earlier on page 43.

Third, Foucault (1982a) argues that a power relationship cannot be reduced to an economic relationship because of 'the types of objectives pursued by those who act upon the actions of others' (p. 792). That is, he distances his conception of power from questions of the capacity to 'modify, use, consume and destroy' things (p. 786). A Foucauldian power relationship is an 'inside-out' or internal relationship of interaction in which both parts are affected (1977c, p. 131); i.e. power is not an external relationship of comparison which can be measured or reduced to a statement because this leaves two people unaffected by each other. In other words, an internal relationship of power cannot be broken up into two different statements because one implies the other. In spite of the above endeavours of Sewell and Wilkinson (1992a-b), one cannot study any power possessions but one is able to see power as an exercise which exists only in inter-/action. In its most conceptually pristine and ideal typical form, a Foucauldian frame of reference is, therefore, incompatible with the standard conceptualisation of power in terms of agency and responsibility.

Fourth, Foucault argues that modern organisations are all alike in sharing an underlying power dynamic. In his carefully chosen words, he states 'prisons resemble factories, schools, barracks, hospitals, which all resemble prisons' (1977a, p. 228; 1981a, p. 73). Prior to this statement, however, he maintains that two things are always different to one another in their particularity. Burrell (1988) points out that Foucault was concerned with parallel centres developed around special social problems. For example, his archaeological research into areas like medicine, psychiatry, psychology, criminology and penology shows at what point the spark of disciplinary power moved from one area to another. What is important to note here again is that the parallel issue is the control of deviancy and in writing the history of

different institutions Foucault only identifies some of the origins of modern organisations (e.g. Giddens, 1984; Morgan, 1990; Thompson, 1990, 1993; Thompson and McHugh, 1990, 1995; Thompson and Ackroyd, 1995; Thompson and Findlay, 1999). Conceptualised in this way, there is a crucial difference between Goffman's concept (1961a-b) of 'total institutions' in which inmates spend their time entirely within the system and work organisations with people moving in and out of them throughout the working week (Giddens, 1984). The conclusion is therefore that 'total institutions' cannot simply be extrapolated to the majority of organisations such as work organisations, in which people spend only part of their time.

However, post-structural supporters and researchers have replied to this criticism by reference to the 'organisational world' idea (Burrell, 1988, p. 232) This societal notion stresses that working organisations have grown so much that they now influence all areas of life. The real point is, according to Burrell (1988), that "we are encarcerated within an organisational world (...) whilst we may not live in total institutions, the institutional organisation of our lives is total" (p. 232). Again, the empirical evidence is barely convincing and there are analysts who reaffirm that "for the vast majority of employees the organisations that they experience day by day are still authoritarian, rule bound and punitive" (Ackroyd and Thompson, 1999, p. 155). Here, the critics break with a post-structural framework as they insist that the informal organisational world and centres of resistance possessed by organisations prevent employed people from being disciplined in the way that others suggest. As Ackroyd and Thompson (1999) tersely observe:

> Post-structuralists make it doubly hard for themselves and everybody else by raising a cry of 'dualism' whenever they engage with an opposing argument. As a stick with which to beat their opponents, it is, we would suggest, a blunt instrument which adds nothing to the capacity of researchers to identify and explain actors and actions in the workplace. Of course, in practice, power or control and resistance interpenetrate rather than mechanistically produce one another. But separating them, as in labour process theory, has been a necessary heuristic device that enables us to 'see' the reciprocal actions. Without such a separation one merely collapses into another and we are left with the confusing and opaque results observed in the work of Foucault and followers (p. 158).

Fifth, Foucault (1982a) draws heavily on the thesis that power relations cannot be regarded independently and analysed without taking into account 'the origin of the former in the latter'; i.e. one must analyse institutions from the standpoint of power relations (p. 791). Indeed, Foucault (1977e) argues that the effects of truth are produced within discrete systems of discourse, language and calculation independent of the conscious speaker. In his work, discourses are an historical source of power, in that people through their expert talk can define situations and create key areas of knowledge forms; e.g. Burrell (1988) in his discussion on Foucault's archaeological period observes, that there is not the 'question of who speaks a discourse, but of what discourse is spoken'[16] (p. 223). On the basis of this point of view, Foucault (1977f) accepts that his analysis implies that one can never step 'outside' disciplinary power because it is 'always already there' (p. 140). Such a 'subjectless' position drives him inexorably towards a critique of the phenomenological theory of human subjects as favoured by Husserlian-Marxists (Mouzelis, 1995, p. 47). According to Kritzman (1988) he "opts for an analysis of the historical conditions and forms of rationality in which the human subject positions itself as an object of knowledge" (p. 17). In this respect, Foucault's work breaks with the structural and transcendental theories of the enlightment tradition and he uses archaeological and genealogical analyses to underscore that different modalities of power are capable of producing a net like organisation of discourses and practices.

In terms of organisational research a Foucauldian view implies the location of discourses and practices in the context of their history and to study the emergence and application of disciplinary power both archaeologically and genealogically. This cannot be translated in terms of looking at the evolving structural and horizontal differentiations within organisations over time during which power is viewed as isomorphic, with an increase in budgets or the number of employees whom one is able to influence or coerce. Foucault (1977a) describes this as a one-dimensional or anti-behavioural view; i.e. an approach which simply analyses consequences of

[16] According to Newton (1998) the relation between self and discourse is never 'static' because the main question is 'how people change in relation to developments in discourse' (p. 435).

legislation or indications of social structure. Instead it is suggested that an organisational analysis should be treated in the context of the history of the human sciences in which a single process derives from a historical formation. From this point of view, Foucault (1977a) advocates the study of the metamorphosis of controlling methods on the basis of a 'political technology of the body' in which one might be able to read 'a common history of power and object relations' (p. 24).

Following these above mentioned theoretical lines, and because Foucault (1982a) emphasises that power is only exercised over free subjects who are able, and have the possibility, to disobey discursive practices, means that the subject is implicated in discursive practices (p. 790). Yet such a stance does not distract from the difficulty for organisational analysis circulating around the question of agency and responsibility. According to Newton (1998) such issues do not disappear as 'a result of suppression' because organisational "people still need to *actively* work through the contradictions between individual sense of themselves and their allegiance to discursive position" (p 440).

A concrete example of this position is shown by Kondo (1990) who is concerned with the examination of life-time employment, consensus and harmony and an ethic of teamwork as components of the Japanese economy. By means of participant-observation, she explores not only a small family-owned business but also its surrounding community. In the case of her work she carefully theorises the self-formation of fe-/male subjectivity in the Japanese world and directly exposes the homogeneity, consensus and employee docility within neo-Confucian workplace relations. Whereas Casey (1995) seeks to neglect the display of conflict and contradictions in the workplace, Kondo's (1990) aim is to illustrate how diversity and discontinuity in Japanese work relationships undermine the manufactured myth of consensus and homogeneity in the Western world. Like Casey (1995), she draws upon a post-structural conception of self to support her empirical findings that the Japanese abstain from western humanistic beliefs in self-autonomy and sovereignty. In her empirical field, there is no problem of dualism because her co-workers do not

apparently reflect and reproduce the conception of themselves as independent subjects. In carrying out her research outwith the primary sector of the economy, Kondo (1990) is able to experience and observe 'uncaring and exploitative practices' trading on a 'truly familylike past' (p. 204). As a participant-observer from the Western world, she had great difficulties to accept that '[n]o single meaning, no single effect, could be isolated in its pristine abstraction' (p. 218). While there is much that reflects the binary oppositions between managers and employees, her research experiences taught her that the very definitions of resistance were *culturally* mediated (p. 221). As a writer of ethnography, Kondo (1990) also reflects on her own accounts within a post-structural perspective and her arguments come close to implying that there is a continuous line from discourse to the constitution of both action and identity.

By examining Kondo's analysis (1990) the consequence of this position for organisational analysis appears understandable in the context of Foucault's work. However, no theoretical framework is provided for understanding how decisions are made within local power relationships that pertain to the body of the employee. Even though there is a theoretical basis for considering the relative influence of the neo-Confucian culture, it is not surprising that Kondo (1990) cannot easily consider the relative influence of the managers in the context of organisational decisions. Yet to understand power and subjectivity in an organisation it is important to address such issues as noted above and to review the historical development of the platform upon which local power relationships are accomplished, such as the developmental processes through which an organisation and its corporate culture have been formed. Furthermore, Kondo (1990) has difficulty in explaining her local observations on how the human subjects relate to discursive practices within the organisation, while still remaining close to her theoretical framework. Although she qualifies her argument by noting the neo-Confucian workplace relations, she has been unable to adequately theorise employment relations, and has provided an inadequate basis upon which to develop an approval of either collective or individual change. As Newton (1998) so clearly put it: "*noting the problematic relationship between the subject and*

discourse is not equivalent to explaining how the subject relates to discourse" (p. 428). It almost seems as though Kondo (1990) tackles the pitfalls of a post-structural framework for organisational analysis by abandoning it in favour of a social constructivist view of organisational life in Japan (Tsoukas, 2000; Reed, 2000b).

With this review of the post-structural research literature I freely admit that I have not answered or attempted to deal with all the confines and explications concerning human action in the workplace. However, the aim of this section was to argue that the characteristic forms of motivation and action associated with bureaucratic or humanistic concerns of the employed person were replaced by those definitive of the disciplined and productive self. By means of post-modern analyses, specifically a reading of Foucault's work, the concept of corporate culture emerged as a total ideology that was intended to remove all prevailing impediments to cultural transformation. It was then shown that this process of alignment is highly partial and selective, given that the implementation of new programmes for a colonised consciousness are likely to be identified by an intense struggle between contradictory theoretical objectives and conflicting empirical interests.

Managing Culture? the Labour Process Perspective

The above review of the research literature illustrates how the current widespread use of the construct of corporate culture can be problematic because '*labour* as a subject has gone missing' (Thompson and Findlay, 1999, p. 174). This is hardly surprising coming from a post-structural perspective that displaces the human subject and consciousness from the centre of theoretical concern. The marginalisation of the human subject is paralleled in functionalist and radical structuralist studies of organisations where the open, reflexive and purposeful quality of the human subject is disregarded. In labour process orthodoxy, for example, Braverman (1974) and the studies of others have followed the mature Marx's (1976a) methodological injunction[17] to deal with the human subjects only insofar as "they are the

[17] People become alienated from each other and the world in which they live through the use of their labour by a system which expropriates and abstracts it from their daily lives. According to Marx (1976a, 1976b) alienation derived from the actual material conditions of capitalist production. In his

personification of economic categories, the bearers [*Träger*] of particular class relations and interests" (p. 92). In this research tradition, there is a strong inclination to represent human behaviour as an effect of external, overt forces (i.e. through the fragmentation of skills, specification, regularisation, standardisation and homogenisation) which means that minor consideration is given to the role of the human subject in the enactment of social and organisational reality.

This crucial development to organisational analysis theorises organisation as a process of power and domination and highlights the inadequacy of existing perspectives used to analyse culture and its performance. However, its implicit structural determinism glosses over counter-ideological details or inherent contradictions of specific strategies of managerial control within the capitalist mode of production and does not follow an ontological framework which conceptualises the complex nature of labour as a self-active agency or subject. As critics from both within and outwith the labour process tradition have argued, Braverman's study (1974) of *Labor and Monopoly Capitalism* was insensitive to important detail because the analytical development did not deal adequately with the central issues which lie at the core of the labour process debate over managed organisation (e.g. Storey, 1985; Armstrong, 1989; Knights and Willmott, 1989; Thompson, 1989, 1990; Reed, 1990; Thompson and McHugh, 1990, 1995; Willmott, 1990, 1994a, 1997; Smith and Thompson, 1998). This view is also exemplified by Littler and Salaman (1982) who argue that the only way of correcting this theoretical lacuna is to develop 'a pre-Braverman sociology of the workplace' which can cope with the breaks and contradictions which occur between the forms of organisational control implemented by managers within the production process and the broader structures of corporate control in which they are located (p. 251). They refer to Cutler [1978] and explain that

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later work or 'mature' work, as encapsulated by Althusser's notion [1969] of an 'epistemological break', Marx appears to reduce ideas to material interests, instead of viewing them in a dialectical fashion (May, 1996).

> the continued capitalist search for control over labour makes no sense outside of labour's assumed centrality and its assumed universal recalcitrance, but both centrality and recalcitrance may vary (p. 256).

Efforts to put the human subject back into the analysis of organisations have been made after the first stage of labour process theory. According to Smith and Thompson (1998) the subject was re-/inserted in three main ways: Firstly, as a source of *opposition* to capital which has created the well-known 'control-resistance paradigm' (p. 560). The work of Friedman (1977) and others suggests that alternative forms of managerial control such as responsible autonomy are reciprocally related to a variety of forms of employee resistance (e.g. Edwards, 1979; Littler, 1982). Edward's work (1979) is also based on historically successive dominant modes of managerial control which reflect employee resistance and changing socio-economic conditions. Departing from the linear model of labour process orthodoxy which leads to a serious underestimation of the diversity and complexity of managerial control processes, these researchers propound a thesis which suggests "a reciprocal relationship between major structural transformations in the economy and the course of the labour process" (Storey, 1985, p. 279). However, Littler and Salaman (1982) warn that descriptive classifications of management control strategies constructed and applied by Friedman (1977) and Edwards (1979) tend to

> *fail to grasp the variety of aspects of organisational control; that they focus on the 'formal' and official, and ignore the informal aspects of control; and that they compare forms of control which are incomplete and therefore incomparable* (p. 264).

Secondly, the subject was re-/inserted as a resource of *creativity* and productivity, without which modern management could not successfully transform 'labour power into profitable labour' (Smith and Thompson, 1998, p. 560). For example, Cressey and MacInnes (1980) documented the contradictions inherent in 'the concept of the real subordination of labour', linking the issue of the indeterminancy of labour power to labour's dual character (p. 7). They argue that capital employs labour not merely because "it pays it wages and therefore 'owns' its performance, but because it actually materially controls what labour does" (p. 8). At the same time, in the endeavour to secure productivity from labour, capital is obliged to develop labour as

a 'subjective force' to unleash labour's powers of social productivity rather than abolish these powers (p. 15). Challenging the empirical accuracy of Braverman's reference (1974) to 'management as the sole subjective element' (p. 171), Cressey and MacInnes (1980) provide a less deterministic and mechanistic account[18] where employees and managers are seen to reproduce as well as challenge their being embedded in relations of tension and contradiction:

> Since labour can only gain access to the means of production through selling its labour-power to capital it has an interest in the maintenance of that relationship and therefore the viability of the unit of capital which employs it. Moreover, the degree of this interest will increase with the skill and scope for self-expression (...) that the job provides. Hence labour too will have a direct interest in developing the forces of production within the factory, but again in contradictory fashion, since it will not wish such development to be used solely to benefit valorisation, but also to increase wages or provide more pleasant jobs (p. 15).

Thirdly, labour as a subject was introduced as a source of *consent* and integration (Smith and Thompson, 1998, p. 560). One classic example[19] is Burawoy's explicit attempt (1979) to re-address and re-work Roy's early analysis (1952, 1954) - even to the extent of using the same site of study. His influential analysis has sought to correct the neglect of the subjective of labour within orthodox labour process analyses; e.g. Braverman's thesis (1974) that labour intensification is the outcome of increases in managerial control associated with the separation of conception from execution. Specifically, Burawoy (1985) develops the notion of *Factory Regime under Capitalism* and argues that people's interpretations of their situation in the workplace are conditioned by, but not reduced to, their positioning within the prevailing political and economic system. Focusing upon the production games of 'making out' (i.e. maximising bonus pay out) played by the people - managers and staff alike - on the shop floor, he contends that these worker-led games "emerge historically out of struggle and bargaining, but they are played within limits defined

[18] This tendency is also exposed in Friedman's account (1977) of responsible autonomy.

[19] Thompson (1989, 1990) takes a similar approach and puts an emphasis on the relative autonomy of the labour process in the context of specific structural pressures to accumulate and reproduce capital. Although these pressures stimulate the continuous transformation of the labour process, they do not constitute sacrosanct laws in the form of the division between intellectual and manual labour, hierarchical control, and deskilling / fragmentation. The actual organisation of work is much more complex, incorporating a plethora of different managerial initiatives and employee responses (Spencer, 2000, pp. 229-30).

by minimum wages and acceptable profit margins" (1979, p. 80). Even though Burawoy is critical of labour process orthodoxy, he argues that the substance and attraction of the meaning of work is conditioned by its development within capitalist modes of production; i.e. he highlights the crucial role of the nation state in creating and maintaining "the material and ideational preconditions for the political and ideological structures of domination through which economic power is exercised" (Reed, 1990, p. 67). However, Burawoy (1985) analyses the meaning of the work on the shop floor as a consequence of 'lived experience or ideology' of employment within capitalist work relations and argues that the creation of these relations is facilitated by the meanings that emerge in the process of doing day-to-day work (p. 36). More specifically, he argues that employed people exercise their agency by participating in 'games', and this 'seductiveness' makes a substantial contribution to generate their active consent to the maintenance of capitalist relations of production (p. 38). Thus, the powerful sense of meaning and social identity, emotions such as pride and social prestige or the reduction of fatigue and boredom, derived from the ideological effect of playing the game, acted to obscure the political and economic relations of exploitation that, from a view of the labour process, comprise 'the objective moment' of productive inter-/activity (Willmott, 1994a, pp. 96-7). Burawoy (1985) makes this argument:

> For the most part (...) shop management (if not higher levels) becomes actively engaged in organising and facilitating games on the shop floor, particularly where they revolve output. It is through their common interest in the preservation of work games that the interests of workers and shop management are coordinated. The workers are interested in the relative satisfactions games can offer while management, from supervisors to departmental superintendents, is concerned with securing cooperation and surplus (p. 39).

Participation in the work games was analysed by Burawoy (1985) not as the result of class structures or external agencies of socialisation but as the product of people's need to compensate for being alienated from their nature. Despite binary oppositions between managers and employees, Burawoy (1979) sees no difficulty in attributing to all people the 'shared common interest in securing and obscuring surplus value' (p. 190). Within a class-conscious theoretical framework, however, this view is interpreted by Willmott (1994a) as "a conception that is promoted through the

discourses and practices of market freedoms, including the freedom to buy and sell labour in the market" (p. 97). Furthered by the individualising effects of capitalist practices, the understanding that human subjects are, and should inter-/act as autonomous and sovereign actors is productive of a heightened sense of responsibility for generating something of themselves. It is the capacity of the workplace games to 'honour' and endorse this *socially constituted* sense of autonomy and sovereignty that makes them irresistibly attractive to people (Willmott, 1994a, p. 97). Unfortunately, as Reed (1990), Willmott (1994a) and Spencer (2000) argue, it is an understanding of the motivational significance of this human desire that is absent in labour process debate and inadequately theorised in Burawoy's reflections upon the 'subjective' dimension of labour (Burawoy, 1985, p. 39).

Though many of the subsequent post-structural and empirical debates are critical of their neo-Marxist categories and radical Weberian lineage, some researchers have been attracted by this sort of framework for analysis which focuses on managerial attempts to engineer corporate values and employee participation and show how these concepts are based self-consciously upon an 'illusion of control' (Peters and Waterman, 1982, p. 80). These commentators are inclined to move away from research approaches based upon a dualism between functionalist and interpretative perspectives of social reality. Adopting a structuralist viewpoint that moves beyond the dualism of paradigmatic closure, they investigate in detail which conflicts between different interest groups are acted out at a local level whilst taking the contextual and historical conditions of an organisation into account. This is a critical response to the lack of structural analysis in the interpretative perspective and the way that the functionalist researchers look at organisational structure and strategy. As noted earlier on page 31, the interpretative perspective is in many ways in direct opposition to the functionalist viewpoint and stresses people's ability to construct their day-to-day life through their social inter-/actions and forms of communicative organisation which are taken for granted. Despite the detailed descriptions of the details of everyday life, the representation of people as having the ability to construct their own meaningful world neglects the existence of political and economic

pressures which attempt to shape their inter-/actions and influence change in organisations.

In contrast to these perspectives, where power is either conflated with action or structure, the labour process analyses not only serve to highlight how organisational reality is constructed through the wider social and organisational context of, and consent over, the labour process but also to show how managerial control over workplace relations is a *Contested Terrain* (Edwards, 1979). It is worth stressing again that these analysts deserted the extreme radical structuralist stance and sought to analyse human subjects at the workplace as 'knowledgeable agents' who draw on *symbolic resources* in their relations of 'contestation and co-operation' (Thompson and Findlay, 1999, p. 176). However, unlike the interpretative accounts of day-to-day life, this sort of analysis ensures that people's subjective views are firmly "situated within cultural and historical contexts, embroiled in organised structures and relations of the wider society" (Collinson, 1992, p. 237). Here, it is argued, the researcher will find

> the play of people developing and deploying differential access to the values, power, rules, discretion, organisation and paradox that undercut and remake fates for our times, not a logic of efficiency, a singular rationality or specific limited sets of contingencies and designs (Clegg, 1994b, p. 168).

Particularly available are detailed analyses of blue-collar, white-collar and managerial workers, among whom the trend of corporate cultures as management strategies is supposedly most pronounced (e.g. Ogbonna and Wilkinson, 1990; Pollitt, 1993; O'Donnell, 1996; Harris and Ogbonna, 1999). These studies are underpinned by a research framework that understands the mobilisation of corporate culture to be like any managerial initiative with power effects and aims to illustrate the tensions and contradictions surrounding the implementation of cultural initiatives. For example, the effectiveness of culture change initiatives has been studied by Ogbonna and Wilkinson (1990) in their in-depth study of major British supermarkets, employing approximately 200,000 people and where senior managers attempted to introduce a company wide cultural programme particularly directed at front-line staff

who come into direct contact with customers. However, Ogbonna and Wilkinson (1990) report that

> supermarket shopfloor staffs have not taken on board the values and assumptions espoused by their senior managements via training films and campaigns. Nonetheless there is evidence that staff have been responsive in terms of the behaviours they display at work. (...) [T]he motives behind the behaviour patterns displayed on the shopfloor were almost invariably either instrumental ("this disarms the customer") or under threat of sanction ("I smile because I'm told to"; "you have to be very careful and polite because they can report you to the manager") (p. 13).

This quotation raises the important issue of the relationship between corporate culture and managerial control and shows that if culture can be changed, vested interests within the organisation can favour or prevent the change process. In the supermarket study described above, the fact that check-out operators did not share the assumptions of senior managers made it difficult to achieve a change in their basic underlying values, beliefs and systems of meaning. But regardless of this, the collectivism which attempts to change culture can develop and may become counter-productive as the people use this to their advantage (Ray, 1986). Against this background, Thompson and Findlay (1999) explicitly argue that interpretations and responses like 'distancing behaviour, cynicism, deep acting or resigned behavioural compliance' should *not* be seen as value internalisation, rather they could and should be understood as 'resistance'[20] (p. 177). However, as Knights and McCabe (1998b) claim, "[i]t is only through examining the ways in which people interpret and respond to the demands made of them that resistance makes any sense" (p. 173).

Other studies, for example Thompson and Wallace (1996), Marks *et al.* (1997), Knights and McCabe (1998a-b), Taylor (1998), Milkman (1998), Ezzamel and Willmott (1998), Mulholland (1998) and Warhust and Thompson (1998b) have taken a similar view in trying to explore the practical activities in which managers are

[20] According to Parker (1998) the idea that day-to-day practices in corporate cultures can be read as legitimations of, or resistance to, the power of authorities is not in itself a new point since examining the conditions for the 'legitimacy' of authority is at the heart of the Weberian project. However, when this is linked to a model of social, political and economic structure it becomes an analytical and critical instrument for questioning the taken-for-granted day-to-day practices. (p. 23).

engaged to ensure that new organisational forms and unprecedented change are achieved, and the ways in which these attempts at control are resisted. This view is also exemplified by Thompson and O'Connell Davidson (1995) who acknowledge a labour process perspective and use qualitative research methods in an attempt to expose particular restructuring discourses are used by managers in post-bureaucratic organisations as an alternative to managerial control. Drawing on the case studies of one of the authors, they examined the sources and patterns of contemporary managerial rhetorics and actions and found out that the rhetoric of "profit-centre management has not entailed any real decentralisation of power or authority, nor has it genuinely created market forces within the organisation" (p. 31). The rhetoric of independent profit-centre management, in their view, could not be identified as a form of devolved power, greater autonomy for individuals and rewards for innovative, entrepreneurial management but as 'an effective instrument in winning very real concessions from direct labour' (p. 31). After all, despite profit-centre strategy and increased centralised control and monitoring, they conclude that the commitment-based rhetoric has helped the employees 'to manage themselves and their relationships with peers and the company' and enabled some of them to use 'ideas and language as a weapon in power struggles with rival functions' (p. 31). But the real story of this case study has been that there remains a disparity between the rhetorical claims for the end of bureaucracy and the day-to-day realities of organisations.

This tendency is even seen in those accounts who ignore any theoretical predisposition and locate the theory and practice of management within a broader sociological framework (e.g. Kunda, 1992; Collinson, 1992; Reed, 1996; Grugulis, Dundon and Wilkinson, 2000). Yet it is noteworthy that much of the evidence is taken from high-tech corporations, often in the U.S., or from non-unionised plants run by foreign investors, with homogeneous, mainly professional work forces (Thompson and Findlay, 1999). This point of view is clearly illustrated by Kunda's study (1992) of *Tech* - a company celebrated for its creativity and progressive people-

oriented style of management. The following interview excerpt is illustrative of how people at *Tech* are surrounded by and continuously subjected, to its culture:

> Tom O'Brien has been around the company for a while; like many others, he has definite ideas about "Tech Culture". (...) But, as he is constantly reminded, so does the company. When he arrives at work each morning, he encounters evidence of the company point of view at every turn. (...) Inside the building where he works, just beyond the security desk, a large television monitor is playing a videotape of a recent speech by Sam Miller [the founder and president of Tech]. As he [Tom] walks by, he hears the familiar voice discuss "our goals, our values, and the way we do things." (...) As he sits down [in his office space], he switches on his terminal. (...) On his technet mail he notices among the many communications another announcement of the afternoon events; a memo titled, "How Others See Our Values," reviewing excerpts on Tech Culture from recent managerial bestsellers. (...) In his mail ("the hardcopy") he finds *Techknowledge*, one of a large number of company newsletters. On the cover is a big picture of Sam Miller against the background of a giant slogan - "We are one." He also finds an order form for company publications, including Ellen Cohen's "Culture Operating Manual." (...) The day has hardly begun, yet Tom is already surrounded by "the culture," the ever-present signs of the company's explicit concern with its employees' state of mind (and heart) (pp. 50-2).

This excerpt conveys the idea of *Tech* as an organisation in which people are continuously exposed to positive images of the corporation and the reinforcement of corporate missions about what is expected from them. Although Kunda (1992) usefully points out how modern management ideologies are routinely mobilised in the hi-tech corporation, he is careful to show that *Tech's* normative exchange does not extend beyond the engineering people who are employed on full-time contracts at managerial levels to the troops of secretarial and clerical staff who are employed on lower grades or temporary contracts. Kunda (1992) also divides the ways in which employees at *Tech* seek to manage them as 'selves' into two groupings. The first is the way in which people manage 'boundaries' between themselves and work (i.e. boundaries around time dedicated to work, and boundaries around the social relationships that develop in the context of work) (p. 163). The second is that people manage their own responses to the affective and cognitive demands of the corporate culture in which they are employed. In this second group, he argues that there is a constant interplay between 'role embracement' and 'role distancing' (p. 170). Despite the potency of *Tech's* culture, Kunda (1992) concludes his research work by arguing that the frustration and psychological degradation experienced by the people

prompted many of them to develop and amplify countervailing images of this seemingly benevolent corporation.

Structure and Context: further Sources of Scepticism

Not all critics, however, share the same approach nor believe that corporate culture initiatives have the same effects. There are some studies which are based upon notions of contingency and change rather than universality and change. These interpretative analyses show that the systematic exposure to corporate culture initiatives can have a significant impact on the attitudes and perceptions of employees. Beer, Eisenstat and Spector (1990) reveal in their four-year study of organisational change at six large corporations that a successful transformation had taken place in so far as the general managers directed a 'non-directive' change process which started at the periphery of the corporation far from corporate headquarters (p. 159). Yet they conclude that none of the six corporations had reached the 'moment of truth':

> Even when corporate leaders intellectually understood the direction of change, they were just beginning to struggle with how they would change themselves and the company as a whole for a total corporate revitalisation (p. 166).

Similarly, Jeremy F. Dent (1991) found out that structural changes for finance-control implicated a counter-culture in a major railway company because all initial changes were based on a controlled process, relying on planning and rational analysis. Through a field study of organisational change, the study then showed

> how accounting can be vested with different meanings in local cultures. And it showed how accounting can enter into organisational settings to constitute cultural knowledge in particular ways, creating particular rationalities for organisational action; and in turn how this can lead to new patterns of organisation, of authority and influence, new concepts of time and legitimate action (p. 728).

Further, Peccei and Rosenthal (1997) conclude that the commitment of 717 employees to customer service in a major food-retailing organisation is primarily a non-calculative phenomenon driven above all by affective, normative and altruistic

concerns, rather than by overtly instrumental considerations. In addition, Rosenthal *et al.* (1997) detected that modern techniques of quality and human resource management can benefit employees because the managerial discourse of quality in a leading supermarket has affected the attitudes and perceptions of a significant number of employees towards customer service. Though highly critical of the control and work intensification impact of the prescriptive culture literature, they conclude that "the optimism of the management writers and others is better supported here than the pessimism of the control school" (p. 497). In addition to making clear that this was not the management of meaning, all these researchers presented empirical evidence that employees had either an awareness of managerial motives or had shown a pre-commitment to organisational change. It is also striking how much of the evidence indicates that some of the above researchers were all too inclined to accept at face value the statements that people made in semi-structured interviews or in documents without examining the actual consequences of managerial action. As Knights and McCabe (1998a) review in the same analytical context "just because management do[es] not declare a stated aim of enhanced control does not mean that this dynamic and the pressures of various control are absent" (p. 435).

Explanations for the general success or failure of corporate culture programmes often focus on organisational continuity and change, patterns and idiosyncracies, as well as the actions of human subjects and groups at various organisational levels, and processes of structuring. Here, the functionalist and interpretative perspectives are inextricably linked and one way of relating them is to see change as a continuous process in context. Perhaps the most influential academic writers and writing partnerships identified with this organisational transition approach to culture theory have been Pettigrew (1987), Whipp, Rosenfeld and Pettigrew (1989), Ferlie and Pettigrew (1990), Pettigrew and Whipp (1991) and Pettigrew, Ferlie and McKee (1992a-b). These have looked at the relations between the political and economic processes and organisational culture in Imperial Chemical Industries (ICI) and other mature industry and service sectors; i.e. automobiles, merchant banking, publishing, health care and assurance. They identified the problems of getting the need for

change accepted (e.g. ICI faced a profits crisis which paved the way for changes at the top of the corporation) and provide considerable evidence that processual or evolutionary change can happen when powerful interest groups line up behind it. What they had in mind, however, was the capacity of organisations to transform themselves from within.

Hope and Hendry (1995) have followed the logic implied by the work of Pettigrew (1987) and his colleagues and argue that their organisational studies usefully highlight 'the diversity of management approaches actually employed' (p. 63). In their own case study, however, Hope and Hendry (1995) observe that "[r]ecent research into imposed cultural change programmes in the late 1980s raises doubts about their effectiveness as change mechanisms, as management control devices and as contributors to business performance" (p. 61). They go on to claim that the situation in the 1990s is somewhat different in that organisations have been forced to respond to global competition and economic recession by continually becoming leaner through delayering and downsizing. Nonetheless, while Hope and Hendry (1995) displayed an awareness of the contextual factors, they raise similar issues as labour process analysts: Firstly, there was 'an attitude of complacency among the staff' which means "they had faith in, and reliance on, the senior management team's ability to direct the organisation in such a way that success, and the consequent rewards which this brought the staff, were still assured" (p. 67). Secondly, 'slow decision making' was clearly identified as an organisational characteristic (p. 67). Thirdly, 'the existence of strong functional divides' within the organisation significantly confined both 'communication and understanding' and had hindered 'the development of any sense of shared responsibility for corporate success' (pp. 67-8).

Despite impressive results, the contingency framework is not without its problems, as the historically and empirically informed accounts of Hope and Hendry (1995) and many others lack a viable general framework to understand the actual organisation of

work. This is the thesis of Thompson (1990) in which he remarks that it is important not to lose sight of the core theory of the labour process. He points out that

> [w]ithout such a framework [i.e. the core theory] there is a danger of returning to an empiricist tradition of accumulating plant studies, differentiated only by appropriating the language some seem so keen to discard (p. 96).

Overall, the above review of the literature suggests that corporate cultures are resistant to many forms of attempted change, but that they can also be amazingly dynamic and active. For example, most of the studies I have been discussing above indicate that managers do not actually have to achieve commitment and shared understanding among their employees to successfully implement their change initiatives. Drawing on their research into imposed, top-down, value-led programmes, Hope and Hendry (1995) explicitly argue that "the change initiatives that have concentrated on behaviour have been far more successful than the initiatives concerned with inculcating shared values" (p. 70). In the light of research, this seems pessimistic because the new armouries of managerial control and remuneration measures are only sufficient to change employee behaviour. Such pessimism is based upon the deployment of two rhetorics on culture - the use of the concept of culture as practices and values - that I have outlined earlier on page 20. It is therefore important to pay attention to illustrating the disparity between the cultural rhetoric and the day-to-day practices and to add an understanding of how people experience and respond to that disparity. While the disparity and people's experience are important, what is also needed is a concern with the wider social and organisational context and political economy which helps to explain the changing nature of work over the past decades.

There is another reason for which the focus on value internalisation may hinder an understanding of the relationships between contemporary culture initiatives and subjectivity. As the research works of Cressey and MacInnes (1980) and Burawoy (1979, 1985) indicate, the participation of people in routine practices can generate creativity and active consent to existing organisational structures and strategies rather than their commitment and shared understanding. This can be further illustrated with

respect to *Empowerment* (e.g. Kanter, 1989; Peters 1988a, 1992; Hart *et al.*, 1990; Slater and Bennis, 1990; Foy, 1994). The transformation to empowering forms of work organisation, in particular quality management, team-based work and consultative committees, is precisely what was neglected in more traditional forms of labour process organisation. Advocates of the 'empowerment thesis' stress that it involves the "delegation of responsibility from management to employees, non-hierarchical forms of work organisation and sharing of information between, and within, different levels of organisation" (Harley, 1999, p. 43). The actual presence of these day-to-day practices does not, however, mean employees are more autonomous or that normative forms of organisation are absent from contemporary workplaces. While empowering work practices are clearly present in an instrumental sense, they are more likely to be effective if people are nurtured who can preach behavioural change and who are willing to practice what they preach in business reality. This tendency, however, has nothing to do with the 'manipulation of corporate culture' (Ray, 1986, p. 294). It therefore is quite plausible to claim that some of these innovative practices can work if there is

> a combination of localised consent to the specific change process and support mechanisms in the sphere of reward systems, decision-making and industrial relations which promote and reward 'appropriate' behaviour (Thompson and Findlay, 1999, p. 179).

This argument is entirely consistent with the research results from Beer *et al.* (1990), Dent (1991), Peccei and Rosenthal (1997) and Rosenthal *et al.* (1997) in which 'organic, emergent behavioural-led change' was more successful than 'imposed, top-down change' (Hope and Hendry, 1995, p. 70). Inevitably the above analyses highlight that co-operation and the generation of consent were systematically built into the labour process and the comprehensive results were a continuum of possible and overlapping employee responses, from "resistance, to accommodation on temporary common objectives, to compliance with the greater power of capital, and consent to production practices" (Thompson and Bannon, 1985, p. 99).

Does the prevalence of accommodation, behavioural compliance and consent without commitment and shared understanding matter? Perhaps this underestimates the distinctiveness of the labour process in the health care sector where the traditions of professional autonomy and an ethic of health care service are shared by the occupational groups employed there. As Thompson (1989) notes in terms of the state service sector: "[t]he labour process *in general* is distinct from a capitalist labour process" (p. 247). The difference between an electronics factory and a health care organisation is not only composed of differences in structure, activities, strategies and control mechanisms. According to Salaman (1979) "it includes different ways of thinking and evaluating, different moralities and cultures" (p. 177). It is these differences I am referring to when I claim that there are different modes of rationality and complexities involved in applying a labour process analysis to the health care sector (e.g. O'Connor, 1973; Habermas, 1976a-b; Offe, 1975a-b, 1976a-b, 1984). For example, nurses do not play 'games' on the ward floor in order to survive or succeed in their day-to-day practice (Burawoy, 1979). Such professionals have a common sense of identity and values, share a consensus as regards to their social role, speak a common language, have distinctive working conditions and are life time members of their occupation. In other words, the relationships between the mobilisation of corporate culture and the work of managers and nursing employees within the health care sector are distinctive and more specific than in production industries or commercial service sectors as will be shown in this doctoral thesis. However, as Cousins (1986, 1987) and others have noted, chief executives must now engage and cope with a specific form of competition and markets within the health care sector in that they must improve economic perspectives, develop service and public relations opportunities, increase service quality and flexibility, reduce cost and inefficiency and step up the development of managers and staff. Labour process analysis could thus well prove to be helpful in exploring and describing the patterns of conflict and accommodation that characterise professional workplace relations and the effects of the introduction of a programme of cultural change into health care sector professionals' labour process.

Conclusion

In this chapter I have tried to set out both the significance of, and the limits to attempts to achieve corporate culture change. The academic literature on changing corporate cultures is polarised since there are clearly two perspectives according to which culture is treated in relation to social disorder and change. There are those who deal with culture on a behavioural level and those who deal with it on the level of values, beliefs and the systems of meaning. The consequence of this polarisation is that there is no convincing conceptual framework which clearly demonstrates how the mobilisation of values, belief and meaning systems could or should be attained. This is despite the fact that one part of the literature accepts such change as constituting a change of corporate culture. What the reader is also presented with in this literature review are post-structural treatments of the mobilisation of corporate culture which either equate it with the systems of discourse and practices or simply assume that modern techniques and technologies, in alliance with disciplinary power, will lead to a change in corporate culture. Attempting to change culture then becomes a journey into the dark side of the project by drawing attention to the subjugating implications of its prescriptions of excellence. Whatever the case, it is clear that the concept of culture has lost much of its meaning and significance as a 'root metaphor' for analysing and interpreting the subjective meanings and behaviour of people at their workplace (Smircich, 1983a, p. 347). Its meaning and significance within the social science domain was resuscitated at the expense of culture being treated as an expedient mechanism of managerial effectiveness within the labour process; i.e. when managers suppress cultural diversity and promote a mono-cultural world. In Thompson and Findlay's (1999) cogent expression, the empirical and theoretical work should be centred on how human subjects within organisations "are attempting to reconstruct the reciprocal but contested nature of the psychological contract in contemporary social, economic and political conditions" (p. 183). That is likely to be more complex in the health care sector where the traditions of professional autonomy and an ethic of service are shared by the employed occupational groups.

Chapter Two

Culture in Context: beyond orthodox Labour Process Theory

Introduction

As the review of the literature in the last chapter has shown, the labour process analysis provides an important framework for the study of organisation and work as it links specific managerial attempts to the wider social and organisational context and the predispositions and power resources of people inside and outside the labour process. Despite major criticisms the labour process approach remains influential, and Braverman's study (1974) of *Labor and Monopoly Capitalism* has been supplemented by insights derived from the second wave of labour process debate (Friedman, 1977; Edwards, 1979; Burawoy, 1979, 1985; Cressey and MacInnes, 1980; Littler, 1982; Thompson, 1989, 1990[1]).

Building on this perspective, a whole body of work has developed, producing highly critical informed accounts of managerial attempts to control the labour process and showing how human subjects are enabled or sometimes constrained to comply with corporate goals. More recently, labour process analysts have also paid some attention to the idea of mobilising corporate cultures and have shown how, especially when combined with participatory and skill-enhancing schemes, the project of changing the culture of an organisation can discourage employees, or encourage their resistance, by strengthening managerial control and increasing effort intensification in the name of organisational development and the more effective management of human resources. But almost all of these studies concern themselves with the complexities

[1] Thompson (1990) examined the major formative theoretical inputs and established a hierarchy of concepts in the analysis of the labour process which retains its emancipatory interest: Firstly, the capital-labour relationship is the central focus of analysis, and changes here are the main motor for change in the rest of the economy and society. Secondly, the capital-labour relationship is highly dynamic; i.e. competing producers have to seek ever greater rates of profit, and hence the labour process will continuously be transformed in pursuit of greater productivity. Thirdly, there is a generalised control imperative; i.e. the means of control are often very complex and forms of control exist outside the labour process. And, fourthly, the capital-labour relationship is based on contradictory elements of conflict and co-operation; i.e. although it contains aspects of co-operation and consent, conflict remains an endemic and structural feature of the labour process. In combining these four key concepts in labour process analysis, it can be theorised as 'a specific set of structures and practices that intersect with practices deriving from other social relations' (p. 22).

of contemporary work within employment in manufacturing and service industries and only few have carefully thought about other levels such as the economic and organisational context of public sector management.

Indeed, if the understanding of changing the culture of organisations is to advance, then more attention needs to be paid to the broader external and societal context of public sector organisations within which labour and associated mechanisms of control are performed. This chapter seeks to address this goal and the primary focus is on the health care sector in capitalist society. Particular attention is also paid to how the structure, objectives and behaviour of health care professionals are influenced by the actual policies and practices adopted by management and the influence they have on the development of health care sector management. Building on this comprehensive, multidimensional framework and as a response to the ideological and practical implications of cultural initiatives, I then introduce an ethnographic approach for labour process analysis. Here, the methodology used, and some of the concerns and potential personal and cultural biases that may have influenced the way in which the overall argument was put together, are discussed.

The Labour Process in the Health Care Sector

A useful analytical starting point for such an analysis has been developed by O'Connor (1973) and critical theorists, in particular, Offe (1976a-b) and Habermas (1976a-b) who differentiate between the different relations of production in capitalist industrial states according to the forms of organisational logic governing the private and state sectors. These sectors are summarised by Cousins (1987): firstly, a private monopoly sector, characterised by highly capital-intensive production industries, oligopolistic transaction markets, national and international affairs, clear unionisation and high wage rates. Secondly, a private competitive sector, characterised by small or medium-sized businesses which are not price makers in sales and capital markets. They are labour-intensive, with low levels of productivity improvement, low unionisation and employment instability. Thirdly, a state sector which is labour-intensive, with low levels of productivity improvement except by employment

growth, political determination of wage rates and centralisation of wage bargaining. Just as the private sector is subdivided, so too, is the state sector. The distinction involves the type of labour within the state sector, the conditions of work, whether the people are employed directly by the state or by private units, and in what way the production or service process is determined by neo-/market forces or by administrative political decree. Fourthly, Habermas (1976a-b) and Offe (1976a-b) add a residual labour power sector consisting of the state-dependent population (i.e. invalids and old-age pensioners or unemployed people), which is also in part a source of reserve labour and a secondary labour market.

Using this sector model it is possible to distinguish the different forms of organisational logic governing private and state sectors. In private sector organisations, according to Habermas (1976a), executive managers are governed by the logic of maximising profit and act in ways which avoid 'the social consequences of capital loss' (i.e. bankruptcy) and 'deprivation of the means of subsistence' (i.e. unemployment) (p. 63). In the state sector, rational and finite criteria which surround capital accumulation and labour relations are not at hand and the same form of organisational logic does not apply. The provision of state service, which historically includes health care provision and its management, is governed by different incentives, for example, budgetary decisions and state sector policy making. Policy formation, however, takes place in the context of a diffusion of objectives between political and cultural interests, professional and other provider groups as well as budgetary constraints. There are no distinct parameters that can be used in the assessment of efficiency or effectiveness as the state's activities 'cannot be calculated in monetary terms since they are not sold on a market' (Offe, 1975b, p. 139). Rather, the state has to operate according to its own administrative logic and complexity which means the state's activities are not those of accumulation but are those of correction and legitimation. As Frankel (1982) has put it:

> [W]hile capitalists are governed by the ultimate threat of bankruptcy or loss of profit, no such threshold governs state activity. That is, irrational and inefficient decisions by state administrations may result in social disorganisation or deprivation but these consequences are not strictly quantifiable. In other words,

> it depends on the population as to what are regarded as *tolerable* disruptions to social life (p. 271).

Cousins (1987), for example, found that the accumulation-legitimation framework provides a fruitful analytical starting point for examining state labour processes. In her study, she shows that state welfare organisations are not governed by "the logic of maximising profits, although they are dependent on the revenues derived from profits and the prosperity of the private sector" (pp. 3-4). Although this analysis concerns itself only with the U.K. and the U.S., it is possible to recognise that productive work within the state welfare sector is generally unproductive of surplus values even though these state welfare organisations provide the social and political conditions necessary for the process of capital accumulation and reproduction to take place. Even though the labour processes in state and private sectors are sometimes similar, according to Cousins (1987), each is governed by 'a different criterion of rationality' (p. 50). The different mode of rationality has created consequences for the strategies adopted by management, trade unions and professional and higher-level workers. However, as Cousins (1987) goes on to explain, state sector managers are often constrained to act as capitalists in that they have to extract value from the labour process, especially in the reorganised state services where they often operate according to competing rationalities.

By differentiating between labour processes in private and state sector organisations Habermas (1976a-b), Offe (1976a-b) in conjunction with O'Connor (1973) are able to distinguish different relations of production in each social constellation. Thus, the theoretical problems which surround discussion of state workers and employees in labour process theory are overcome by considering the macro-contextual milieu through a critical theory whose categories are geared to explaining state labour as not only reproducing capitalist social relations but also as negating them. As Frankel (1982) notes, critical theorists consider the provision of state service as a form of productive labour which not merely reproduces capitalist social relations but also negates them by introducing new, and additional forms of social relations of production. Yet, although the state and the contemporary capitalist society are

dependent upon the productive activities and the compliance of state workers and employees, they can still respond to prevalent problems even where that might create conflict with capital interests. Those in health and other areas of the state sector are not directly entangled in conditions of exchange between capitalist production and labour provision[2] but are structurally distanced from, yet highly dependent upon, revenues derived from capital accumulation for their economic resources and success.

The problem is that the state's two politically determined functions may be mutually exclusive, particularly when the state is involved in its regulatory crisis-management activities. Offe (1984) uses the example of the growth of the welfare state, with such institutions developing in part because the state needed to compensate for the inability of the market to deal with systemic needs, interests, demands, crises, etc. To the extent that state welfare provision is a response to socio-economic crises, it is very much a public affair. Yet, at the same time, the state threatens the process of capital accumulation and reproduction by expanding the range of social activities met by services for use, or by creating financial crises with an ever-increasing social wage and budget. This theme can be found in early interpretations, such as those offered by Marshall (1964) and by Briggs (1961), both of whom focus on the role of the state in regulating access to welfare services as well as picturing the welfare state as an institution which modifies or supplants the mechanism of the free market. The same topic is presented in some of the literature on the growth and decline of welfare states. For example, in Offe's argument (1984) that there are recurrent contradictions to which all welfare states are subject in capitalist economies, or in Flora's claim

[2] This can be demonstrated in the case of health care professionals. Although it is accurate to claim that their labour power is *hired* for a wage, it is not accurate to claim that the *purpose* of their labour is to produce commodities for sale. The purpose of their labour is, rather, to produce such use-values (i.e. service for use) which put commodity owners in a position to actually sell their commodities. Thus, health care organisations do not *sell* their products, although they help to maintain and to *improve the saleability* of the commodities of the *recipients* of their products. But to the recipients the non-commodified products of health care activities are distributed through channels different from exchange. Although one can find nominal *fees* as a mechanism playing a role in the distribution of their services, the prevailing mechanism is by no means sale but such things as legal claims, acknowledged need or simply free use. The same is true in such organisations such as schools, prisons and other parts of the state sector (Offe and Ronge, 1982, p. 255).

(1986) that the welfare states had by the mid 1980s reached their limits. This argument stretches from Titmuss (1958), who detected crisis arguments concerning the harmful effects of an excessively expanding welfare state on economic performance and work discipline (pp. 35-8), to neo-/liberal and neo-/Marxist writers who reached a consensus that the contradictions within the welfare states were becoming increasingly difficult to manage[3] (e.g. Preston, Chua and Neu, 1997; Chernichovsky, 1995; LeGrand and Bartlett, 1993; Navarro, 1993; Harrison, Hunter, Marnock and Pollitt, 1992; Levitt and Wall, 1992; Saltman and von Otter, 1992; Herzlinger, 1989). But if welfare states had reached their limits, the same must be true of operational forms such as bureaucratic, purposive-rational, and democratic modes of internal organisation of productive state activity[4] (Offe, 1975a-b). As a consequence, welfare states are imperfectly co-ordinated, and on account of their deficient capacity for perception and planning, they continue to grow and to become even more costly - although at different rates[5] (e.g. OECD, 1990, 1992; Eurostat Yearbook, 1997). The particular problem of the capitalist state, Thompson and McHugh (1995) have argued, is that

> [it] does not function unambiguously in the interests of a single class; it is a state *in* capitalist society rather than *the* capitalist state, and it is an arena of struggle constituted and divided by opposing interests rather than a centralised and unified political actor. National differences are an important factor in the specific evolution of state structures and practices (p. 93).

In examining complex issues of health care politics, Moran (1992, 1995, 1999) describes the 'health care state' not simply as a subsystem of the welfare state but as

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[3] The most important point separating neo-/Marxists from other advocates of fiscal crisis concerns the nature of contradictory imperatives (Freeman, 2000). For neo-/Marxists the problem is that capitalism could neither live with, nor live without, the welfare state; for neo-/liberal and conservative critics the problem is that democracy could neither live with, nor without, the same institution. See Moran (1988) for a short review of the crisis literature.

[4] None of these three organising principles is adequate for solving the specific problem of the state in capitalist societies, which is to establish "a balance between its *required functions*, which result from a certain state of the accumulation process, and its dynamics on the one side and its *internal structure* on the other side" (Offe, 1975b, p. 140).

[5] The faith that the bourgeois political economy - whether Keynesian or Monetarist - is inherently capable of solving socio-economic crises is only believed by 'capitalists with an eye to past glories', and by '[l]eftists who uncritically believe that capitalist states have an infinite capacity for technocratic solutions' (Frankel, 1982, p. 273).

being part of the capitalist industrial state and the pluralist democratic state. It comprises the organisation of health care as a series of industrial undertakings, and the participation of state institutions such as hospitals in regulating and promoting those enterprises. Hence, the health care state is composed of complex and often internally contradictory and inconsistent organisational apparatus. Moran (1995) suggests that 'health care industries' include the service and the manufacturing sectors and that, for him, explanations of health care policy must take into account that

> [t]he institutions of the health care industries are similarly diverse: They include religious charities that altruistically recruit staff and deliver care, and multinational corporations central to competitive struggles in the most advanced capitalist sectors (p. 768).

As a consequence of this extraordinarily diverse range of activities and organisations, Moran (1995) identifies the three distinct faces of the health care state as being regulation, financing and provision. Yet the boundaries between the three faces overlap and to study the health care state

> we must examine it as the regulator of patient care conditions; as the participant in competition among producers of health care goods and services; and as the arena in which distributional conflicts occur (p. 770).

Three separate, though related, faces of the health care state can thus be identified and provide potential researchers with the means to acquire 'some overarching conception of the meaning of health care politics', and to explore 'the tensions created by the different structures and processes working in health care systems' (Moran, 1995, p. 780). However, although this approach is empirically valuable and sensitive to the complexities of policy analyses and policy making in highlighting the health care state's centrality in advanced capitalist economies, there is a tendency to omit, or refuse to acknowledge, the structural properties implicit in the state's mode of organisation which differentiate them from private sector organisation and condition employee and managerial strategies.

In the critical theory literature, on the other hand, the analytical distinction between the different modes of rationality governing state and private sectors is a vital contribution to labour process analysis; adding a new dimension to class struggle and analysis. Critical theorists point here to the limited capacity of the state to devise modes of internal operation which meet pressures both from the requirements to sustain the process of capital accumulation and from certain non-capitalist interests represented through the political process. Moreover, Offe (1984) shows that the corporate state can be subject to specific political choices and technical practices such as cash limits on the total budget of each service, modifications through privatisation or contracting-out, a new managerialism based on the introduction of private sector practices, or the creation of market-like competitions. Different institutional structures and policy legacies give the state the possibility of creating distinctive organisational models and of increasing the efficiency and effectiveness of its organisations. However, the state's activities do not necessarily always ensure that the interests of capital will be met, as the state is also dependent upon the productive activities, loyalty, consent or even just compliance of professional and higher-level state workers. Offe (1976a) suggests that large and relatively homogeneous status groups represent institutionalised interests, fractions of capital, organised labour or professional associations and for this reason they are granted structurally determined privileges to make the most effective contribution to the avoidance of social risks[6]. However, the state selectively intervenes, so that the professionals and higher-level workers are able to define "the scope of 'realistic' issues and demands, which are then filtered through political and administrative processes"[7] (Cousins, 1986, p. 93). Pointing to the state's repressive character,

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[6] This representation is achieved not through an association of natural people in whom these needs directly reside, but through 'alliances of multi-functional, juridical persons', in other words, organisations whose particular functions predetermine and superintend the specific forms through which these needs are to be satisfied; or through 'such organisations which, because of the nature of their particular economic and professional interests, are directly involved within some sector of such general social needs' (Offe, 1976a, p. 401). At the same time, however, such organisations or the corresponding functional groups must be *capable of conflict*, and the degree to which they are so determines their prospect for exerting a political influence (Offe, 1976a, p. 402).

[7] The state intervenes in the relationship between health care professionals and patient clientele to define both the needs of patients and the manner in which they will be met. In this way, the state guarantees a patient clientele and therefore work for the health care professionals, and the resources for satisfactory types of diagnostic process and therapy.

Cousins (1987) refers to Offe [1972] and suggests that a wide range of democratic interests and social needs are excluded and de-politicised:

> As a consequence, general social interests which are not institutionally organised, and peripheral groups and depressed areas which do not generate dangers to the system, are excluded from access to political decision-making. Moreover, a new technocratic concept of politics becomes relevant where public policy making is not directed to the solutions of 'correct and just vital reforms', but to the 'conservation of social relations which claim mere functionality as their justification' (p. 59).

But, as noted earlier, there is no simple correlation between structural objectives, organisational activities and final outcomes or quality of state services such as health care. Apart from when ill, the patient clientele itself does not, unlike consumers in the free market, create demands and make rational choices, for these are determined by the heterogeneous health care professionals. It is worth noting here again that managers in the health care sector are lacking clear and definite criteria which surround capital accumulation and labour relations. As state agents, they make choices within structural constraints and have to rely on the verdict of medical doctors and other occupational groups as to what are sufficient human and financial resources and satisfactory types of diagnostic processes and therapy. This has meant that not only have the interests of the most powerful groups been privileged, but that the health care professionals have had an enormous impact on the total health care spending.

The Health Care Sector and Management Control

If the foregoing analysis is correct, state sector organisations such as those in health care operate and are embedded in an environment with its own mode of rationality. This implies that the state has an increased interest in extending control in new directions while professional and higher-level workers point to the ways in which these state policies undermine and damage the purposes of the state's activities. Nonetheless, this view neglects that the state in capitalist society selectively intervenes and introduces bureaucratic and purposive-rational techniques into the

health care sector, so that 'political issues or practical problems are transformed into technical problems and solutions'[8] (Cousins, 1987, p. 60).

Although the state as legislator is the 'main force' acting to restructure the health care sector, it cannot always be the 'direct agent' (Thompson and McHugh, 1995, p. 88). Health care organisations in capitalist societies and forms of administration and organisations in socialist and post-communist ones such as those in China, North Korea, Vietnam, Nicaragua, Cuba and the former U.S.S.R. also show evidence of executive authority, hierarchical control and work fragmentation. For Salaman (1979) bureaucracy is not a feature of capitalism only, but is "a key feature of the modern world dominated by rationality" (p. 22). This shows that the dynamics of bureaucratisation are partly independent on capitalist and other class-divided forms of work organisation, and that the analytical framework of critical theorists needs conceptions that enable potential researchers to focus on that particular problem. This is where Max Weber (1946, 1947, 1982) enters the scene, for he has defined a series of features which are a necessary part of explaining these complex processes. For example, he anticipated that state socialist systems would be more bureaucratic than capitalist ones because of the absence of countervailing power structures between the socialist state and competitive markets. In such an economy, 'the power of bureaucratised management' would continue and advance, as would the autocracy or 'dictatorship of the official' (Sayer, 1991, pp. 145-6).

Both state and private sector organisations operate on the basis of a hierarchy of offices in a pyramid of authority, and in most cases, formal control and co-ordination

[8] In Germany, for example, a number of state policies were vehicles for rationalisation processes in the health care sector which sought, among other things, to engage in a more systematic management approach and to provide incentives to induce more cost consciousness. These parts of state policies brought about, firstly, the representation of chief nursing executives on hospital boards, the implementation of tripartite management boards (Deutsche Krankenhausgesellschaft, 1969, 1989), and the rationalisation of management structures such as the introduction of chief executive officers in hospitals following the *2. Stufe der Gesundheitsreform* [i.e. 2nd Health Care Reform Act] (Gesundheitsstrukturgesetz, 1993). Secondly, the increased use of capital investments and centralisation to achieve control over strategic resources and economies of scale (Krankenhausfinanzierungsgesetz, 1972, 1985, 1991). Thirdly, the introduction of prospective payment systems and fixed budgets as well as the increased use of principles and measures of human resource planning (Gesundheitsstrukturgesetz, 1993; Pflegepersonalregelung, 1993).

procedures are important to define people's responsibilities, rights and duties as well as to govern the conduct of their work. As Littler (1982) and Littler and Salaman (1982) have identified, a Weberian lineage is central to an understanding of the employment relationship and the career system of economically powerful groups in particular[9]. More generally, calculable rules and set-down organisational procedures are prevalent in the analysis of "those structural conditions which surround the appointment, promotion and dismissal of individuals" (Littler, 1982, p. 37). Together with the relevant categories of critical theorists, such an analysis is important to the explication of the labour processes within a particular social context such as health care since these various aspects of organisations are based upon consensual rules and emphasise 'the continuity in social relations' in and beyond state sector organisations in modern or capitalist society (Thompson and McHugh, 1995, p. 378).

If this argument is accepted, then it is in this sphere of the employment relationship that Littler (1982) and Littler and Salaman (1982) add something new, but this is accorded very little attention by writers such as Offe (1975a-b, 1976a-b, 1984). Hence, contrary to the view of critical theorists, the introduction of a more powerful general management and administrative infrastructure in the health care sector can itself be a disciplining force:

> The career structure linked to the bureaucratic hierarchy strengthens a commitment to the organisation (...). A specific form of bureaucratic motivation is also sustained by the identification of job security, status, rewards and performance to organisational structure. Employees may react against the bureaucratisation of control embodied in rules prescribing the way a task is performed, but welcome rules governing selection, training and promotion within the employment relationship (Thompson and McHugh, 1995, p. 41).

It would be wrong, therefore, to suggest that the analytical framework of critical theorists is all that is needed because their proposition may understate the relevance of Weberian categories or the focus of labour process analyses for examining and describing the dynamics through which classes are constituted. In Smith and

[9] According to Littler and Salaman (1982), the most crucial dimension of the employment relationship is that of 'dependency' which is determined by 'the capacity of subordinates to organise' and by 'alternative sources of need-satisfaction' (p. 261).

Willmott's words (1991), the perspective is upon '*class as a relationship*' (p. 30) and, as a result, upon the capacity of state management for designing and directing 'utilitarian' or bureaucratic forms of control to health care work (Etzioni, 1964, p. 271). In this way, as Salaman (1979) has maintained, control is exercised through administration:

> mainly a question of the administration of resources, the establishment of guidelines and budgetary and other controls, and the recruitment and selection of suitably, expert, staff (p. 139).

However, the actual structuring of the employment relationship depends as much on bureaucratic forms of control as it does on the use of normative symbols (e.g. prestige and esteem) and social symbols (e.g. love and acceptance) for control purposes. According to Etzioni (1964), humanistic or 'normative' control is exercised by those in higher ranks to control the lower ranks indirectly, such as when a higher-level office holder 'gives a pep talk to his men [sic]' or appeals to his/her employees to engage in self-discipline and to act autonomously in their own interests (p. 271). It diverges from the characteristics that Weber (1946, 1947, 1982) associated with bureaucratic control in several ways even though both control strategies aim at increasing employees' loyalty and, ultimately, productivity; i.e. bottom-up decision-making, less specialisation, life-time employment, group-oriented production and the merging of work and private lives. In using this form of control, it is not just employees' behaviours and activities that are differentiated, assessed and remunerated or sanctioned; rather, they are driven by an internal commitment and strong identification with corporate objectives so that they gain satisfaction from work. Under normative forms of control, the employment relationship is based not only upon the behavioural or economic inter-/actions traditionally associated with organisations but on inter-/action which derives from subjective experiences; "one in which symbolic rewards are exchanged for a moral orientation to the organisation" (Kunda, 1992, p. 11). This has been recognised by management practitioners and academics who have demonstrated how management seeks to engineer people's consent in order to operate more successfully; whether

through formal-rational means or ideological rhetorics[10]. Hence, Parker (2000) and numerous others could argue that "an understanding of organisation necessarily involves an appreciation of the various methods that attempt to ensure co-operation is achieved" (p. 55).

The Health Care Professions and Professional Autonomy

Nevertheless, despite the legitimacy and interests arising from bureaucratic and normative systems, it is in the health care sector that the professional provider groups have developed a particular distinctive role and high social status. Without clear parameters to assess their complex activities, it has been the medical and nursing professionals, to a greater and lesser degree, who have been responsible for determining and controlling the priorities of health care. To some extent, as Dent (1993) notes, the relation between the state and health care professionals would appear to parallel Friedman's concept (1977) of *responsible autonomy* (p. 6). In his analysis of strategies of managerial control, Friedman (1977) has re-thought the ideas of labour process orthodoxy and generalises by distinguishing between central and peripheral employees. He demonstrates that employers can divide their employees in terms of the particular strategy which is used to maintain authority. Central employees are granted responsible autonomy with an outer circle of casual or 'float' employees subject to direct control strategy (p. 234). The first type of managerial strategy attempts "to harness the adaptability of labour power by giving workers leeway and encouraging them to adapt to changing situations in a manner beneficial to the firm" (p. 78).

On the surface, there are a number of corresponding similarities between the autonomy of central employees and health care professionals. However, the central role of the former is different in that its extent and nature is determined by managerial strategies within a context of prevailing labour market conditions and

[10] This is where the idea of mobilising cultures of organisations comes in, for it infers that the iron cage of bureaucracy is now made of velvet, indicating that the final frontier of management control has at least been crossed (du Gay and Salaman, 1992). However, the managerial methods used in introducing corporate culture change are those common to any management strategy aimed at changing employees' behaviour but with particular emphasis on their symbolic content.

employee resistance (Friedman, 1977). By contrast, the autonomy of the latter, i.e., the professional autonomy of health care professionals, derives from their occupational strategies and technical competence that historically predates the emergence of capitalist labour markets and different forms of organisational control. Moreover, professional autonomy characterises the outcome of negotiations between organised occupational groups and the state and not directly the outcome of class conflict at the workplace. Because this is so, it is simply wrong to hold that professional autonomy should be an imitation of responsible autonomy, which is the emphasis in much current thinking. According to Dent (1993), Friedman's concept (1977) of responsible autonomy can only be a 'starting point' as this alternative structure of managerial control is not concerned directly with the question of 'professionalism' within the health care sector (p. 247).

Yet professionalism is not unaffected by the principles of the state and certain professional groups have been promoted by the state to unequivocally meet the requirements of the state within capitalist society. For example, Dent (1993) argues that the concept of responsible autonomy, though inaccurate in terms of describing the actual relations, has long been 'the preferred strategy of the British state towards the medical profession' (p. 247). It has been the ability of the medical profession to protect their occupational interests, maintaining socio-economic privileges and a monopoly of theoretically grounded knowledge (e.g. Foucault, 1970, 1973). Hence, the medical profession has been able to exercise power in the production of certain bodies of knowledge and in definitions of satisfactory types of diagnostic processes and therapy. It is this enormous power over both state policy and the personal affairs of individuals that underpins what Freidson (1970, 1994) has conceptualised as *professional dominance*[11] (1994, p. 31). He distinguishes between the well-established professions (such as law, medicine and architecture) and the technical professions - those with more education and complex skills than most workers (like

[11] This is a multidimensional conception the components of which were listed by Light and Levine (1988) in the U.S. context as follows: firstly, the 'autonomy over work'; secondly, 'control over the work of others in one's domain'; thirdly, 'cultural beliefs and deference' and fourthly, 'institutional power' (p.12).

teaching, social work and nursing). Freidson (1994) considers that the latter have few prospects because

> they are part of productive domains which are already organised and controlled either 1) by dominant professionals and their allies, or 2) by managerial agents of either the state (...) or corporate capital. In the massive and still growing domains of health, welfare, law and education, the division of labour is organised around the central authority of dominant professions. (...) When they are licensed, certified, or registered the legitimacy, even the legality of their work hinges upon their nominal supervision by that dominant profession. (...) They are thus bound into an occupationally subordinate position even though many have organised themselves into occupational associations (...) and have claimed many of the attributes ascribed to professions (pp. 116-7).

Freidson's influential definition of professions (1994), however, misses the significance that the autonomy and dominance of the division of health care labour are by no means the only ways of ordering expertise. For example, Johnson (1972) has argued that accounts which focus on the supposed qualities of professions have never been able to agree to a list of 'traits' or 'attributes' that are typical of all professions in all circumstances (e.g. Greenwood, 1957; Etzioni, 1969; Katz, 1969; Freidson, 1970). Similarly, the proposition that professions serve central social needs is also problematic because the alleged intrinsically altruistic service of professionals has often been the base of exaggerated claims about their ethical and progressive role[12] (for less optimistic, more critical nursing accounts see, for example, Inglesby, 1992; Brykczynska, 1993; Salvage, 1995; Mackay, 1996; Morrall, 2001). As Johnson (1972) demonstrates in his critique of such a functionalist approach, this falls into 'the error of accepting the professionals' own definition of themselves' (p. 25) and he described this deficiency as a conceptual 'straight-jacket' (p. 89).

Instead of regarding professionalism as an inherent characteristic of few selected occupations, according to ethnomethodologists and symbolic interactionists in general (e.g. Hughes, 1958; Bucher and Strauss, 1960/1961; Becker, 1970), it is best

[12] In his discussion of institutional altruism, Merton (1982) notes that the ideal and the reality do not coincide: "Especially when technical expertise is employed without coordinate regard for the purposes to which it is put, there develops that kind of imbalance which often makes professionalism a term of abuse" (p. 118).

regarded as a form of occupational strategy and development, whereby ideologically powerful groups attempt to gain recognition as professions in order to reap the rewards of the older classic professions. In his own investigation and analysis of *Men and their Work*, Hughes (1958) indicates, that he "passed from the false question 'Is this occupation a profession?' to the more fundamental one, 'What are the circumstances in which people in an occupation attempt to turn it into a profession and themselves into professional people?'" (p. 45). The analytical scope moves here to the indispensable process of occupational groups attempting collectively to control and upgrade their purpose and standing. On a more theoretical level, the positions of symbolic interactionists and ethnomethodologists have been substantially developed, in an interpretative, hermeneutic and phenomenological direction, within the contemporary sociology of the professions. For example, Dingwall (1976) has argued that

> what we need to do is to examine how occupations are established as discriminable events through the interpretive work of their members and of outsiders, and how certain occupations further seek to establish themselves as 'professions' through certain kinds of appeals (p. 347).

Consequently, the professionalisation of both medicine and nursing[13] is considered primarily as a self-seeking strategy and development by these groups of people. The purpose of it is self-government and, with the support of the state, to achieve legal monopoly over recruitment, training and certification.

Nonetheless, this perspective neglects that the occupational groups of health care are powerful groups in society and their power and practices are based upon particular roles and functions carried out with professional autonomy and control. Their

[13] For example, an interactionist study of the occupational socialisation of nurses by Melia (1987) develops Bucher and Strauss' notion (1960/1961) of 'segmentation' (p. 3) and investigates the "differences between the idealised version of work as it is presented to new recruits and the work as it is practised daily by members of the occupation" (p. 1). She identifies *service* and *education* as the two main segments that exist within the profession, "each with its own particular reason for canvassing the version of nursing which it has made its own" (p. 4). One thing that becomes apparent on reading this approach to the study of the occupational socialisation of nurses is that Melia (1987) has paid attention on the behaviour rather than roles. More specifically, she started from the point of view that nursing students would react to the service as well as educational process and negotiate a role for themselves accordingly.

demands for professional autonomy, according to Armstrong (1986) "may express not so much a desire for independence, but an ambition to be numbered amongst the controllers rather than the controlled" (p. 25). As a result, radical Weberians and orthodox Marxists have not followed an ethnomethodologist or symbolic interactionist perspective, rather they developed their arguments and reached the conclusion that professionals are "not so much public-spirited altruists serving the common good, as powerful groups in society in pursuit of their own, and more abstract 'capitalist', interests"[14] (Crompton, 1990, p. 154). Nevertheless, despite the assaults from the radical Weberian and the orthodox Marxist movements, the dependence of the patient clientele on professional expertise and the impossibility of them ever acquiring such specialist knowledge explicates why, in respect of these health care groups

> *nobless oblige*, not *caveat emptor*, is the rule, though far from being the behavioural fact (Merton, 1982, p. 117).

In other words, given the nature of professional expertise and the vulnerability of the patient clientele with respect to expert service, health care interactions between professionals and their dependants could not function in the absence of some kind of ethic of service and welfare. Indeed, according to Crompton (1990), a degree of 'moral' regulation among professionals is not incompatible with "the practice of strategies of exclusion and closure in order to gain an occupational advantage, or an emphasis on the pursuit of capitalist interests over those of other clients" (p. 155). In addition to the principles of professional autonomy and occupational strategy, the division of health care labour also has a capacity to generate norms relating to its use and disposition which are accurately conceptualised in Merton's definition (1982) of 'institutionalised altruism':

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[14] For example, Navarro (1993) maintains that health care professionals are aligned with the capitalist class and, therefore, contribute to the exploitation of the proletariat, and benefit in terms of remuneration and status from performing as an agency of social control on behalf of the state. According to Navarro (1993) health care professionals have created more problems than they have solved because they are trustworthy representatives of the capitalist class; i.e. they get sick people well thereby sending them back into the workplace in order to generate more profits for the bourgeoisie.

> [P]rofessionals should do everything they can for a client, to a degree even at the expense of maximising their own distinct interests. Correlatively, the norm proscribes professionals acting in ways that will result to their advantage, and not only monetary advantage, when this is at the expense of clients. (...) As normatively *preferred* rather than *required*, altruism involves a voluntary element in which the professional does more than is required. In a word, altruism is supererogatory (p. 115).

The work of health care professionals is distinguishable, therefore, from that of most other workers in contemporary society; i.e. they are to some degree controlled through their internal commitment to professional objectives which emphasises the importance and value of a particular activity, condition or practice and to some considerable extent they regulate their own work behaviour. However, it is undoubtedly important to note that this commitment is not only associated with an ethical code of service to protect the patient clientele but also with monopolistic closure and privileged societal positions. Such conditions, as Larson (1980) argues, lead to the creation and control of 'a protected, or institutional market' for professional services and 'a project of collective occupational and social ascension' (p. 141).

Despite all this, the form of professional autonomy carried out by highly skilled, knowledge-based professionals does not distract from established powers and functions of health care sector management. As Crompton (1990) has maintained, "the regulation of abstract knowledge, and thus expert labour, is common to all societies" and facilitates the embedding of professions in positions of power within structures of organisations (p. 157). It is because of this incorporation that health care professionals in the current context are not only historically but also institutionally bound and this represents a shift away from the sociology of the professions in the direction of the employment of occupational groups. It is this employment relationship that unites professionals in a health care organisation and enables them to have a meaningful collaboration in the controlling and manipulating of this organisation[15].

[15] It appears then that Weber's model (1947, 1982) of rational-legal authority and control contains two potentially conflicting, and certainly conceptually distinct, elements: "one consisting of behaviour bound by rules and specification backed up by hierarchical authority, the other involving expertise and

This perspective on professional groups and organisation in the state sector has attracted considerable support and attention; i.e. it has been recognised by labour process writers such as Dent (1999a-c, 1995a-b, 1993, 1991b-c, 1990), Ackroyd and Bolton, (1999), Dent and Burtney (1996, 1997), Parker and Dent (1996), Ackroyd (1996a-b, 1997), Whitston and Edwards (1990) and Ackroyd, Hughes and Soothill (1989) who have demonstrated how health care professionals are ineffectively subject to management priorities and authority because they retain as well as share considerable degrees of autonomy and control in their day-to-day work to serve their patient clientele and occupational interests.

At the labour process level, they follow Larson (1980) and Derber's definition (1983a-b) of proletarianisation and found some evidence that the health care professionals' labour process is 'analogous to, but not identical with' the labour process experienced by private sector workers (Dent, 1993, p. 252). It is not the routinisation, fragmentation and mechanisation of the health care labour process as some commentators have tried to make us believe[16] (e.g. Pollitt, 1993; Walby, Greenwell with Mackay and Soothill, 1994; Adams, Lugsden, Chase, Arber and Bond, 2000) but the 'transformation of professionalisation strategies into generalised credentialism' and legal licence that leads to a general loss of the self-employing status that may come to be interpreted subjectively as 'proletarianisation' (Larson, 1980, pp. 144-5). Hence, Cousins (1987) is entirely correct to suggest that professionals in state welfare organisations are exposed to different structural conditions and experience subordination in "their inability to define the ends and social purposes to which their work is put" (p. 97). What she bears in mind is that

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technical knowledge as the basis of member's behaviour and authority" (Salaman, 1979, p. 131). That is, "authority deriving from (professional) expertise as contrasted with authority derived from (managerial) bureaucratic office" (Crompton, 1990, p. 151). The former is conducted by someone accountable for the day-to-day practice, guided by occupational standards and ethical codes, and monitored by senior professionals and corporate bodies, while the latter is conducted by someone who takes responsibility for the structure of health care organisations, so that detailed rules can appear as incentive or restriction.

[16] The scientific management approach has been applied to the work of health care professionals in Russia in the late 1980s. On an automated conveyor belt, eye surgery was carried out using a controversial five-stage assembly-line operation. Each step of the operation was performed by a different eye surgeon, and each eye operation took a maximum of ten minutes. See Buchanan and Huczynski (1997) for a short review of Taylorism in health care action (p. 344).

differentiation has always existed in state welfare organisations, and that professionals are unable and unwilling to question the real nature of their 'contribution' or the power behind their 'spurious freedom' (Salaman, 1979, p. 139). In this context Derber (1983a) suggests proletarianisation may be the basis for a highly sophisticated '[i]deological cooptation', whereby health care professionals' moral concerns for the patient clientele can be accommodated in a form of practice that serves occupational as well as bureaucratic ends (p. 332). In return for their on-going cooptation with corporate objectives, they retain their professional autonomy and self-direction which may contribute to state 'management interests more than it threatens these interests' (Cousins, 1987, p. 98). As a result, health care professionals enjoy a benign employment relationship with their employing organisations and for this reason the employment relationship which supports and underwrites the provision of health care services takes characteristic forms. As the following quotation from Blau and Schoenherr (1971) indicates:

> An organisation can be governed by recruiting anybody and everybody and then using a chain of command to rule them (...) or installing a technology that harnesses them to machines. But an organisation can also be managed by recruiting selectively only those employees that have the technical qualifications and professional interest to perform on their own the various tasks for which the organisation is responsible and then give them discretion to do what needs to be done within the broad framework of basic policies and administrative guidelines (p. 350).

Hence, it has been well established by this and other scholarly work that health care professionals maintain and dominate the labour process as long as they willingly fulfil their purposeful duties in ways consistent with management priorities and practices. But the recognition that state management cannot directly control and dominate the performance of health care professionals leads to the question of how they actually achieve control, direction and legitimacy of health care professionals' relatively unconstrained conduct.

Health Care Sector Professionals and their Management

Because health care professionals provide complex, discretionary services to the public and use specialised knowledge and power for socio-economic gain and

monopoly control, they may pose real dilemmas for the stability and further developments of state welfare sectors and organisations. According to Bertilsson (1990), with regard to the occupational status and power that the traditional professions used to have modern societies have closed the gap:

> Professions are today held accountable either by means of state control or by means of organisations of customers or clients, in particular by powerful insurance organisations in pursuit of malpractice (pp. 129-30).

This has important implications and the outcome taken as a whole[17], offers compelling insights into the variety of management strategies such as the kind of centralised, bureaucratic control exemplified by Max Weber (1946, 1947, 1982). When there is pressure to contain cost and to use resources more effectively[18], as Ackroyd and Bolton (1999) have described it, management has the power to control 'the supply of the other things necessary to the provision of health care', including crucially, the numbers of patients (p. 374). As a consequence, they can change the parameters by appropriate impersonal mechanisms of control within which health care professionals exercise autonomy in their work. For example, the key strategic objectives of health care sector management are secured by increasing the numbers of patients with which health care professionals are challenged. What is important to note here is that health care sector management can reduce the amount of 'time' available to treat the patient clientele and by doing so, they establish 'key conditions' within which professional groups have to work (p. 374). In this way, health care professionals are induced to work harder unless they willingly neglect 'their own ideas and standards about what is appropriate to adequate hospital care' (p. 374). That is to say, management can greatly increase the usefulness and efficiency of health care professionals by increasing the throughput of patients. However, as

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[17] Without health care sector management, state policies of cost monitoring, measurement and control could not be effectively translated into actual control. The burgeoning of health care cost has encouraged the view that health care sector managers should be responsible for considerable inefficiency, mismanagement and waste and the idea that effective and functional management has to be put in place has been repeatedly proposed in different countries.

[18] The rationalisation of management structures such as the introduction of chief executive officers in hospitals following the *2. Stufe der Gesundheitsreform* [i.e. 2nd Health Care Reform Act] and their attempts to control health care cost and resources is the German example which portrays the recent tensions between state management and the professions (Gesundheitsstrukturgesetz, 1993).

Ackroyd and Bolton (1999) stress, this self-control necessitates higher levels of skills, flexibility and commitment from health care professionals in so far as they 'remain if it is to be successful' (p. 383). From the point of view of the professional or managerial organisational member, this contradiction is a potential source of conflict because it depends on a particular historical context for its meaning and health care sector management may be inclined to choose alternative strategies of control within which commitment and shared understanding can be retained and reconciled to new corporate objectives.

Central to the design of more efficient, flexible and innovative health care services is the use of various forms of task-centred, decentralised, human-based management. Here, bureaucratic controls are relaxed or removed in favour of post-bureaucratic programmes that, for example, seek to increase internal commitment and use various participatory and skill-enhancing schemes to improve health care performance. Once again, Ezzamel and Willmott (1998) demonstrate what this means: "the objective of these methods is not simply to improve the coordination of productive effort but, more fundamentally, to induce and discipline employees to work at a pace or in ways that are intended to increase or at least maintain profitability" (p. 362). New forms of control, including the concept of corporate culture, are welcomed as long as it is anticipated that they will enable health care sector management to ensure that they will monitor and shape what health care professionals actually do. This requires health care sector management to convince professionals, through practical or ideological schemes, to provide health care work from which the patient clientele as well as the health care organisation will gain and benefit. In other words, health care sector management needs to rely on its professionals as an ideological resource to identify and solve serious problems[19] and to give a homogenous performance on every occasion. While the health care services for the patient clientele may improve,

[19] Such schemes encompass a range of techniques including "performance review, staff appraisal systems, performance-related pay, scrutinies, so-called 'quality audits', customer feedback mechanisms, comparative tables of performance indicators including 'league tables', chartermarks, customer charters, quality standards and total quality management" (Hoggett, 1996, p. 20).

the implications for health care sector management and professionals may be very different because the former wants more than mere compliance from the latter.

Unlike many other perspectives, it is at this shifting frontier of control that the entrepreneurial dynamics of health care sector management collide with the 'processes of interpretation' and the 'self-formation process of employee subjectivity' which are inescapable features of health care organisations[20] (Knights and McCabe, 2000, pp. 421-2). These features include the implications of changing practices for sustaining the traditions of professional autonomy and control and for adopting newer principles based on 'responsible autonomy' (Friedman, 1977, p. 6). This is not to say that such features always stand in opposition to corporate objectives since they can often have the unintended consequence to work in the health care organisation's favour. For example, health care professionals may create a much stronger sense of service-orientation in advance of management development and improve the quality of their performance. Considered in this way, active management is just a more complex form of negotiation and intervention than constant and intimate conflict between health care sector management and professionals. Nevertheless, spaces for resistance and misbehaviour do occur in health care organisations just as in other areas of organisational life and may drive health care sector management to implement additional forms of control. For example, health care professionals may genuinely empathise with the patient clientele but may show 'organisational misbehaviour' and 'irresponsible autonomy' towards management actions (Ackroyd and Thompson, 1999, p. 164). The existence and relevance of this interplay and conflict for understanding health care organisations is ignored when the mobilisation of corporate culture is treated as equivalent to the notions of institutional excellence. Indeed, the reluctance of functionalist writers to acknowledge the structure of management and professional autonomy and control in which mechanisms of institutional excellence are embedded was illustrated in Chapter One.

[20] In this way, health care professionals are not displayed as adaptive simpletons, regulated by a modus *operandi* they know nothing of, but as 'knowledgeable agents' who draw on *symbolic resources* in their relations of 'contestation and co-operation' (Thompson and Findlay, 1999, p. 176).

A Note on professional Variations within the Health Care Sector

However, a difficulty remains; i.e. that the explanation offered has not so far differentiated between professional provider groups in the health care sector. The problem with the above explanations is not so much that they are wrong but they are incomplete. For example, Abbott (1988) has argued that such an approach ignores the wider context of 'interprofessional competition' over knowledge that illustrates how and why professions grow or decline (p. 167). The question remains of how one explains the differences in the progress of different employed occupational groups along the path of professionalism. Why are medical doctors, say, capable of sustaining their professional status, while nurses are not? An answer has been given by Fincham and Rhodes (1992) when they argue that the question itself is not of importance: "certain occupations have simply managed to acquire the totem of professional prestige while others have not" (p. 287). Others, however, seek more distinctive explanations and take historical and political factors into account. Thus, for example, it has been pointed out that state interference and regulation in the professions and their occupational development seems to be a major factor explaining why some occupational groups are now more influential than others (e.g. Johnson, 1972, 1977a-b, 1980; Larson, 1980; Rueschemeyer, 1983; Crompton, 1990). The shifts in the boundaries between medicine and nursing in the United Kingdom are particularly useful for understanding the previous claim:

> With the continuing attempts to reduce the hours of junior doctors (NHS Management Executive, 1991), increasing interest in shifting some tasks to nurses, and the renewed professionalisation project of nurses seeking to upskill their occupation (UKCC, 1986), the negotiation of the complex boundary between the tasks of medicine and nursing is a matter of pressing policy concern (Walby *et al.*, 1994, p. 12).

The ethics of service and welfare that have been shaped by the state reflect rules of the state employing health care professionals, while control over the service of health care being provided resides with different health care professionals. However, the more powerful and prestigious medical doctors have been able to exercise an important influence in the determination of health care policy and remain the primary decision-makers in the delivery of health care services. According to Larson (1980)

this has much to do with the dependence of the state on the medical profession in the organisation and control of health care delivery.

On a more abstract level, one can find two related concepts that help to explain variations in professional autonomy and control: firstly, Carchedi (1977) has drawn attention to the contrasting labour forces operating on middle-class occupations, some of which degrade and constrain occupational control while others serve to enhance an occupation's market position. The explanation the author gives reflects the extent to which the processes of capital accumulation and reproduction are (not) being served. If the occupation concerned plays an important role in administrative and control functions crucial to the logic of maximising profit, it will command the decision-making power that will bring occupational prestige and exceptional rewards. However, if an occupation has tenuous links with these fundamental capitalist processes, occupational prestige will be much more marginal. In terms of the state's two politically determined functions, there are plausible reasons for thinking that health care professionals - medical doctors and nurses alike - fulfil both roles and they are, therefore, in a contradictory position. However, as Hanlon (1998) argues, the structure of health care professionals itself may become 'an important political feature' since 'the distribution of functions' within such a position is important (p. 46).

Secondly, Jamous and Peloille (1970) pointed out that the power, prestige and rewards accruing to a profession are determined by the continued possession of a control strategy and the nature of the work involved. They argue that where a high degree of 'indeterminacy' and a certain mystique exists in the day-to-day practice of a profession (i.e. where tasks are variable and non-rationalised), the people who control this uncertainty are likely to enjoy decision-making power, occupational privilege and high social status (p. 112). Conversely, where such work has been systematised and subject to laid-down procedures, it becomes possible for forces outside the profession to codify and regulate the labour process. As the authors put it, 'technicality' refers to the extent to which a systematic body of knowledge is used

in the justification of professional expertise; i.e. it is "the part played in the production process by 'means' that can be mastered and communicated in the form of rules" (p. 112). Hence, Jamous and Peloille (1970) see the power that professionals display around occupational attributes such as the level of technical content and the 'indeterminacy' of the judgements which form the basis of the expertise in question (p. 112).

To a certain extent, both concepts seem to provide an explanation of why it is that medical doctors rather than nurses achieve a wider range of autonomy and self-regulation. However, playing an important role in functions crucial to the production of surplus value and relying on a high degree of indeterminacy in the work of professionals are not the only objective features of the health care labour process. That is, socio-political and historical components also play a crucial part in creating, or failing to create these conditions. For example, medical doctors were able to capitalise on the objective conditions of their situation at crucial points of their development (e.g. Harrison and Ahmad, 2000; Kitchener, 2000; Freidson, 1994; 1970, 1963; Brazier, Lovecy, Moran and Potton, 1993). This is due largely to the fact that they were able to organise themselves into a professional group before the state became a major employer of medical practitioners. In Germany and elsewhere, medical doctors achieved a body of technical-theoretical knowledge and, above all, a monopoly of specific expertise before the intervention of the state into the provision of health care services. Because of its vital concern for the individual and the community, they established an arena for medical services and were successful in securing a professional role in policy determination and state-sponsorship for considerable degrees of control outside (i.e. through the associations and the practice of licensing practitioners) and inside (i.e. through informal organisation) employing organisations (e.g. Moran, 1994, 1999; Freeman, 1998, 2000). This can be regarded as a kind of 'dual closure' of labour markets and recruitment through occupational self-regulation[21] (Parkin, 1979, p. 89).

[21] Parkin (1979) refers to Weber's definition of social closure and recasts it into two forms: i.e. social closure as exclusion and social closure as usurpation. He goes on to explain that professionalisation is a form of social closure which relies on credentialism (i.e. the use of educational qualifications) and

Other occupational groups such as nurses have developed under the more traditional institutions of religion and law as well as under the control and direction of medical practitioners which means they may have less say in the purposes of their own work (e.g. Nelson, 1997; Müller, 1997; Lister, 1997; Steppe, 1996, 1997; Wanner, 1993; Walby *et al.*, 1994; Hummel, 1986; Bischoff, 1984). Since the medical doctors are largely responsible for initiating health care services, they were able to establish greater control over nursing services and serve the functions of capital in the processes of reproduction. Judged in this sort of way, the professional autonomy of nurses is limited and this is in line with the notion expressed by Mackay, Soothill and Melia (1998) that

> [n]ursing is dependent upon medicine for the creation of patients, as the definition of 'sick' and the status of 'patient' depends upon medical sanctions (p. 134).

Since nurses lack the labour market control which professionalism provides, they have made an enormous attempt to improve their market situation and working conditions. That is, in order to secure a wider range of autonomy and self-regulation, the profession must unify its cognitive base which needs to be formalised sufficiently to allow standardisation of the area of work as well as of the providers. At the same time, as noticed by Witz (1992), their expertise must be scientific in Kuhn's sense (1970) of a field in which progress is marked, so that its changing nature prevents systematisation[22] (p. 58). This suggests, according to Armstrong (1986), that, beyond a certain stage of differentiation, the labour process in health care organisations can be seen as "a collection of relatively self-conscious specialisms which compete at a group level for access to the key positions of command" (p. 26). Perhaps because nurses have not yet succeeded in gaining the professional autonomy and self-control which they believe is possible and necessary nurses are highly conscious that they

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knowledgeable discourse (i.e. the re-production of universalistic and objective criteria) as 'a means of monitoring the entry to key positions in the division of labour' (p. 54). Dual closure strategies entail the use of both exclusionary as well as usurpationary activities.

[22] In Kuhn's words (1970) "[w]e tend to see as science any field in which progress is marked (...). If we doubt, as many do, that non-scientific fields make progress, that cannot be because individual schools make none. Rather, it must be because there are always competing schools, each of which constantly questions the very foundations of the others" (pp. 162-3).

face competition for positions of corporate power from medical doctors. The kind of interpersonal tactics used by individual nurses in such situations are described by Mackay (1996) and Allen (1998) in accounts on nursing and doctoring which also emphasise the active role played by them in defining the problems for which they purport to offer solutions.

However, the dilemma facing nursing, as Jamous and Peloille (1970) point out, is that the search for best practice may mean codifying and mechanising its work, thereby shifting control to external elements. In other words, nurses can only use their knowledge as a basis for self-direction, if "their professional knowledge (...) is sufficiently indeterminate to prevent the detachment of the function from the professionals themselves" (Armstrong, 1986, p. 24). Unfortunately for the nurses, the medical doctors may attempt to monopolise for themselves the indeterminate elements of health care practice whilst delegating the routine elements to nurses. For this reason, the labour processes of nurses may be more vulnerable to encroachments of management control while medical doctors may attempt to maintain their professional power, privilege and superior status by engaging in strategies of solidarity and exclusion. The occupational strategies of the latter group, which medical doctors best understand, emphasise the indeterminacy of their professional knowledge and practice and describe the means to escape managerial and governmental rules. However, nurses can still develop strategies and tactics within their specific labour processes that have their own histories, cultures and resources. For example, they are capable of acting defensively towards health care sector management in authority over them, and against medical doctors which might threaten their organisational position. In this sense, the concepts of Carchedi (1977) and Jamous and Peloille (1970) help to explain the crucial act of professional groups seizing, or failing to seize upon the objective conditions which the health care organisation provides in their struggles to exert professional autonomy and power over an occupational domain.

This is not to say that the sometimes acute struggles and conflicts between health care professionals and against health care sector management go unchallenged. At the present time, the primary orientation of health care sector management is towards the enhancement of corporate control and the objectives of more efficient, flexible and innovative health care services. In doing so they inevitably enter into conflict or form a coalition of interests with health care professionals who are seeking to protect and extend their own interests in health care work. Taken together, this forms the basis on which the processes of alliances and divisions take place and demonstrates the importance of a wide variety of ideas about what an organisation is and should be doing. Thus, to adopt the idea proposed by labour process analysts and further developed by Johnson (1980) it is important to note that

> [w]e cannot identify these processes by reference to ownership and non-ownership alone nor can we effectively analyse the production process as simply reflecting the rationalised consequences of bureaucratisation or the technical exigencies of the division of labour. Nor can we characterise the role of the state as a monolithic undifferentiated apparatus. An adequate analysis of work and power demands an account of the differentiating consequences of each of the processes discussed under the headings appropriation, realisation and reproduction, and an assessment of their consequences for the process of class formation (p. 367).

Although the nature of work in the health care sector is more complex, this quote argues for an approach to a construction of professional autonomy and control that is influenced by broader external forces and lived experience. In particular, there is a need for recognition of attempts by health care sector management to design and impose new control initiatives and redraw the boundaries around arenas where medical doctors and nurses have traditionally exercised their professional autonomy in health care organisations. However, there is also a need to recognise the different reactions to these attempts and to understand in greater detail the different performances and associated motivations which make up a health care organisation's day-to-day life. Such a view seeks to penetrate below the surface appearances of health care sector organisations to consider their social structure and the basic processes that are held to constitute health care organising. It appears, therefore, that the extended labour process perspective is a comprehensive, multidimensional

framework that can be usefully applied to the analysis of health care sector organisations and the labour process of nursing services.

Critical Realist Ethnography and the Representation of Practice

So far this thesis has set out a comprehensive, multidimensional framework for the analysis of the traditional organisation of health care professionals[23] which in turn must be set against an equally realistic assessment of the organisational changes affecting them, such as the flattening of hierarchies and the mobilisation of corporate culture in health care sector organisations. In the last four sections some detailed conceptions were offered to theoretically extend the labour process analysis introduced in the previous chapter. The overall effect of such a perspective is to question the analytical coherence and explanatory usefulness of the concept of corporate culture within the wider organisational context in which it is located and to provide an understanding of novel forms of conflict and adaptation within health care sector organisations. It is in this sense that this thesis draws on a labour process analysis because it is intended to reveal not only what is present but also that which is absent in the day-to-day practice of health care sector organisations. Amongst other things, this perspective assumes that the practices and talk of human subjects can be interpreted and understood as the accomplishments of people as they construct and reproduce social reality. The particular merit of this modernist mind-set is that it starts out from the reality of observed behaviour and avoids seeing the day-to-day practices and talk of human subjects outwith their wider socio-political and historical context. It makes use of context in order to account for observed patterns of human activity in organisational practice and traces its roots to the British anthropologists of the late 19th century through to the Chicago School of Ethnography of the 1920s and late 1960s. In the last 40 years, ethnography and other forms of qualitative method have moved from a marginal position within the social science domain towards a much more central place. According to Marcus and Fischer (1986), it can be termed

[23] In the current study, however, nurses are treated in very much the same ways as medical doctors. How they are constituted and how they constitute themselves in the health care organisation is a critical aspect of the study.

> a research process in which the anthropologist closely observes, records, and engages in the daily life of another culture – an experience labelled as the fieldwork method – and then writes accounts of this culture, emphasising descriptive detail (p. 18).

From this point of view, Hammersley (1992) advocates, that

> the goal of ethnographic research is to discover and represent faithfully the true nature of social phenomena. And the superiority of ethnography is based precisely on the grounds that it is able to get closer to social reality than other methods (p. 44).

However, Hammersley (1990, 1992) summarises three apparent problems which link the epistemological claims that are made for ethnography, and the kinds of analytical and methodological claims used in this study. He notes that the central problem which arises for the researcher is to explicate the representational claims of a study and to make apparent the values and assumptions upon which the study is predicated. The logic of this position is based on the assertion that there is a requirement to focus empirical research on the theoretical issues that it is designed to illuminate and to examine the explanatory status of a methodology which rejects determinism. However, one problem not elaborated by the author is the relationship between social structure and human action in ethnography. As noted earlier, I want to avoid a perspective neglecting the fundamental importance of the structure-action confrontation which Porter (2000) seeks to support through adding a fourth ethnographic problematic. In contrast to post-structural or Foucauldian inspired forms of organisational analysis in which the search for ontological order and explanatory coherence is rejected as a fallacy perpetrated by representationalist methodologies[24] (e.g. Law, 1994; Chia, 1995; Knights, 1997), "[t]here is a need to make explicit the ontological status ascribed to social structures" (p. 142). It is Porter's contention (2000) and the contention of others[25] that the use of Roy

[24] As noted in Chapter One, these social and organisational analysts focus on a highly fragmented, disordered and contingent reality while working with a weak ontology, in which 'the processual character of social reality totally occupies the analytical and explanatory space available' for a form of organisational analysis, in which 'the socially constructed and mediated nature of scientific knowledge counteracts the naïve objectivism and determinism of representational methodologies' (Reed, 2000a, p. 48).

[25] See Ackroyd and Fleetwood (2000) for an excellent review of the literature.

Bhaskar's critical realism (1977, 1989, 1998) is one way to solve these problems since he has developed a realist ontology and epistemology of science which has major implications for social thought and labour process analysis.

Critical realism both rejects the standard antithetical positions of positivism (i.e. searching for an objective reality) and constructionism (i.e. reality is the result of subjective interpretation) and offers an alternative direction in epistemology[26] by re-interpreting human understanding of the material and social world. It is argued that

> the existence of social structure is a necessary condition for any human activity. Society provides the means, media, rules and resources for everything we do. (...) It is the unmotivated condition for all our motivated productions. We do not create society – the error of voluntarism. But these structures which pre-exist us are only produced or transformed in our everyday activities; thus society does not exist independently of human agency – the error of reification. The social world is reproduced and transformed in daily life (Bhaskar, 1989, pp. 3-4).

For Bhaskar, what human subjects experience as objective reality can be viewed as contingent upon the relative values of their cultural and temporal existence. This does not mean that real objects cannot be perceived but that human subjects are restricted in their ability to identify these realities because of the inevitable limitations imposed on them by cultural norms, and the cognitive *a priori* mechanisms utilised by social scientists to reveal objective realities. However, according to Bhaskar (1977), there are concrete realities if the causal criterion for reality is accepted; i.e. that to be is to be able to believe, theorise, describe, etc. From such a stance, human subjects are shaped by, and assist in the shaping of, the social and natural world. In this respect, they can examine the effects of concrete realities through empirical testing, and demonstrate through reflexive processes the existence of these realities. Put simply:

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[26] It has been suggested by Reed (2000a) that critical realism establishes the most promising analytical and explanatory framework for conducting a critical, in-depth analysis of the interplay between social structure and human action as it shapes the reproduction and transformation of organisational forms. However, it is not the only attempt to come to terms with the complex relationship between social structure and human action for organisational analysis; e.g. Berger and Luckmann's thesis on the social construction of reality (1966), Gidden's structuration theory (1984), and the work of Rom Harré (1979) are alternative models. Bhaskar (1977, 1989, 1998) makes a number of general points which need to be made in relation to these alternative models and moves on to criticise them as they are ill-equipped to take the essential unity of method between the natural and social sciences into account.

> [t]he basic theoretical assumption of critical realism is that human action is enabled and constrained by social structures, but this action, in turn reproduces or transforms those structures (Porter, 2000, p. 143).

Indeed, the work of Bhaskar (1977, 1989, 1998) suggests an acceptance of the reality of concrete objective qualities and this is in contrast to methodological individualism which focuses on the experiences of an individual, atomic subject to explain particular facts about society and social phenomena in general. It also rejects the abstracted reification of methodological collectivism which reduces systematic knowledge of and explanation to society for groups. As Bhaskar (1998) says, they both fail to grasp the "persistent *relations* between individuals (and groups), and with the relations between these relations (and between such relations and the nature and the products of such relations)" (pp. 28-9). However, Bhaskar (1977) argues that invariable objects existing with or without the knowledge of human subjects (i.e. the *intransitive objects of knowledge*) can only be mediated through the vocabulary, concepts and technologies of the science of the day (i.e. the *transitive* objects of knowledge) (pp. 21-3). From this point of view, scientific endeavour is about exploring and describing "the real structures, processes, mechanisms and events of the world, through the use of understanding and prognostications that have been socially assembled over a period of time" (Morrall, 2001, pp. 59-60). Hence, an abstract analysis of the wider organisational context, and the predispositions and power resources of people inside and outside the labour process is an essential prerequisite to the understanding of health care sector organisations[27]. In turn, the concept of corporate culture and its implications for human subjectivity and health care work needs to be empirically explored and described in the day-to-day practice of pre-existing contexts and interests. However, there are two significant limitations to the possibility of meaningful *measurement* in the social science domain; i.e. the *irreversibility* of ontologically irreducible processes entails the necessity for concepts of qualitative rather than merely quantitative change. But the *conceptual* aspect of

[27] For example, the institution of subordination presupposes the employment relationship of management/employee and the structure of health care organisations presupposes the relationship between state management and health care professionals in which health care work by the latter for the former and its patient clientele sets the terms on which that employment relationship is organised. These structures possess a control imperative and professional capabilities that explain their 'way of acting' on social practices (Reed, 2000a, p. 57).

the subject-matter of the social-science (sub-)disciplines circumscribes the possibility of measurement in an even more fundamental way (Bhaskar, 1998, p. 46). On these grounds, according to Outhwaite (1987), the critical realist perspective of exploration and description involves three basic steps:

> [T]he postulation on a possible mechanism, the attempt to collect evidence for or against its existence, and the elimination of possible alternatives (p. 58)

It is at this point that ethnographic procedures come into play because the purpose of such an in-depth investigation is, according to Porter (2000), not only to illuminate subjective/micro-social events, but "to use examination of human agency to shed light on the relationship between agency and structure" (p. 143). It is therefore necessary to focus research explicitly on the disparity between the claims of the cultural rhetoric and the reality of its day-to-day practice and then add an understanding of how nurses' common sense of identity and values as well as their working conditions make them more or less responsive to moves in the direction of corporate culture change. That is to say, the research focus is on stratified structural relations, bureaucratic and normative mechanisms, as well as contradictory or competing events, so as to obtain a fuller understanding of what constitutes the spatial, temporal and social processes in a particular health care setting[28]. Consequently, critical realism is primarily concerned with social structures and human action to which these contribute; i.e. practices such as ethnographic research and labour process analysis.

It is clear from the previous exposition of Bhaskar's critical realism (1977, 1989, 1998) that such a perspective does not leave the problem of representation and legitimation behind. The problem is not simply how the researcher reveals particular aspects of his/her theoretical position while s/he is discussing data, it is also how s/he

[28] This ethnographic study focuses on a very narrow setting: the nursing division of one general hospital and some of its managers and employees. It also aims to examine what appears to be systematic in terms of corporate culturism and symbolism over time. The purpose of using such a study form is to analyse detailed data in order to explore and describe more general theories (Yin, 1994). How characteristic or representative the setting's rhetoric and its day-to-day practice is of Germany, Europe etc. I leave to those readers who may wish to widen the perspective on these matters.

represents data as they are made into an object of reflection. This is the other side of Bhaskar's distinction (1977) between social structure and human action which I have noted and the following claim brings out the implications. Representations are 'the *transitive* objects of knowledge', created by human subjects to represent 'the *intransitive objects of knowledge*', the entities and structures of reality (pp. 21-3). Therefore,

> whenever we speak of things or events etc. in science we must always speak of them and know them under particular descriptions, descriptions which will always be to a greater or lesser extent theoretically determined, which are not neutral reflections of a given world (Bhaskar, 1977, p. 249).

This does not mean that every representation is equally as good, only that there is the researcher who participates in the creation of data and the distinction between understanding and explanation requires that 'the ways truth is pursued, ignored, etc. in science and ordinary life' must be examined (Outhwaite, 1987, p. 34). Regarding this view, Strathern (1991) claims that an ethnographic researcher cannot occupy a position outside his/her productions since s/he brings his/her assumptions and value-orientations into play by 'the act of narration' (p. 7). Such a claim makes explicit how an ethnographer reveals particular aspects of his/her theoretical position and wider cultural values whilst s/he is discussing research material[29]. Strathern (1991) calls this 'the 'observer's' relation to 'the world'' (p. 121) and in dealing with interpretative matters as a biased vector his/her 'own participation in the constructed narrative must be made explicit' (p. 7). This issue can be addressed by questioning "[w]hat kind of self, person, observer, can collect observations, interpret and report them to what kind of public" (Reddy, 1992, p. 140). A self-display is reflexive when the researcher tries to be explicit and open about the influential circumstances and

[29] In studying the Azande, Evans-Pritchard (1976 [1937]) recognised that he, as a foreigner, that is anthropologist of the culture under study, had been compelled analytically to live outside of Azande's community and had not been able to join their world. This became obvious as he realised that an account of Azande's beliefs in magic and their practices of consulting oracles lead his own perspective into a paradigm of the irrational. As an anthropologist, he was only able to show how such a system of mistaken belief and inefficacious practices can maintain itself in the face of objection that seems obvious to the people of the western world. This was due to the fact that Evans-Pritchard had already had a theoretical interest in studying the subjects and applied certain ethnographic procedures which are social achievements of academia within the western world.

affirms the theoretical embodiment on which knowledge claims are going to be confirmed. The same issue can be considered by letting the reader know that the researcher is visible and therefore influences the dialogue within the study to some degree. In these terms, Brewer (1994) refers to various themes such as the researcher's background and experience in the setting and of the topic, the length of field work, the special access negotiated, discussing the trust and rapport developed with interviewees and so on. He goes on to explain that experiences during all stages of the research, especially 'the constraints imposed therein' and 'the strengths and weaknesses of the research design and strategy' have to be outlined in order to guarantee a researcher's integrity (p. 235). Such a stance is oriented towards the reader who is taken on an 'evocatory' journey which can be understood as 'a process of departure *and return*' (Strathern, 1991, p. 14). But critical realisms insists that this occurs

> *within a pre-existing structure* of material, social and discursive relations which simply cannot be ignored or re-defined out of existence (...) because *it will significantly constrain and shape the trajectories and outcomes of such a rebuilding process* (Reed, 2000b, p. 528).

There is, of course, a great deal more to be said about critical realism because the representations that the researcher generates are much less than teleological theories or laws but more than relative/social constructivist descriptions[30]. For promoters of the former, it is what positivism and natural science represent, rather than what they do. Bhaskar (1998) asserts that the continuous re-arranging and updating of scientific knowledge fails to recognise 'the ontological distinction between causal laws and patterns of events' which enables the researcher 'to sustain the universality of the former in the face of the non-invariance of the latter' (p. 10). Unlike a constant conjunction analysis, as Outhwaite (1987) has noted, such an analysis can

[30] As I have noted in Chapter One, a critical realist perspective overcomes the weaknesses associated with post-structuralism, in the sense that "while it retains a commitment to the socially constructed nature of the social world, it refuses to take the next, unwarranted step and conclude that the social world is *merely* socially constructed" (Ackroyd and Fleetwood, 2000, p. 12).

> account for the interaction of various causal tendencies within the complex and open system among which we live, and which we ourselves are (Outhwaite, 1987, p. 22)

Science, both natural and social, within critical realism must be seen as a social process in which the researcher's aim is "the production of the knowledge of the mechanisms of production of phenomena in nature" (Bhaskar, 1998, pp. 11-2). The latter argument is important, for it is a particular virtue of a realist analysis that enables the researcher to see the parallels between his/her own causal powers and liabilities and those of other concrete objects such as the structural reality of more permanent and hierarchical power relations. As a consequence, s/he is able to reflect on those power structures and formulate long-term projects to develop and use them; e.g. by justifying the introduction of a new cultural politics and supporting its day-to-day practice in a health care sector organisation. Starting from an ontology which identifies the material and social constructions and the mechanisms through which they are generated, however, the critical realist researcher does not make a claim about the actual outcome which will in general be co-determined by the activity of other mechanisms; i.e. the medium of human agency. However, this does not mean an exclusive orientation based upon pure description and an uncritical acceptance of human subjects' own accounts. Elaborating or understanding human subjects' symbols and meanings may be a necessary condition for social thought, however the simple compilation of this kind of knowledge is not sufficient because the material and (history-shaped) social constructions as well as the researcher's theoretical assumptions and value-orientations directly coincide. In this sense, it is not possible to tell the reader what s/he will find in this critical realist ethnography[31] because ethnographic writings vary considerably as do social structures and people's actions. That is simply how it is.

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[31] Although this study does not raise an explicit or particular research question, it provides a detailed exploration and description of the impact of corporate culture change on nursing employees and their health care work in one hospital organisation. Nonetheless, it poses the following questions: firstly, what effect has the idea of mobilising corporate cultures had on nursing employees and their health care work? Secondly, how do the organisational people, health care sector management and nursing employees alike, experience the outcomes of cultural strategies? Thirdly, what have the nursing employees done to the hospital, its management and patient clientele? These questions are examined within the wider context of the German health care sector and its organised structures.

Conclusion

In this chapter I have shown concern for the labour process in the health care sector and the socio-political and historical influence of health care professionals over health care sector management and vice versa. I have also linked the health care labour process to the functioning of a state in capitalist societies and the emergence of new management practices. That is, a comprehensive, multidimensional framework for labour process analysis was unfolded within which the analytical coherence and explanatory usefulness of the concept of corporate culture and an understanding of novel forms of conflict and adaptation within health care sector organisations can be explored and described. Towards the end of the chapter, the issue of ethnography has been discussed in terms of its ontological and epistemological implications. However, because existing forms of ethnography face apparent problems, an alternative, critical realist perspective has been outlined to explicate the relationship between social structures and human actions and to distinguish between the description of objective realities and the reality which I attempt to explore and describe.

Chapter Three

Time and Space in the ethnographic Field

Negotiation of Access and Selection of Hospital

I approached one general hospital in South Germany, Bavaria, to negotiate access in order to carry out this study. This hospital was chosen because one of the strategic requirements was the location of a site that contains the people and the social activity with a bearing upon my particular research interest (Schatzman and Strauss, 1973; Hammersley and Atkinson, 1983, 1992). Additionally, this hospital has proved to be a suitable place for a study such as this because informal contacts and a former researcher indicated that it was open to the prospect of research.

In September 1995 there was a preliminary discussion with the Chief Nursing Executive (CNE) about how the research would be conducted. In December 1995 there followed a talk with the Chief Executive Officer (CEO) in charge of the hospital main chair. His motivation, as well as the interest of the CNE, encouraged me to write to the hospital management board for permission to gain formal access. A research proposal outlining the objectives of the study and the study design was developed and submitted to the members of the board. In summer 1996, the CNE sought details regarding when and how I wished to commence the study as well as which hospital ward I preferred to use for the collection of research material. Formal access was granted in September 1996 and my proposal was discussed among the members of senior management of the hospital board. Unlike the problems reported by Collinson (1992) and Purkis (1994), negotiation of access and final approval of this site was a straightforward political, as well as social, process. Fieldwork began in November 1996 and I was prepared for a long stay in residence. This study was conducted over a considerable amount of time because the data collection period on the ward lasted more than three months and six months in the hospital as a whole. In order to become very close to the organisation I was staying and working for five working days per week during the above mentioned time period.

Prior to the commencement of my data collection period, all members working on the ward as well as the people of the nursing directorate and management board had access to a proposal which announced my research project. Furthermore, records from a number of ward sister meetings and ward meetings included notice that I would be on the site collecting research material. This was initiated by senior members of nursing management. Furthermore, prior to the beginning of the collection of data I introduced myself informally and made efforts to gain some tactical advantages. I presented myself as representative from academia with a lecture of my studies at the University of Edinburgh as well as my life in Scotland. I showed slides and photographs to inform people and gave them a chance to express their concerns. Additionally, I had a meeting with the sister, charge nurses and staff nurses on the ward I had selected for the purpose of gathering my research data. During this time, I discussed my general plans and answered their questions.

Methodological Procedures and Data Sources

The aim of a critical realist approach is to reflect upon, analyse and consider a broad spectrum of research data from different points of view. Three different research methods have been employed to obtain representations in order to grasp the day-to-day inter-/actions and language of organisational members of the site. These included observation and semi-structured conversational interviews as well as documentary material. The use of more than one method is described in Campbell and Fiske (1959) as 'triangulation' which involves, among other things, the use of multiple methods especially apparent in the natural sciences as well as in positivistic-quantitative research (p. 101). The aim of using triangulated sources in qualitative research is "a plan of action that will raise the researcher above the personalistic biases that stem from single methodologies" (Denzin, 1989b, p. 236; 1978, p. 295). By combining methods, the problems and pitfalls of sociological research can be partially avoided and the deficiencies that flow from one single methodological procedure can be overcome. In this sense triangulation underpins an emergence of different pictures and aims to optimise the validity of research findings and therefore enhances robust ethnographic accounts.

Speaking of triangulation in ethnographic research, however, is illogical because such an approach cannot be said to utilise triangulation of methods even though the ethnographer may use semi-structured interviews, some level of participant-observation as well as records and documents (Begley, 1996a-b). Morse (1991) stresses that the combination of such techniques constitutes ethnography and makes ethnography what it is. Following this line of thought I have combined several ethnographic procedures in one single piece of research and do not use the word triangulation as such in order to rationalise the validity claim of my fieldwork research. According to Morse's argument (1991), my ethnographic approach is recognised as respectable and useful in its own right because problems of bias, error and invalidity arc not really resolved by blending and integrating two or more methods as supplements in order to identify more accurately a particular research area. Departing from metaphysical analyses and drawing on post-Kuhnian contributions to scientific thought - i.e. through the adoption of critical realism as an under-labouring philosophy for ethnographic research (Bhaskar, 1998, 1989, 1977) - I contend that the only person who can judge the plausibility as well as re-work the credibility of my research is the reader who is taken on a processional trek.

The research methods applied in this study aim to represent 'the lines of action taken toward the empirical world' of the setting, and are 'different means of acting' within the day-to-day practice of this hospital organisation (Denzin, 1989b, p. 235). Each of the three methods applied imply different lines of action to shed light on the relationship between agency and structure and will reveal various aspects, depending on the angle involved. For example, the angle of being a participating observer or an observing participant describes the researcher's presence during the day-to-day conduct of practice. In this respect the researcher cannot expect to find a static representation of the everyday world, instead s/he is able to see a moving object which does not permit one interpretation to be stamped upon it. Thus, I employed three research methods in order to investigate the social structure and activity of concern and to base the subsequent research achievements of this ethnographic study.

The specific procedures regarding the collection of the research data will now be described.

Observation Material

The importance of observation material to this research project has been clearly evident throughout this discussion. Such material is a representation of the social reality created by peoples' inter-/actions; i.e. one part of research material in this thesis is taken from notes, written down during periods of observation. I have structured my observations in two ways: first, observations gathered when I was participating on the ward as an active nurse, and second, my observation of the day-to-day practice through my participation in various meetings and through the application of the management by wandering around approach used by the CNE and his deputy. Schatzman and Strauss (1973) favoured these multiple positions because they provide comparative data of all sorts and the researcher gets a wider perspective. Therefore, I was able to gather data by participating overtly in the everyday life of the groups I have studied.

There were several reasons for starting from the so-called bottom or employee perspective[1] but most importantly, I was able to separate myself from the position as chief nursing executive and to establish my independence in all social relations as an ethnographic researcher. I also managed to see the day-to-day practice from the people's point of view rather than in terms of managerial categories applied to them by the CNE and others. On the ward I collected research material every day of my five working days per week. Observation material was collected eight hours a day across all working days of the week but was most likely to be gathered between 6.00 a.m. and 9.00 p.m. As described by Mueller (1995) the observational data provides 'a cross-section of interactions' amongst various occupations on the ward and within the whole hospital setting (p. 264).

[1] With reference to Willis [1975] Collinson (1992) claims that "[i]t is very important when conducting research, 'to avoid being perceived as a bosses man'" (p. 15).

The fieldwork part of the study was very time consuming and labour intensive. I spent more than three months working as an active nurse on one ward and the time it took to escort the walk-about events of the CNE required almost three months as well. The importance of long residence was described by social and cultural anthropologists such as Evans-Pritchard (1976), Scott (1985) and Cohen (1987, 1992) who were interested in collecting information from the foreign world in order to make sense of their experiences of the cultural world. Although the procedures involved in the collection of research data as well as the different emphases on interpretations and descriptions have broadened the ethnographic perspective, the importance of a long residence and doing participant-observation has not changed for institutional ethnographers.

Acting as a practising nurse did not provide me with a special status as researcher and did not exempt me from conducting work in the way in which other nurses on the ward did. Anthropologists refer to this central research position as being immersed as a direct or full participant, which describes the researcher's active involvement in the day-to-day conduct of practice. This means I dressed myself in a uniform of the organisation to look like the other nurses and was participating in those activities which nursing members practised in their day-to-day work. In this context, Hammersley and Atkinson (1992) state that the personal appearance of the researcher needs a salient consideration and sometimes it is necessary to dress in a way that is very similar to the people being studied. That is, I made myself more acceptable to others in order to develop a trusting relationship with the organisational members of the setting. Apart from maintaining an on-going dialogue with the people in the organisation, I removed myself from active nursing work as I saw particular points of interest; e.g. the walkabout-events done by senior management, in order to do my observational task. The approach I took brought about a constant interchange with contacts I made at this organisational site. The aim of an active presence was to become integrated and to normalise the situation for the ward team. As a temporary insider I had immediate access to different sorts of data and was able to establish mutuality which facilitated the collection of my research material. As in

Mueller's research project (1995) I anticipated that the nature of inter-/actions would change, but organisational life on the ward went on much as it did after people lost interest in impressing the researcher as such.

As a result of my accepted presence on the ward I was able to carry out precise observations and concern myself with the activity of watching, listening and writing during these periods. This kind of data gathering has been described in literature as participant-observation, with the ethnographer becoming part of the situation being studied in order to see and feel what it is like for the people in that situation (Gold, 1958; Becker, 1958; Becker and Geer, 1960; Sanday, 1979; Nachmias and Frankfort-Nachmias, 1992; Hammersley and Atkinson, 1983, 1992; Silverman, 1993; Adler and Adler, 1994). That is to say participant-observation is the process by which the investigator attempts to obtain membership of, or a close attachment to, the group s/he wishes to study. Wright (1994) refers to a research project done by Emmett and Morgan [1982] who described participant-observation in more concrete terms:

> While 'participant' meant becoming as much as possible an insider, 'observer' took on the additional meaning of not only watching and recording systematically but of being an outsider with a theoretical understanding of society, against which the detail of the field was being constantly held up (p. 11).

This means the researcher is known and close to those being studied in order to collect the desired data in an adequate way. Moreover, an awareness of being a theory-led outsider of the organisational world allows him/her to get deep insights into the processes of interchangeable relations. In this sense, being a participating member of the group I studied doing participant-observation and due to my theoretical understanding maximised the possibility of coming upon (un-)expected circumstances, as it is stated research material.

I watched my points of interest as carefully as possible to see, for example, in what situations managers and staff ordinarily meet and how they behave in them. Being a practising nurse and a full participant on this ward enabled me to talk with all the people involved in inter-/actions, and to discover their interpretations of the

structures, mechanisms and events I observed. Further, the observational situation gave rise to later conversations and I took advantage of this to gather background data about events that had happened or were assumed would happen. Sometimes, as Mueller (1995) has observed, people told me of things that I had missed because I was working on different shifts. Then they started sentences with phrases like "You should have been here this morning ... !" or "Imagine what has happened ...!"

In addition to observational material from the ward, I attended the CNE's wandering around activities within the hospital. Going around with the CNE or his deputy provided a special overview of their activities; i.e. I got a view from the top as regards the present state and future plans of this hospital organisation. During the first days of my attendance the CNE and his deputy informed me about the specialities of each ward or department and provided me with a schedule of ward sisters and people's names. With the regularity of appearance I got to know most of the staff and become known in all wards and departments as the researcher from the University of Edinburgh / Scotland.

From my own experience as a practising nurse as well as chief nursing executive, I realised from the beginning of my stay that there was a great deal I did not and could not know. For instance, I did not know what perspective of care (e.g. the applied theoretical nursing model, the patient allocation systems, usual times of reportage, etc.) was characteristic in the day-to-day practice and I had limited knowledge of current techniques by which nurses were engaged in direct and indirect patient care. Furthermore, I did not know enough about the patterns of social relationships the nursing service and others had in their organisational environment. All these gaps in my knowledge committed me to work with and learn more about the organisational reality in the course of this research project. I learned many things during this fieldwork and the organisational world was full of words and inter-/actions that could not be selected, lifted out and contemplated in this study. But I was also aware that not even in ideal situations of observation would the projected end of knowledge about the organisation's reality ever be achieved. For example, as an active

participant in nursing I had to learn the in-/formal rules which describe how to act as a member of that organisation. What I learned was how it might be to be an organisational member but as a theory-led outsider I had a pre-conceived framework and therefore knew more about my research interests than the informants. This means the generalised information about the organisational world, familiar to many of the informants, became aggregated in my mind and is represented in this thesis as the culture of these people.

The observational data I was able to collect provided a rich seam of qualitative data as it contained research material on a wide range of phenomena seen from multiple points of view: being an ex-nurse and ex-chief nursing executive, from my experiences as practising nurse, from the perspective of staff nurses, charge nurses and ward sisters as well as from the viewpoint of CNE and others. This means I did not follow any particular research design and I did not narrow myself down to a single-minded way of mirroring a specific structure, mechanism or event. In this way, this kind of research data reflect the shifting emphases of organisational life and the effects of day-to-day practices. I kept an ongoing log in the form of a loose-leaf notebook. Field notes have been clearly dated in order to know, at the analysis stage, when I made particular judgements and interpretations of observed events. Watching and listening in itself, as well as writing down notes promptly and regularly, was hard work and was quite uneconomical in the expenditure of time. For example, as one angle of observation, I tried to describe how people behaved in interactions, how they used or abused these encounters to follow their interests and how they made sense of it. The observational data are based on my word-for-word or scratch notes from the field, which I analysed and are therefore my intellectual capital of this thesis.

I disciplined myself to record the notes immediately or, if this was not appropriate, shortly afterwards or as I left the day-to-day practice. Sometimes I differentiated in my writings between 'headnotes' which only mapped out certain points, and 'fieldnotes' in which I described exactly what was going on (Ottenberg, 1990). This distinction was made to avoid any time pressure and hurry when writing down my

observations. Sometimes headnotes acquired greater importance than the fieldnotes themselves because they involved a particular 'driving force' and generated a memory of context (Ottenberg, 1990, p. 147). This means headnotes created notes in my mind and were the memories of my field research behind the written notes. Writing notes disciplined and immersed me deeply in my particular field of interest. I never trusted my memory because reconstructing details of certain structures, mechanisms and events after days or weeks would have been very faulty in a long-term perspective. My observational notes were based on scratch notes taken in longhand or stenography with a pencil on small pads of paper and then typed up. The hand written notes were brief sentences, phrases, words, sometimes quotes and these were my originally written text. Each day I transferred my hand written notes, constructed at or around the time of observation, into my personal notebook computer. Therefore I was able to complete the transcription of all the substantive notes recording chronological events, persons, conversations, meetings and observations of the workplace site, during the six months' period I was allowed to stay at the site of my research. However, watching is limited and can produce questionable results as regards what has been seen or heard as well as because of the complexity and unfamiliarity of the situation. For these reasons I also employed the method of interviewing which provides an important source of data.

Interview Material

The second source of research data collected was interview material, which provided interviewee's accounts of their social relations and day-to-day practice. Interviews were conducted with a range of organisational people using a semi-structured conversational format. Most of the interview related distinctions are concerned with the choice of interviewing style and are essentially method-driven. This has generated an extensive technical literature on how to achieve the chosen ends (such as Schatzman and Strauss, 1973; Spradely, 1979; Nachmias and Frankfort-Nachmias, 1992; Hammersley and Atkinson, 1992; Fontana and Frey, 1994; Wimpenny and Gass, 2000). Pawson (1996) questions such a purpose because it merely advances data in order to inspire, validate, falsify and modify sociological explanation. This

means in one way or another, ethnographic researchers always end up talking to people and thereby impose a particular flow of information. For example, drawing on critical theoretical insights, my theory-driven thesis is to a certain degree "*the subject matter of the interview, and the subject is there to confirm or falsify and, above all, to refine that theory*" (Pawson, 1996, p. 299). In this sense, the spoken word as such always retains a residual ambiguity, no matter how sensitive one is in choosing questions. Interviewing is a face-to-face interchange between people, and cannot merely be seen as a form of technology or as a kind of particular encounter in which people behave as though they are equal.

In following Thomas (1994) and Mueller's (1995) approach I started with questions about the day-to-day practice to avoid a particular focus on one topic and to help the subjects to disengage from what they were doing immediately before the interview. This was helpful because people needed the transitional period before they could get fully engaged in what I was pursuing. The other questions were driven by the essence that people regarded the interview as a chance to tell their own story. By this means the interviewees directed our interaction in order to discern activities and issues of concern to them, while I was able to return to my semi-structured format in order to help change the direction of the conversation, if necessary. I steered only minimally and was concerned that the subjects' voices should be recorded without superior influence from the researcher. I had compiled a list of broad questions which would be used in the event of an uncomfortable or empty moment during the interviews. The following questions were put to staff nurses, charge nurses and ward sisters. These questions are of course part and parcel of the negotiation of meaning which goes on in any substantial interview:

- Describe a typical day at work.
- Tell me about the contacts you have during your day at work. Who do you work with?
- Who do you talk to or have contact with?

- Who do you consider to be a particularly meaningful person in this hospital organisation?
- Tell me about the contacts you have with the CNE. When and how do you talk with him/her?
- Tell me about the CNE's ward rounds. What things do you (not) very much like to see happening when s/he is going around?
- What changes have been taking place in the last year at this ward?
- Who was supportive when these changes were introduced?
- Can you tell me about an incident that gave you great pleasure while working here during the last year?
- Can you tell mc about a moment or situation which was more disappointing while working here during the last year?

With some variances, the same questions were put to the CNE and other senior managers in this hospital organisation. The following prompts and questions were those which guided the interviews with the CNE and his deputy:

- Describe a typical day at work. What do you do and how do you plan your day at work?
- What managerial part do you play in this hospital? What are your priorities?
- Who is with you in your day-to-day practice?
- Who comes to be with you in your day-to-day practice?
- How do you manage to spend time with your employees?
- Tell me how and when you talk to ward sisters and/or nurses on the ward.
- What are your priorities when going around the wards?
- What have you found surprising when going around?
- Tell me about one incident that gave you great pleasure while working here during the last year?
- Tell me about a moment or situation that you found most disappointing while working here during the last year?

I also prepared some follow-on questions in case certain responses were raised so as to invite the interviewee to give further explanations as well as examples:

- What do you think about it?
- Why is this particular aspect important? Give me an example.
- You forgot to talk about the people. What happens with them?

The use of as well as the request of examples enabled Mueller (1995) to place particular topics of interest within their own chronology since expressed examples always refer to a particular time such as last year or the day before yesterday. I followed these excellent lines of thought and the people interviewed were reflective as well as discursive. In addition to using the interview accounts as an occasion for soliciting participants' recollections perspectives and opinions, I specifically asked for any documentary evidence the interviewee could provide to help me to understand and follow the exemplary project.

Interviewees were selected on a voluntary basis and at the convenience of the willing participants. Most interviews took place in the situational day-to-day world of the organisation; i.e. an appropriate room was chosen taking into account privacy and also interviewees' preferences. These two aspects are felt to be favourable for the constructed interview narratives. As far as I was able, I created a conversational setting with coffee/tea as well as biscuit arrangements. The interviews ranged in length between 25 - 75 minutes and were taped using a portable audio-recorder. I transcribed the interviews verbatim into a personal notebook computer afterwards and I tried to maintain almost the original conversation by the forms of notations used throughout this thesis (see Appendix Two). These transcriptions were translated afterwards by an English native-speaker and recognised translator who was able to understand the accent of the Bavarian narrators[2].

[2] The importance of using only one translator to obtain consistency and to maximise the reliability of the study was demonstrated in a nursing research reported by Twinn (1997).

Interview accounts from the wards involved six staff nurses, one pool nurse, one student nurse, one charge nurse and one ward sister. Two of the directorate of nursing were interviewed and several other interviews were conducted in this hospital. That is to say, that the CEO, the CME as well as the head of Department of General, Further and Post-registration Education were included. Demographic details of the interviewees have been documented by means of a short-report card system. At the end of each interview, I requested permission to note down their names, age, qualification, position, etc. and that they sign to show their consent in participating in this research project (see Appendix Three).

The participating people of the hospital have been given fictitious names in order to protect their anonymity. In following Kondo (1990) and Mueller's strategy (1995), each person has been given a name as an identification rather than a code or number in order to enhance the readers' view of subjects as persons and to allow participants to have names in order to become particular beings. In my research project I gave them the opportunity to select a pseudonym from a prepared list of names which are used within this study. People are now able to identify themselves and this protection of privacy depends upon the degree to which anonymity can be maintained. However, the tapes (voices of participants) reveal a certain degree of identity but all material relevant to this research project has been kept under lock and key, available only to the researcher in accordance with the German Data Protection Act - 1992 (Bundesdatenschutzgesetz, 1992) as well as the British Data Protection Act - 1984 (Campbell and Connor, 1986).

After completion of the interview as well as this administrative work I took some time to write down some notes of my personal impression of the interviewee as well as the situation as such. Interviews were conducted with nurses as well as others across all hierarchical levels in order to gain a cross-section from all people and to guard against a single traced view. I therefore obtained a wide range of interview accounts which provided multiple perspectives of various people working in this particular setting. That is not an argument claiming that these accounts are versions

of a more enhanced truth than my observations of the day-to-day practice, but can be regarded as another dimension of accountability.

Documentary Material

The third and last source of my research material gathered from this organisational setting were written reports; i.e. documentation, fliers, memos, operating bulletins, circulars, letters that had been written or received. According to Hammersley and Atkinson (1992) documents are not the original rationale proposed for ethnographies but the purpose of collecting such documents was to review written forms generated by and available to nursing staff and others within the organisation. A document is a kind of social structure which relies, for example, on a formalised mission or world view for all people working in the organisation. Hammersley and Atkinson (1992) as well as Jupp and Norris (1993) refer to the early and seminal influence of Thomas and Zananiecki's work [1958] *The Polish Peasant in Europe and America* which was first published between 1918 and 1920. This classic example of documentary research addresses important and wider theoretical issues because it used personal as well as other written accounts to analyse Polish immigration in the U.S. at the turn of the last century. It established the documentary method in social science research and differentiated itself from the positivist intertwinement which was common at this time. More recently, Latimer (1994) provides a review of written sources in her ethnographic research on nursing assessment and shows how official medical and nursing documents and reports supplement observation as well as interview material.

During the course of negotiating research access, senior managers of the selected organisation suggested and provided documentary resources which they perceived might be of interest to me. For example, before starting fieldwork I was given the organisational chart, brochures for patients, the organisational philosophy and code of practice of all organisational members, the flier of the school of nursing and the hospital organisation as well as the quarterly news release called 'Sidelong Glances' in the form of an organisational magazine. These documents provided background and proved valuable in helping me to gain familiarity, not only with the topic of

interest but also with the history of the organisational setting. In retrospect, the corporate chart, the organisational philosophy, the hospital magazine and the *patienten-orientierten Tagesablaufrahmenprogramm* (POT) [i.e. patient-oriented day-to-day programme] gave assistance to reflect the social structures and daily practice. In addition they helped to formulate a list of specific people to interview and to build up a preliminary chronology of organisational mechanisms and events. In following Thomas' strategy (1994) I did not launch directly into the fieldwork but used the written records as a platform for preparing myself for the observational period and interviews that would follow. For example, formal documents, such as the organisational philosophy or the POT, are intended to reflect the day-to-day practice and what members do when they interact with each other and/or take care of their patient clientele.

While I was collecting my research data, all organisational people freely provided material, including the various service's short and long term goals, performance appraisals, departmental policies and reports, copies of minutes of group leader meetings, etc. On other occasions, I initiated a request to particular people; e.g. I asked the CNE for permission to obtain insight into particular documents such as budgetary reports and procedures, annual reports, short and long term objectives of the whole hospital organisation. I transcribed some documents into my personal computer and placed all these texts alongside my observational notes as well as interview accounts[3]. Together with other documents these texts formed the basis for the analysis presented in this thesis. The research data collected do not reflect alleged facts or figures but constituted texts which are the foundation of my analytic procedures.

Informed Consent

The above outlined way of gathering research data is characterised by intimate participation in the daily life of people. Traditional ethical concerns have addressed

[3] Some documents (e.g. organisational philosophy) were translated by the same English native-speaker and recognised translator who translated the interview data.

the topic of informed consent which has to be obtained from the human subject after s/he has been carefully and truthfully informed by the ethnographer about the research. In this respect, Nachmias and Frankfort-Nachmias (1992) state that "very often the fieldworkers have more power than their hosts" or "they may be perceived as being able to allocate material resources, political connections and social prestige" (p. 288). I participated in the setting as already suggested in a controlled way which means that I have been aware of the insights gained through this ethnographic research and the power of knowledge. To counteract this point of view, conventional researchers rely on informed consent throughout the study because this ought to be the most fundamental safeguard against using individuals as a means to an end. In following Mueller's approach (1995) '[v]erbal consent was obtained informally when interviews were scheduled' and a written consent form was requested from every participant as I filled out the short-report card at the end of each interview (p. 270).

No particular form of consent was sought for the observational periods conducted on the ward nor for attending the rounds of the CNE. This tactic was chosen because the way I negotiated access was agreed to by senior management and the ward team. Moreover, to explain my topic of interest to all people involved in the walk-about events would have been an impossible task and would have brought a lot of mistrust as well as disturbance in the day-to-day practice. As already explained, I discussed my general plans for observation with nurses on the wards and conducted interviews with them as they agreed to being interviewees. Importantly, throughout the collection of research data, I was aware of the uncertainty and imbalance of particular employees during periods of observation and maintained sensitivity towards their personal attitudes. In this sense, I exercised common sense and moral responsibility in learning about others in this hospital setting.

As time progressed I became very close to the informants on the ward and as a participating nurse I became a part of the group. Here, a parallel can be drawn between the research of Thomas (1994), Cohen (1987, 1992), Kunda (1992) or Kondo (1990) because this was rooted in my desire to develop closeness to the site

and its people in order to collect the required research data. The adopted approach brought about a continuous social intercourse with people and in some cases the dialogue has gone on to this day. In general, the relations between most people and myself were open and informal. That is, as demonstrated by Cohen (1987), my attachment to organisational people became 'personal and emotional rather than academic' (p. 205). Here, is an example showing a ward sister's perceptions regarding my participation:

> Ruby: With you it was especially fascinating, because they [nursing staff] didn't know what to think. On the one hand you were doing a practical, but not really. On the other hand you were working like a qualified nurse, but weren't on the staff. Up until now it had always been the case that as soon as someone was on the staff they were accepted with open arms. Whether it always remained like that is another question. With people doing practicals you wait and see how they are and if someone's all fingers and thumbs then well the warm welcome doesn't last. That doesn't go down well, especially if they're cheeky as well. But in your case they didn't know what to make of you. As far as I could tell, anyway. I saw they had trouble deciding whether to recognise you as one of the team or to accept you as an outsider. But you're approachable and because you get on with the others you're fully accepted in the team now. Hardly anyone wants you to go now and I think you should stay here too [laughter].
>
> Maggie: [tentative laughter] Well, I noticed. (...)

As this interview excerpt reveals, making close friendships was not restricted but I avoided becoming an ally of senior managers or nurses on the wards which would most likely lead to an 'exhausted self' (Cohen, 1987, p. 203). I was also conscious of the fact that my principal commitment had not restricted my freedom of inter-/action related to my research project. Mindful of this, I followed the need to identify with and at the same time to remain distant from the processes under study. In other words my perception of the everyday world of this hospital did not become distorted as I was collecting research data and the effectiveness in collecting data was not lost.

Ethnography and the Conduct of the Researcher

In this ethnographic approach I have put myself in the same place as those whose conduct I sought to analyse. How this was achieved is already described in my discussion above. But my conduct as a researcher as well as the consequent flux of the organisational world are made more 'explicit' in this section (Strathern, 1991, p.

7). First, I introduced myself to all the staff as a nurse, particularly interested and experienced in hospital management, doing a study about the communicational and organisational practices in this hospital organisation[4]. I participated in ward work as such and I was fully involved in indirect as well as direct patient care. As a newcomer on this hospital ward I was allocated to an experienced staff nurse and tried to catch up with the organisational work flow. At the time of commencing my fieldwork, I had not nursed in direct care for more than seven years and I showed my lack of confidence in skills which are regularly done in nursing care. On a regular basis, my casually raised questions and inquiries lead to a certain degree of surprise among the ward members. I had perhaps not thought sufficiently hard about this causing such a surprise but from their perspective, I was '*expected* to know' the day-to-day practice of nursing care (Cohen, 1992, p. 340).

In addition to the contacts via the formal interviews, informal discussions occurred with all organisational people from different hierarchical levels. Most of them expressed their concern and motivated me to cope with the demanding work while accomplishing my data collection. The efforts of senior managers to acknowledge my presence within the hospital; e.g. the article about the study and myself in the organisational journal 'Sidelong Glances' affected the situation as such very positively. Apart from an allocated office space (and national telephone access) which facilitated a certain degree of availability because people were able to contact me, I had free access to drinks and food at hand from the organisational restaurant.

Second, the organisational world of the setting was in a state of continuous flow and change and what also changed during my presence was the building construction. The whole redevelopment to more spacious and functional surroundings had been mooted with varying degrees of seriousness since late 1970s. Some of the wards

[4] In this respect I concealed the main focus of my study - the mobilisation of corporate culture and its effects upon human subjectivity and health care work. The ethical status of such a decision is not without its problems but I believe that concealing the purpose of the research was one of the ways and means by which I avoided disturbing the integrity of the hospital. Further reasons I am able to give of my decision relates to my intention to keep the hospital's people as unaware as possible of what they said, experienced and did in their day-to-day practice.

were moved to a new architectural section with U-shaped ward design. These changes in ward layout, size and facilities that occurred during my fieldwork were directly related to the assumption of improving the organisational workflow and enhancing the effectiveness of the services provided. But what also changed were the environmental values and the aesthetics involved in these wards. These aspects had been relegated to an inferior position in the former architectural construction. The aim was to make the environment for organisational people and the patient clientele as comfortable and safe as possible. For example, the new wards were made light, open, airy and contained a range of so-called living choices and colour options.

In all, it does not mean that the hospital setting has become less like itself but that its organisational world has changed over a relatively short period of time. The hospital and its services had to change if it wanted to retain its success. As a result I have to come to the conclusion that I do not know the organisation as it is now because since I left the field other changes have occurred. But indeed, I am still trying to make sense of the organisational life 'I thought I knew *before*' (Cohen, 1992, p. 343). Thus, it can be argued that the more I know of the site of my research the more I am aware of how little I actually know and can say or write about it. This highlights a particular degree of uncertainty about my interpretations of the earlier situation in the hospital organisation but takes into consideration my 'post-fieldwork' attitude that 'there is no end to this process' (Cohen, 1992, p. 343).

However, I have also changed since I began my Ph.D. just as the field and also the subjects in the organisational setting have changed. In considering questions of meaning, people - like you and me - change 'their minds about meaning over time' (Cohen, 1992, p. 346). Human subjects do not merely change their use of particular words but also statements change over time as one accumulates knowledge and experience. Ethnographic interpretations and writing can be merely regarded as 'temporary' and is therefore 'continually subject to revision' (Cohen, 1992, p. 346). In this sense, an altered understanding during my time in the field was inevitable

because apart from six months life span in the interregnum I could never be quite the same afterwards as I experienced private as well as professional challenges and changes. Working in the day-to-day practice and experiencing the structural world of the site under study was not enough to influence my personal intellect; but as I was doing this research project other things in my day-to-day life lead to deviated ethnographic accounts.

In summary, in this section I have shown the course of an ethnographic reflexivity and have tried to address in detail the conduct of the researcher. I have not merely mentioned the processes of saying hello or goodbye but have also taken into account the post-fieldwork problem that time does not stand still for informants and the researcher. There is a continuation of maturation and I assume a recent contact with the constructed field would change my previous views of the organisational context.

Pragmatic Aspects of Analysis

The experience involved in this fieldwork (i.e. my own personal experience and the multiple positions as a researcher) have given me a 'different angle of vision' and a 'different "access"' to my research data (Cohen, 1992, p. 339). With respect to this concern I do not claim to base my ethnographic writing alone on what I have seen or what I have heard in the organisational world. The methodological procedures employed to study this site have been designed to give insights from different perspectives, meanings and understandings through which I was able to examine and describe the hospital's wider context and its everyday practice. Such a stance reflects a venture undertaken between structure and various interest groups (i.e. me as a researcher, an ex-nurse and an ex-chief nursing executive, the managers of various disciplines and different levels, the staff nurses on the wards and others) and the notions of 'similarities and differences' play an important part in the construction of meaning (Putnam, 1983, p. 41).

Being a participating nurse on the ward, being flexible and thus available for the walk-about events done by the CNE and doing, in concert, the on-going interview

activities, protected my self as well as the research material obtained from any preliminary formal analysis. That is to say, analysing my data while doing the collection of research material would have been an impossible task and an unbearable burden. My personal time as well as my physiological and psychological resources were kept tightly within bounds and controlled by the way I collected the volume of research material required. Rather than being distracted by analysing data, I was able to concentrate on the fieldwork as well as the collection of my data. However, to postpone the formal analysis until all data were collected did not prevent me being reflective and informal fore-closure occurred as I was writing down notes on a daily basis. This draws attention to the unavoidable and initial analytic processes, already embedded in the process of noting down field notes or recording interviews.

There are different styles and approaches to data management or handling research material in order to make sense out of qualitative data. In most ethnographic studies similar processes are involved and analysis took place in an orderly fashion[5]. Like the processes reported by Mueller (1995), I dealt with my obtained data in particular ways in order to create an approach which enabled me to create a sequence of tenses which was employed to order the daily and weekly hours of data collection. This means observational notes were fully transferred to the computer. Also each interview tape was transcribed and organised in the chronological order in which the research material had been collected. I have done cross-examinations for clarity and precision in order to guarantee authentic correctness which subsequently stood as the constructed research text. Some of the documentary sources were put on a file of my computer and re-read for textual access. All these time and labour intensive activities established an exactitude of the data available to the researcher which therefore assured an accurate record of the text. At the same time as I was doing this research-related work I became closely familiar with the research data obtained.

[5] See, for example, Titschler, Meyer, Wodak and Vetter (2000), Hammersley (1990, 1992, 1997), Huberman and Miles (1994), Manning and Cullum-Swan (1994), Silverman (1993), Hammersely and Atkinson (1992, 1983).

Critical realist ethnography tries to identify the properties existing in the everyday world and to develop concepts which help the reader to gain a fuller understanding of what constitutes the social structures and socio-political processes in a particular setting. My data have been organised in the form of a text derived from written observational notes, transcribed interview accounts and documentary sources. The data were voluminous, resulting in more than 700 pages of printed text to be read, re-read and analysed as well as stored in such a form that it can be easily accessed and retrieved. Daily inter-/actions and social structures in the form of a text illustrate an emphasis on seeing which goes beyond the language information given. Thus, the transcription of my data offers a connecting link to the site which I am able to provide through empirical data as text. The first attempt to make sense of the data was frustrating because of my restless endeavour to locate and illustrate a particular concept or event of organisational life. My re-start was done after a more subsequent reading as well as re-reading in order to see similarities and differences between practices taken in one social structure and reflecting it back to another within the text. I started to question the textual data as such and I was engaged in a deep inquiry of my data material. For instance, I was interested in how a typical work day occurs on this particular ward. This involved an investigation of who does what kind of work; what the work consists of; which kind of contacts occur during the day at work; who is getting informed about the changes that have to be done; who is most likely to be a particularly meaningful communication partner; when does the CNE walk around; who interacts with the CEO, how people are informed about things they had to do; how people give account of their work they do; etc. The aim of this interrogation was to identify significant concepts or patterns as well as noticeable themes in the hospital's wider context and people's inter-/actions.

At this particular time of my analysis, I made an attempt to make sense of the day-to-day practice and it became obvious that it was not practised in the ideal ways referred to in the managerial rhetoric on institutional excellence. As a result of this analysis, some parts of the research material required a more detailed examination and I took these problematic, taken for granted textual pieces which enabled me to dig beneath

the surface appearances. Meanwhile, the process of reading and re-reading in the course of examining one line after another as well as paragraph by paragraph did not stop. There was a backward and forward movement like an iterative loop through the data as a whole following up key linkages and various paths of inter-/actions. As I returned to read the text again and again, meaning of problematic inter-/actions and new understanding evolved from the research data. For example, the practices of staff nurses were held up and reflected against the practices of others and vice versa. After discovering practices which occurred on a regular basis, this analysis began to point out from where such practices derive and how these practices came into organisational life. The recurring practices have been dissected and I tried to read through the lens of a labour process perspective which served as a guide of where to look and what to see. I interrogated the data and asked whether particular practices occurred in the same or different ways for nurses with nurses, compared to nurses with others. As will be shown in the subsequent chapters, I was rewarded with good insights that partially supported the official story portrayed. But taken together this also gave rise to unofficial versions that emerged from the data to describe different perspectives. All this became more concrete as I wrote up the official account and then my point of view (as an ex-nurse and ex-chief nursing executive as well as researcher) of what keeps the practice going in this organisational world. This can be found in Denzin's (1994) argument as he states that field workers "can neither make sense nor understand what has been learned until they sit down and write the interpretive text, telling the story first to themselves and then to their significant others, and then to the public" (p. 502). This part of the analysis brought about an on-going process in which any potential reader is required to participate within the author's text and to adopt a particular position towards the ethnographic text by virtue of 'the system of presences and absences that function within it' (Mumby and Stohl, 1991, p. 318).

Another way of describing the process of my ethnographic analysis was to identify my adopted critical stance upon which a particular line of inquiry taken is based (Putnam, Bantz, Deetz, Mumby and Van Maanen, 1993). Such an embedded view

enables the researcher to show how particular interests are expressed, and uncovers links between discourse and rhetoric in organisational life. Therefore, I did not make sense out of data by relying on what I have observed by means of my knowledge of the social context, but by looking at the discourse involved in particular words and inter-/actions. That is, I tried to break down the taken for granted barrier that keeps the profane out of everyday life and made the un-presentable presentable. Such an analysis provides an account of the relationship between the constructed discourse and cultural rhetoric which integrates the concept of power. For an example see the following discussion:

In subverting a conventional way of thinking I have re-examined a piece of textual reading of what one probably thinks is real. I have selected an example from *Salt on our Skin* (Groult, 1992) which should be both fun and something for which every person has a passion:

> [H]ow to write from the heart about the surgings and subsidings, dissolutions, resolutions, and resurrection of desire? What sort of emotion is evoked by the word 'coition'? *Co-ire*, the Latin word for 'go together'. But when two bodies go together, what becomes of the pleasure? (p. 5).

Here, Groult (1992) denies the existence of an essential meaning of the word 'coition' and with reference to its Latin origin she erases the word as such and adds another phrase as supplement. In doing so, she is able to expose a process of multiple interpretations:

> Then there's [the word] 'penetration'. We're in the law courts here: 'Did penetration actually take place, Miss Smith?'. 'Fornication' has a whiff of surplices and sin. 'Copulation' is ponderous, 'coupling' animal, 'sleeping with' boring and inaccurate, and 'fucking' altogether too brisk. Well then, there's 'swiving', 'tupping', 'hauchmagandy', 'quenching the fire'. These, alas, are the forgotten coinings of a youthful language, before it was bridled by sobriety. In these days of verbal inflation, when words fall out of fashion as fast as our clothes, we have only grubby obscenities rendered meaningless by constant repetition. The worthy 'making love' is always at hand, ready to serve but devoid of emotional thrill, neither scandalous nor erotic. Not fit for literature then (p. 5).

Like many others, Groult (1992) tried to join the band of writers who wanted to capture the pleasurable words which can get such a grip on the heart. Nearly every independent reviewer would read this text as a parable connected with physiological and psychological desire, love, sex, mystery, rapture, private life, dream, atmosphere, euphoria, sin, etc. and no serious person would probably recommend this book as a must-read for every ethnographic researcher. I have chosen this paragraph from Groult (1992) because of its multiple images of love reality and I do not read this literary piece of work so much as representative of a particular genre but as a text that does not grant certain notions privilege over others and continues to explain itself. In that context I do not know what is or will be more bizarre - the quote itself or the interpretation of the person who will read it. Eventually, a person connects the text's meaning mistakenly back to his/her own feelings s/he experiences while reading it. Be that as it may, from my point of view, Groult's quote (1992) provides a trip beneath the surface and avoids imposing received images on the transparency one seeks of this so-called bliss of going together.

Documentary sources and interview accounts were analysed in the same way and social knowledge was created by a body of discourse which has not developed incrementally, cumulatively or linearly but which instead revealed an amount of contradictions and no logical consistency. This form of analysis was ongoing and revealed a particular system presenting different types of notions, themes and patterns which were neither in opposition nor complementary as such. As a researcher, I move the reader back and forth across the text and thereby let him/her participate in a dialogue with various perspectives and multiple meanings. In other words, I present to an intended audience a recognisable and an invisible slice of social reality of this hospital organisation. In the end, I suggest that there is nothing more commonplace than to write up the lines of multiple meanings and therefore, multiple readings.

In this respect, I did not follow the purpose of data analysis as favoured by analytic induction; for example as described by Glaser and Strauss (1967). Their procedures

correspond to the 'grounded theory' approach[6] which itself shares important features with other approaches[7] and stands in opposition to positivism. In this model research data must be transcribed as soon as possible because data collection and data analysis occurs simultaneously. For them, the systematic analysis of research data feeds into the process of data collection and this is one of the strategic ideas of generating a conceptually dense theory which is grounded in data by a process of induction. Glaser and Strauss (1967) call this purposeful part of their technique theoretical sampling which is "the process of data collection for generating theory whereby the analyst jointly collects, codes and analyses his [sic] data and decides what data to collect and where to find them, in order to develop his theory as it emerges" (p. 45). Therefore, formal analysis is set into motion as the next to first interview is conducted and transcribed because data collection is guided by successively evolving interpretations. Strauss and Corbin (1990) summed it up quite neatly:

> **[C]onceptualizing our data becomes the first step in analysis**. By breaking down and conceptualizing we mean taking apart an observation, a sentence, a paragraph and giving each discrete incident, idea or event a name, something that stands for or represents a phenomenon (p. 63).

Starting in the analytical way as quoted above, a constant comparison during this phase of analysis takes place. The so-called 'constant comparative method' works by comparing item to item and/or to concepts of data which are developed (Glaser and Strauss, 1967, pp. 101-15). This means the research data is closely examined for all instances of phenomena that seem to be similar to determine whether or not there is a fit with the established categories. As soon as the evolving categories are saturated

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[6] Glaser (1992), however, is now raising questions about the original version of grounded theory (Glaser and Strauss, 1967) and argues that the more recent ideas on grounded theory discussed in detail by Strauss [1987] and Strauss and Corbin (1990) are betraying their original version. A detailed account of how the harsh dispute between the two co-originators of grounded theory is structured can be found in Dey (1999) and Melia's (1997, 1996) reviews. Melia (1996) hopes that "this dispute over grounded theory versus full conceptual description will join the ranks of academic differences of opinion and ultimately will not damage the larger enterprise that was launched with *The Discovery of Grounded Theory*" (p. 378).

[7] Glaser and Strauss's (1967) constant comparative analysis is based upon Schutz's (1976) *Phenomenology of the Social World* in which he argues that "social scientists should interpret social life from the point of view of participants by recovering the 'subjectively intended meanings' that actors attach to their actions in daily life, while themselves maintaining a detached 'objectifying attitude' to the contexts in question" (Harrington, 2000, p. 727).

> the researcher must formulate a definition based on the properties inherent in the category. This definition will state the criteria that will be used for putting further instances into the category. The definition acts as a guide for further data gathering and should also stimulate theoretical reflection on the part of the researcher (Field and Morse, 1985, p. 112).

Then, the resemblance between the discovered categories has to be worked out and Glaser and Strauss (1967) insist that the researcher has to have a sound knowledge base of the general theory in the field of study for comparative purposes. *Verstehen* [i.e. interpretative understanding] which emerges within such a phenomenological mode of conceptualisation is the product of interactions between the researcher and the subjects under study. In this respect Denzin (1989a) remarks that "meaningful interpretation of human experience can only come from these persons who have thoroughly immersed themselves in the phenomena they wish to interpret and understand" (p. 26). Here, the development of sound description and theory rests upon the dialectical process between the researcher's sensitivity and creative skills involved in these social inter-/actions and on his/her ability to recognise and negotiate meaning in a plausible way.

In spite of his commitment to and understanding of qualitative analysis, Dey (1999) criticises the development of 'a conceptual framework in advance of data analysis' which does not sit very easily with the inductive emphasis in grounded theory (p. 14). Further criticism concerns 'rigid rules' for judging the value of a theory which is grounded or the 'premature closure', by which Wilson and Hutchinson (1996) mean the failure to analyse qualitative data fully and especially to develop the more abstract 'conceptual and theoretical codes' which they regard as the building blocks of grounded theory (p. 123). Another strand of criticism advanced by Wilson and Hutchinson (1996) is that the translated 'rules' for grounded theory also break with 'the philosophy of pragmatism undergirding the method' (Dey, 1999, p. 15). Instead, it is suggested, 'canons of quantitative, positivist method' are being adapted through grounded theory to qualitative methods of analysis:

> The outcome is a study report replete with conventional positivistic terminology, including random sampling, reliability and validity statistics, independent and dependent variables, and the like (Wilson and Hutchinson, 1996, p. 124).

What becomes clear is that my approach taken in analysing the research data of this study is distinct from the above mentioned way as described by Glaser and Strauss (1967) because their way of analysis would lead to a 'data filling system' (Field and Morse, 1985, p. 97). Such an approach stands in opposition to the aims in this research project because inherent in my approach is a concentration on the research text and a sensitivity to the specifications of the empirical reality. In this respect I am not interested in segmenting my data through so-called 'natural breaks' and developing plausible categories as a linear manoeuvre where all themes and notions fit into an established grand theory. My theoretical view as well as the way I analysed my data are associated with a different approach which does not interpret the organisational world in front of the researcher in terms of some decontextualised abstractions and recontextualised construction of the activities in the social world. Rather, I aim to deal with a more problematic view at hand and aim to study the pre-existent forms of social structures and moments of inter-/actions differently by being an active participant in the interpretative process and by playing them off against each other within the empirical material. Of course, the hospital's world is social because it requires inter-/actions on behalf of human subjects for its existence, but the analytical position I have adopted in this research work and how I dealt with the data material sets out from another point than that in which the researcher identifies overarching analytic themes and develops subjective/micro-level categories outside the empirical reality. As a result, the critical realist approach taken here permits 'cross-checking of my interpretations and assertions by other readers' based on the presented social structures and inter-/actions (Mueller, 1995, p. 275) rather than 'a merger of data sources, or a construction' of the social phenomenon (Koch, 1996, p. 176).

In contrast, the centre of grounded theory is generated from and grounded in data, and works with a researcher's situation as a naïve observer in order to search for, or relate to, aspects that pertain to the research problem at hand. It is a way of organising or interpreting field experiences and according to Putnam *et al.* (1993) it is 'imaginative and flexible, sensitive to lived events, and not trapped by a

preconceived goal' (p. 233). But what exactly is a theory? I question this point of view and would argue that the view of a theory which ought to be grounded means it is always laden with ontology and epistemology. Indeed, Charmaz (1990) suggests that "the major problems with the grounded theory method lie in glossing over its epistemological assumptions and in minimising its relation to extant sociological theory" (p. 1164). This is perhaps hardly surprising since Charmaz (1990) argues that '[t]he relation between subjectivist and objectivist realities and levels of explanation remains unspecified' in a grounded theory approach (p. 1164). In Charmaz's view (1990) a grounded theory

> explicates a phenomena, specifies concepts which categorise the relevant phenomena, explains relationships between concepts and provides a framework for making predictions (p. 1164).

Whether explicit or implicit, understanding this nexus itself and the intellectual environment is crucial here because this is a further distinction between my conception outlined above and a grounded theory approach. From this perspective my study relies on critical realist assumptions because we - like the ethnographic researcher and any potential reader - are not able to understand ourselves or what meaning we are producing and reproducing or what we are doing. Importantly, the 'concept-dependency' and 'evaluation' of the world cannot be erased simply with modified methods because methodological and theoretical approaches are integrated in one another and cannot be separated (Bhaskar, 1989, pp. 185-6). This becomes even more clear in Strathern's account (1991) that "[e]ach juxtaposition is generated out of thoughts left over from a previous position" (p. xxv). Thus, when I think of myself as a researcher, the labour process stance becomes an aid and it introduces thoughts I would otherwise not entertain. In this sense, I had to deal with the conceptual consequences of linking my topic of interest to a realist ontological and epistemological base.

What counts in the long run is not how the study is dressed up but whether I have managed to capture the imagination of others and to advance knowledge in a critical way. As already dealt with on page 126, I have taken on board neutral research

positions, and, as an ex-nurse and ex-chief nursing executive I do not reaffirm a managerial or employee orientation in this discussion. An alternative way of describing such an approach is to see it not only as the attempt to identify what people in an organisation do and how they interact with each other in everyday affairs but also as the outlining of the relational organisation with reference to the structure and wider context of power and authority. This enables me to centre my activity on the questions of 'what, how and why is it happening' rather than to describe, prescribe and predict 'what ought, should, must or have to be happening'. An important aspect in my critical realist analysis is the exploring and describing of the cultural rhetoric and the day-to-day practices, and adding an understanding of how people experience and respond to them within the wider context of, and contests over, the labour process. And that's what my doctoral thesis is about. This means I have not allowed myself or others to push me and to locate the study within one or more micro-social categories. The rigour invested in this study lies in re-visiting the data again and again, and using an extended labour process perspective as a guide of my analytical procedures makes my writing more dense and substantial.

Chapter Four

Going to Market

Introduction

This chapter addresses the complex issue of how the health care system and its recent reforms are structured in Germany. Here, I shall attempt to demonstrate some of the general principles and effects of the German health care system and address, albeit in a tangential manner, the complex issue of whether the *2. Stufe der Gesundheitsreform*; i.e. *Gesundheitsstrukturgesetz;* [i.e. 2nd Health Care Reform Act] (1993) was intended to contain health care costs and to introduce market principles into the health care sector. As required for labour process analysis, in this chapter I aim to outline the broader external and societal context of health care sector organisations.

The German Health Care System

The health care system in the Federal Republic of Germany is now more than one century old. Its inception was based on Chancellor Otto von Bismarck's ideal that insurance against the consequences of industrial accidents should be available to virtually all employees. Thus, the *Deutsche Reich* [i.e. German Empire] made insurance obligatory, fixed benefits (e.g. medical costs and compensation for loss of earnings) and provided adjudication in disputes and cases of appeal. It also required commissions to be established, on which representatives of both employees and employers would sit, with "the function of devising binding regulations for accident prevention for the respective areas of industry" (Rosenhhaft, 1994, p. 29). The scheme was financed, however, entirely through employer contributions and administered by associations of employing organisations. Similar, though not identical, principles applied to the statutory system of sickness insurance which was introduced in June 1883. The introduction of compulsory insurance and the transformation of previously voluntary health insurance funds into agents of the state was an important component of a comprehensive welfare programme without having a form of 'socialised medicine' (OECD, 1990, p. 101). Later, in 1919, the *Weimarer*

Verfassung [i.e. Weimarer Constitution] clearly underlined that health care is a state responsibility which is to be put into effect by a social insurance scheme (Schwartz and Busse, 1997).

The basis for the present system of health care was largely laid down in the years following the decision in the summer of 1948 to create a new West German state. Under the first government of Chancellor Konrad Adenauer the system of health care as it had existed before World War II was substantially restored. Its significance lies in the fact that it was pioneer of a funding principle, usually called 'compulsory insurance' (Moran, 1994, p. 83). However, there are no governmental agencies but there are *Gesetzliche Krankenversicherungen* [i.e. health insurance funds] which are a constituent part of the *mittelbaren Staatsverwaltung* [i.e. para-public administration] (Lauer-Kirschbaum, 1994, p. 218; Offe, 1991, p. 124). That is, they are almost completely independent of the federal government and the *Länder* [i.e. the representative states]. This importance of the health care system is reinforced by its style of policy making which means that the policy makers rely on the key governing principle of co-operative federalism. According to Moran (1994), this principle dictates that "policy-making should be guided by the search for a consensus between the major interests in the policy process, especially the major territorial interests" (p. 84). Since Germany is a federal state, the government cannot impose major policy innovations on the member-states of the federation. Thus, the allocation of authority is diffused between the federal state and local levels. However, Germany is not only a complex federal system, it is a federal system with a *Grundgesetz* [i.e. Basic Law] - the name given to the West German constitution of 1949.

By far the greatest part of health care is guaranteed through the insurance funds which are independent bodies with their own board of senior management. Membership of a health insurance fund is compulsory for working people whose gross income does not exceed a certain level and voluntary for those above that level and the self-employed. According to the Statistisches Taschenbuch Gesundheit (1998), the funds cover 88.46 per cent of the population of whom 72.6 per cent are

compulsorily insured, 6.71 per cent voluntarily insured and 20.69 per cent retired but still insured (p. 10.1). Those who earn more than 77,400 German Marks [39,573.99 Euro] per year in the former West German countries or those who earn more than 63,900 German Marks [32,671.55 Euro] in the former East German countries can opt out and join a private scheme (GKV-Gesundheitsreformgesetz, 2000). Therefore 9.05 per cent of the population have private sickness insurance and 2.36 per cent of the population have some other forms of health insurance (Statistisches Taschenbuch Gesundheit, 1998, p. 10.17, p. 10.1). Together with the presence of the private fee-paying patients (i.e. 0.13 per cent of the German population), they act as bill-covering authorities (p. 10.1).

Most of the wage-earning population, including a large proportion of the middle class, are entitled to their health care through the payment of an income-dependent contribution to their insurance association. Health care benefits are available to the wage earner him/herself but also to dependants; i.e. their married partners and their children. Subscribers' premiums are set at a uniform percentage of gross income and the employing organisation contributes 50 per cent. While it is conventionally said that the Germans pay for health insurance, in reality the insurance premium is, according to Moran (1994), a 'payroll tax, with the tax 'hypothecated' (allocated) to health care' (p. 86). Membership of a health insurance fund covers not only workers and their dependants but also retired people and those who are dependent upon social security. As a result, virtually every citizen shares an entitlement to free health care at the time of treatment. This statutory health care funding system relies heavily on the principles of solidarity. As Kamke (1998) has put it:

> The fundamental principles the German social security system is based upon are 'solidarity' and 'subsidarity'. There is a shared view in industrialised countries that, as a community, all members of the society have a responsibility to provide for one another an adequate level of well-being through collective action (principle of solidarity). As far as the health care system is concerned, 'solidarity' can be understood in the sense that there is a sharing of health risks among the population insured. 'Solidarity' also means that contributions should rise in line with the ability to pay (p. 172).

To receive treatment from a hospital, for instance, it is necessary only to produce the *Versichertenkarte* [i.e. insurance chip card] issued by the health insurance fund as proof of eligibility; the hospital provides the appropriate treatment and then submits the bill. The most popular insurance arrangements combine a health insurance with financial compensation and guarantee health care and offer an incentive to hospitals and other health care providers to limit costs of health care to the price recommended by health insurance funds or separate organisations outside the state structure with responsibilities for making and implementing health care policy. The health insurance funds have to follow the principles of a *einnahme-orientierten Ausgabenpolitik* [i.e. revenue-oriented expenditure policy] which means that it is the health insurance contributions or premiums which must ultimately fund the health care costs of their members. The functioning of the health care system represents also a particularly well-developed case of the deep-rooted German system of *Selbstverwaltung* [i.e. self-government]. That is, regional associations of the health insurance funds and individual hospital authorities are bound together into mutual dependency and are obliged to negotiate with one another over rates of payment without governmental interference. These negotiations take place under guidelines for rates of increase of health expenditures set by the *Konzertierte Aktion im Gesundheitswesen* [i.e. Concerted Action in Health Care][1]. Similar to the hospital care context in the United States (U.S.) most of the public and private hospitals are integrated 'vertically' into the health care system to supply comprehensive health care services, and they are integrated 'horizontally' into public utility chains to obtain economies of scale (Herzlinger, 1989, p. 97).

The principles of health care insurance and of self-government deeply influence the funding and the structure of health care in Germany. However, there is a clear division between ambulatory and institutional care which means that hospitals are restricted in providing out-patient care. Most ambulatory care is performed by

[1] The Concerted Action Committee is 'a national body consisting of representatives of interested parties in the health care system which meets twice a year to agree on maximum rates of increases in health care expenditure' on ambulatory, dental and hospital care, pharmaceuticals and other medical supplies (OECD, 1992, p. 57).

Hausärzte [i.e. general practitioners] and *Fachärzte* [i.e. medical specialists] in local practices who have been long among 'the leaders of the medical profession in both prestige and pay' (Moran, 1994, p. 88). This means a wide range of medical services are at the disposal of the patient clientele, who can simply walk off the street into medical surgeries and the costs are largely determined by the way ambulatory health care is delivered. In turn, institutional care is provided by three types of hospitals in Germany: *öffentliche Krankenhäuser* [i.e. public hospitals], which may be owned by the Länder or local governments accounting for 51 per cent of beds; *freigemeinnützige Krankenhäuser* [i.e. private voluntary hospitals], which are usually owned by religious or non-profit associations, accounting for 35 per cent of beds; and *private Krankenhäuser* [i.e. private, propriety hospitals], which are usually owned by individual people or for-profit organisations, accounting for 14 per cent of beds (OECD, 1992, p. 61). The hospital sector is characterised by a large number of hospitals with low average bed capacity, and the ratio of beds to population is very high. Payments to hospitals are made on a dual basis, with operating costs coming mainly from health insurance funds (i.e. 60 per cent) or private insurers (i.e. 7 per cent) and investment expenditures coming mainly from the federal state, the Länder and local governments (i.e. 21 per cent)[2] (OECD, 1992, p. 59). Since 1986, payments for operating costs have been governed mainly by prospective hospital budgets negotiated locally by representatives of health insurance funds and individual hospitals. The negotiations are based on a detailed review of operating costs, including personnel salaries and an expected occupancy rate.

The financing of this universal health care system became unpopular with federal and state executives because health care expenditures increased rapidly and financial resources to meet the system's needs were often insufficient. The assault on the health care system was originally perceived as health insurance funds cash limit because health care was one of the fastest growing elements of German expenditure during the 1970s and 1980s (OECD, 1990, 1992; Statistisches Bundesamt, 1997, 1998; Statistisches Taschenbuch Gesundheit, 1998). It became apparent that such a

[2] The payments made by the patient clientele account for 11 per cent (OECD, 1992).

high rate of increase in expenditure could not be sustained without severe injury to the German economy as well as society. The 'altered scene' (Herzlinger, 1989, p. 96) grew out of profound changes in medical technology, in population characteristics, and in social expectations of the health care delivery system (Bundesministerium für Gesundheit, 1997a-b, 1996). Higher life expectancy and environmental pollution has prompted the rise of chronic diseases and a demographic-related multi-morbidity of the German population. Also significant were the changes in economic growth, employment relations, pharmaceutical technology and people's higher expectations of what the health care system should be. In addition to these circumstances it is important to note that people increasingly charged the health insurance funds with promoting or maintaining their health instead of just treating their diseases. For example, the remarkable decline in the incidence of cervical (neck of the womb) cancer was mostly due to the fact that women had a cervical smear test on an annual basis (Arbeitsgemeinschaft Bevölkerungsbezogener Krebsregister in Deutschland, 1997, p. 34).

Faced with these above mentioned problems, the question became one of how and through which instruments the cost of general health care was to be contained in such a way that the quality and access to health care would not appear to be constrained. There have been successive piecemeal attempts at reform and each of these has involved the painstaking attempt to reconcile the different interests in the health care system. The federal government and the *Länder* attempted to initiate financial legislation, audit techniques and limited hospital payments, and its literature began to reflect the emergence of cost containment as a major discourse in German hospitals (Krankenhausfinanzierungsgesetz, 1972, 1985; Bundespflegesatzverordnung, 1972, 1985; Abgrenzungsverordnung, 1985; Sozialgesetzbuch Fünftes Buch, 1989). By the late 1980s the promise for betterment had given way to an unsatisfactory situation and an ever-escalating bill to maintain the well-being of a resilient population[3] (Gesundheitsreformgesetz, 1989; Bundesministerium für Gesundheit, 1995b).

[3] The total health spending in 1986 amounted to 8.5 per cent GDP, in 1990 it amounted to 8.9 percent GDP and in 1992 it amounted to 9.3 per cent GDP. Measured in ECU, converted at purchasing power parity exchange rates, health expenditure per capita was 1,325.00 ECU [i.e. 2,611.67 Deutsche Marks]

At that time, the main theme and characteristic of the legislator's policy was related to the failure to meet the original hopes for an unified and comprehensive health care service. For example, when compulsory payments by patients were introduced for some smaller parts of the service (e.g. prescription charges, fees for dentures and orthodontic services, charges for hospital fees, charges for spa treatment) the idea of an all-embracing health care service was definitely breached. A far more important and larger problem was, however, that the *Versicherungsbeiträge* [i.e. health insurance fund premiums] rose very rapidly. To some extent the increase of these premiums was attributable to the globalisation of the economy, the world wide recession and the growing unemployment rate after unification[4], and there were some fears that more than 14.3 per cent per capita income might be paid by the end of the millennium[5] (Bundesministerium für Gesundheit, 1998b-c). A negative feature of the health care system in Germany was also a certain lack of equity both in terms of finance between members of different kinds of health insurance funds and in terms of service provision between different geographical areas (Moran, 1994; OECD, 1992). What was seen to be an excessive cost inflation was attributed not only to a lack of cost consciousness among health care providers and the patient clientele, but also to the oversupply of hospital beds and physician services (OECD, 1990, 1992). Throughout the early 1990s the federal government was faced with these problems of health care and the debate once again focused on the provision of institutional and ambulatory care to the German population.

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in 1986, 1,642.00 ECU [i.e. 3,236.50 Deutsche Marks] in 1990 and 1,900.00 ECU [i.e. 3,745.03 Deutsche Marks] in 1992, close to France but approximately 40 per cent more than that in the United Kingdom (Eurostat Yearbook, 1997, p. 142).

[4] Even before reunification, the German health care system was the biggest in Europe, measured in terms of people covered, personnel employed or money spent (Moran, 1994; OECD, 1992). The addition of the 16 million people of the former German Democratic Republic (GDR) has created long-term welfare problems which arose from the very modest projections of economic performance in a Germany that, with unification, slipped from second to eighth place in the European Union in terms of per capita Gross Domestic Product (GDP) (Mangen, 1994).

[5] The burdens of reunification have encouraged the German government to hold the tax rates going into health care to an average of 13 per cent of payroll. The philosophy behind the payroll tax stability is to steer the health care sector according to the revenue available and thus hold down labour costs (OECD, 1990).

The 2nd Health Care Reform Act - Achievements and Problems

By June 1992, a committee of inquiry, set up by the *Bundesministerium für Gesundheit* [i.e. German Health Care Office], examined the administration and management of the health care services and on 21st December 1992 the legislator published its 2nd Health Care Reform Act. At the core of this act lay two proposals: first, the containment of the costs of general health care, and second, a simplification of the hospital structure and administrative complexity. There was also a central announcement that, in keeping with the previous aspects, (inefficient) hospitals would be closed or reduced in size and there would be a reduction in - and critical evaluation of - the organisational structure of the health insurance funds. The publication by the Health Care Office set out a coherent scheme for allocating hospital beds across the decentralised German *Länder* structure according to population needs rather than historical or incremental criteria. In the past, hospital planning was almost entirely concerned with increasing the number of hospital beds and improving the design standards for various departments. Under the auspices of the 2nd Health Care Reform Act, however, there was a growing awareness of the need to engage in a more systematic management approach, to provide incentives to induce more cost consciousness and to reduce the over-provision of hospital beds. As Hinrich's (1995) effectively pointed out,

> [t]his reform act (...) represents the state's recovery of strategic capacities and autonomy against the priority of self-government in the health care sector because it imposed strict material and procedural provisions. Nevertheless, the self-governing bodies and interest associations active in the health care policy arena were involved in the legislative process (p. 671).

Parts of the Act also represented a shift in matters of accountancy and finance in hospitals, abolishing the existing dualistic procedures in such a way that bureaucratic delay could be minimised. In other words, it replaced the dualistic cost regime and the financing of investments, promotions and accounts receivable for the day-to-day operating costs was intended to be done by the purchasing authorities (Müller, 1994; Neubauer and Schallermair, 1999). Under the federal system, however, the most important executive responsibilities are lodged with the government of the individual *Länder*, which means it is the representative states which have prime responsibility

for education and training and they control a large part of the hospital system (e.g. Bayerisches Krankenhausgesetz, 1990, 1997). Thus the *Länder* have the final say over the actual delivery of health care and by 1993, the proposal, though modest, was challenged by their decision to finance investments and promotions in full through local taxation. The reason for this decision was linked to the fact that the assurance of health care quality was becoming a key concern in Germany and a statutory requirement for hospitals; i.e. parts of the Act specify that quality assurance should be carried out in German hospitals, but they do not show how it should be done (see SGB V - §§ 135, 136, 137 and also §§ 115b, 112, 108, 70 Abs. 1). Thus this part of the health care reform failed in its most important objective, which was to contain health care expenditures and to curb the powerful sectional interests.

Another vital element of the 2nd Health Care Reform was concerned with the financial deficit that arose if a hospital was not able to manage its capital scheme efficiently and/or treated more or less patients than its yearly budget dictated. From the 1970s, when the modern system of hospital financing[6] began, hospitals could charge the health insurance funds for whatever they claimed as being necessary and reasonable costs expended in service provision. These reimbursements were expressed as *Pflegesätze* [i.e. rates per in-patient day], for health care services provided to the patient clientele (Bundespflegesatzverordnung, 1972). If in-patient days fell short of expected in-patient days, the hospital still received 75 per cent of the daily rate for the missed bed days. That is, hospitals were required to carry 25 per cent of the losses if utilisation was lower than expected. It also used to be the rule that 75 per cent of the exceeded in-patient bed days had to be returned to the health insurance funds at the end of the year, thus penalising those hospitals who, through

[6] According to the *Krankenhausfinanzierungsgesetz* [i.e. Hospital Finance Act] (1972, 1985, 1991) the financing of investments and promotions which generates benefits; e.g. the erection of new buildings, the adaptation of existing buildings for health care purposes, the costs of initial equipment, furniture and stores for these buildings and medical technology was granted initially by the federal state of Germany and by the representative states from 1985 onwards. The accounts receivable, on the other hand, cover the operating costs of day-to-day services in the current year and were funded separately and financed by the purchasing authorities (Müller, 1994).

wise financial and occupancy management, had been able to achieve economies of scale. As Kamke (1998) has put it:

> Reimbursements by constant per diem rates did neither provide incentives to use resources economically nor to shorten the average length-of-stay being higher than in other Western countries (p. 183).

By 1992, the self-governing bodies began to experiment with radical new forms of hospital reimbursements to help contain hospital costs, and this activity was underpinned by the idea of introducing new monetary considerations within a different payment system. That is, there was a detailed recommendation to directly control the overall expenditure level of hospitals and to introduce a new prospective costing regime in the sense of specifying a separate price per case, or volume mix, which would be then contingent on every set of circumstances. Fixed hospital budgets were first introduced in 1993 to limit the nation-wide growth in expenditure for the years 1993, 1994 and 1995, during which a certain amount of growth above the targeted level was nevertheless allowed (Bundesministerium für Gesundheit, 1995a). In 1996 the effectiveness of budget caps as an instrument for containing costs in the hospital sector was extended for additional three years. Here, it might be argued that the control of hospital spending focused primarily on long-term expenditures; however, it had no direct effect on the volume of service provided.

To promote the use of out-patient surgery and a shorter length of stay, the 2nd Health Care Reform Act reformed the hospital payment system, shifting from per diem to prospective payment based on specific rates for individual procedures and conditions. This prospective payment system includes Basispflegesätze [i.e. lump-sum payments], Hotelleistungen [i.e. hotel service rates], *Fallpauschalen* [i.e. Diagnosis Related Groups], *Sonderentgelte* [i.e. Procedure Fees][7] and *Abteilungspflegesätze*

[7] According to paragraph 11 of the *Bundespflegesatzverordnung* (1995) *Sonderentgelte* are similar to *Fallpauschalen* and classify medical care done by another medical discipline than the one initiated at the beginning of hospitalised care; e.g. for major surgery such as transplants or for minor surgery like the insertion of a pacemaker. *Sonderentgelte* and *Fallpauschalen*, which are paid on top of *Abteilungspflegesätze*, already existed but there are now 140 instead of 16 (Schwartz and Bussse, 1997).

[i.e. department-specific per diem rates], and theoretical models generally conclude that it is based closely on the first prospective payment system used in the United States (Schwartz and Busse, 1997; Mansky, 1997; Hildebrand, 1995; Kamke, 1998). By the end of 1996, the prospective payment system was based upon a small set of Diagnosis Related Groups (DRGs) by which patients are classified and grouped together according to similar principal diagnosis and sub-diagnosis. Developed from historical data, a costing principle like this consists of different hospital costs, and DRGs appear as one fully bundled price. They classify 'an "episode" of care' and the assumption is that these diagnoses require similar treatment protocols and therefore similar amounts of resource consumption (Preston *et al.*, 1997, p. 148).

These reimbursement rates are set by the German Health Care Office but they are administered by the financing administration of the health insurance funds and the *Krankenhausträger* [i.e. the individual hospital authorities] who are responsible for hospital data auditing, resource utilisation review and quality assurance (Bundespflegesatzverordnung, 1995). However, in terms of quality assurance, the health insurance funds also contract with an independent medical advisory service; i.e. *Medizinischer Dienst der Krankenversicherung* (see SGB V 1989 and 1997 - from §§ 275 to 283) to undertake detailed reviews of the appropriateness and quality of ambulatory care, and to initiate immediate action if necessary. In terms of financial and organisational effectivity, other self-regulatory bodies make sure that hospitals comply with state and federal policies; e.g. *Bayerischer Kommunaler Prüfungsverband* (Sozialgesetzbuch Fünftes Buch, 1997).

The 2nd Heath Care Reform Act and the Health Care Market

Most of the health care reforms which the German government introduced from the mid 1970s onwards were devoted either to 'increasing cost-consciousness' among patient clientele and health care providers, or to 'strengthening the bargaining power' of the health insurance funds in their negotiations with hospitals (OECD, 1992, p. 63). Following a jump in average insurance contribution rates in the late 1980s and early 1990s, which was due both to rising unemployment and to further increases in

health care expenditure, the government introduced a further package of reforms in the 2nd Health Care Reform Act. When these are finally implemented, fundamental changes will have taken place in the structure of the health care system. Freeman (1998) summed them up quite neatly:

> In 1992, the Structural Reform of Health Care Act restricted the growth of health spending to growth of sickness fund revenues; relaxed the former strict demarcation of hospital and ambulatory care in the interest of improved coordination and reduced duplication of services; fixed doctor-to-population ratios; required that any overspend[ing] of newly fixed drug budgets be repaid by doctors' associations and pharmaceutical industry; introduced risk pooling between sickness funds to improve equity; introduced freedom of movement for workers between different kind of fund; laid the basis for the prospective amalgamation of funds and brought some marginal increase in cost sharing (p. 186).

As this quotation indicates, there was great interest in improving equity and in strengthening the position of purchasers of care in their relations with hospitals and other health care providers. The result was a reform which sought to implement 'market principles' and to facilitate a specific form of competition within the health care sector (e.g. Hildebrand, 1999; Bundesministerium für Gesundheit, 1998a, 1995a; Gerdelmann, 1995; Hinrichs, 1995; Meurer, 1996; Müller, 1994; Igl, 1995; Wolf, 1994; OECD, 1992). As Moran (1994) puts it: from 1996, "contributers will be free to choose their own health insurance fund, thus increasing the pressure on funds to compete with each other by offering economical rates" (pp. 98-9). Nevertheless, imbalances between health insurance funds will be eliminated by a national risk-adjustment scheme; i.e. a system of compensation payments between those in deficit and those in surplus. As health minister Horst Seehofer (1993) has claimed, "risk adjustment and consumer choice make for a new competitive order which improves the conditions for economic efficiency and contributes to downward pressure on contribution rates"[8] (p. 102).

[8] Mit dem Risikostrukturausgleich und der Kassenwahlfreiheit wird eine neue Wettbewerbsordnung geschaffen, die die Bedingungen für Wirtschaftlichkeit verbessert und den Wettbewerb über günstige Beitragssätze fördert (Seehhofer, 1993, p. 102).

In a conventional or free market, however, supply is not controlled by government and responds purely to the market consumer. In that context Harrison *et al.* (1992) refer to Satori [1987] and claim that a market is not run by a single chain of command and is a 'spontaneous order' monitored by its feedback, its conflict with a 'rational order' shaped by targets (p. 119). The characteristic of the German health care market is that this market is not free and is bound to the federal state, which typically remains in the position of being the regulatory authority. Here, a dependency has been created, making the ordinary health insurance fund dependent because this particular situation does not entail marketable commodities. Such a dependency is guaranteed and self-perpetuating since health insurance funds, now market contributors or market beneficiaries, cannot proceed with the business of their organisation without an eye to the logic of this established 'quasi-market' (LeGrand and Bartlett, 1993). An excellent illustration of this kind of analysis has been provided by Freeman (1998) who claims that '[c]ompetition, which in theory produces variety, is predicated on uniformity' (p. 188). Von Stillfried and Arnold (1993) go on to reflect another concern:

> Although the reformers claim to be generating equal conditions for competition between the funds before introducing unlimited choice between statutory health insurers, they have effectively standardised all activities of the funds. This opens up the prospect of a single national sickness fund in the near future (p. 1017).

Another factor associated with the German health care market is that competition between health care suppliers and a new system of payment for in-patient care increases quality and effecitivity and reduces prices and inefficiency within the organisation (Levitt and Wall, 1992; Freeman, 1998). Here, general hospitals would be competing with each other for patient clientele because they differentiate as regards the quality and price of health care service (OECD, 1992). Although the German population has a free choice regarding the access to health care, if hospitals were no longer receptive to peoples' needs and involved themselves in rigorous market-like competition, general access to health care would be enormously impacted. In contrast to conventional markets, the nation state bears the final responsibility for orderly provision of health care, particularly social benefits. That

is, the German state needs to secure an environment that safeguards the viability of hospital institutions "from market imperfections while also promoting systemic efficiency, assuring quality, and protecting equal access to social entitlements" (Chernichovsky, 1995, p. 364). In this respect, hospitals cannot be essentially concerned with maximising their profits because they follow different objectives and are agencies of identification (Vogel, 1980; Gärtner, 1994). Before the 1992 reform, there was no incentive to treat more or less patients due to pre-determined budgets. If however, more patients and a shorter length of stay mean more money, it becomes more likely that hospitals will increase their efforts to achieve a greater patient throughput (Levitt and Wall, 1992).

However, the recognition of the potential to limit access and to constrain the quality of health care has led to the fact that the health insurance funds have the power to dictate many of the rules according to the political agenda and they are inclined to put national health care reforms into motion. What really emerged was the concept of an 'internal market' (Dent, 1998, p. 205; Dent, 1996, p. 145) or 'regulated market'[9] (Saltman and von Otter, 1992, p. 17) which relies on an inter-dependent economy with self-governing partners or associations and has some parallels with the concepts of the U.S. health care service[10] as outlined in various critical discussions surrounding the re-organisation of health care services (Mansky, 1997; Dent, 1993, 1995a; Chernichovsky, 1995). This argument is in line with Freidson's claim (1994) who draws on the health-care systems of today:

> It is only *within* the organised and regulated structures of the system that competition can exist, and it need not necessarily be directly grounded on material gain. Policies that try to introduce the material incentives and values connected with the free-market model into a system from which the essential conditions for anything resembling a free market are absent will not only fail, but

[9] On the supply side, as with conventional markets, there is a competition because people have the choice to select which health insurance fund they want to join. But, on the demand side the health insurance funds are confined to the principle of solidarity and to the purchase of specific services and at specific prices from various hospitals. If this can be described as a market, it is one which is not merely regulated but rigged (Sayer, 1995).

[10] According to Chernichovsky (1995) Germany shares three major traits with the United States health care system: firstly, medical care is provided by private physicians and by private and public hospitals and patients have a free choice of physicians; secondly, most people receive health insurance coverage through their workplace and thirdly, health insurance is provided by multiple third-party insurers.

> will also threaten the conditions upon which the effective functioning of the system depends (p. 192).

In spite of all this, the *Pflegepersonalregelung* (PPR) [i.e. a formula for planning nursing resources] (1993) which was part of the 2nd Health Care Reform Act became law[11]. In the early 1990s, the persistent lack and limited funding of skilled nursing personnel had produced a crisis situation for many hospitals. That is, the shortage of qualified nursing staff led to ward closures and this effect, was of course, not desirable. As a whole, the workforce planning of nursing resources had been a long drawn-out affair, involving extensive consultation with various occupational groups, substantial political input and work by different bodies of expertise within the German hospital and nursing associations.

According to article 13 of the 2nd Health Care Reform Act the PPR is a method of classifying patients into categories of care in order to describe the workload and utilisation of nursing resources and therefore to determine nursing costs. The principle characteristic of the PPR is its reliance on measures of patient dependency related to the number of nursing minutes required to maintain acceptable levels of defined direct and indirect nursing care. Although the system does not include psychiatric wards, intensive care and emergency units or theatre nursing, it has been an improvement on the former method of calculating demand according to the number of occupied beds. That is, the planning of nursing resources became dependent upon the type and amount of nursing care the patient receives and is sufficiently financed to cover the costs of nursing labour. In this way a nursing division was able to gain more control over the structure and processes of work within hospital care services. However, this is not a situation unique to Germany because very similar conditions arose in the United Kingdom in the late 1960s and early 1970s. For example, see the publications on *The Aberdeen Formula* by the

[11] This was due to the fact that paragraph 19 section 2 of the *Krankenhausfinanzierungsgesetz* [i.e. Hospital Finance Act] enabled the legislator to establish principles and measures of human resource planning in nursing. According to paragraph 19 section 1 of the *Krankenhausfinanzierungsgesetz* (1972, 1985, 1991) the representatives of the self-governing bodies have the permission to co-operate regarding measures of nursing resource planning. Since 1969 there have not been any agreements and therefore both parties were without a co-operative result.

Scottish Home and Health Department (1969), Crompton, Mitchell and Cameron (1976a-b), Cameron (1979), Mackley, Heslop and McAllister (1979a-c) and Rhys Hearn (1979).

By 1992, there was some indication that, fairly or otherwise, nursing became to be quite widely perceived within the health care service as the German government's favoured profession. That is, the PPR system was a particularly good example of a modernist project because it had been designed to free the workforce planning of nursing resources from the macro approach of demand modelling. Even though the long-term effects on the number of nurses employed were not predictable, one has to take into account that the same Health Care Reform Act pointed out that hospitals are required to fix their budgets and to introduce Procedure Fees and Diagnosis Related Groups.

The basic structure of the welfare state in 1996 was very much the same as in 1990 and the vast majority of the German population was served by an insurance-funded system of health care; i.e. the 2nd Health Care Reform Act has not led to significant service reductions in the health insurance benefit catalogue. Although the total health expenditure per head of population jumped from 1,642.00 ECU[12] [i.e. 3,236.50 Deutsche Marks] to 2222.00 ECU [i.e. 4,379.72 Deutsche Marks] between 1990 and 1996, the proportion of national resources going into the health care system decreased significantly (Eurostat Yearbook, 1997, p. 142). In 1996 the monetary input was a significantly lower percentage (i.e. 7.5 per cent) of the *Bruttoinlandsprodukt* [i.e. Gross Domestic Product] than it had been in 1990 (i.e. 8.9 per cent) (Eurostat Yearbook, 1997, p. 142). Despite the 'altered scene' and the burdens of reunification, the federal government was successful in reducing the share of health care expenditure in the Gross Domestic Product following the cost explosion in the late 1980s and early 1990s[13]. There were suggestions, however, that

[12] On 1st July 1997 1.00 ECU was equivalent to 1.97107 Deutsche Marks.

[13] When long-term care insurance took effect in 1995 - the provision of home care benefits started in April 1995; on 1st July 1996, benefits for people cared in nursing homes were added - the health insurance funds were relieved of responsibility for these payments. However, the constituency of this branch of the German social insurance system is identical to the membership of the health insurance

per capita health care expenditure was lying above the regression line suggested by macro-economic figures; i.e. the growth of health care expenditure was not in line with the growth of wages and salaries of the health care insurance fund members.

Since the introduction of the 2nd Health Care Reform Act various aspects of this law were subjected to governmental influence, such as the stability of the contribution rates[14] , the extension of the nation-wide block of all hospital budgets, and other adjustments to account for changes in accounting patterns that were expected under the new system (Bundespflegesatzverordnung, 1997; Stabilisierungsgesetz 1996; Beitragsentlastungsgesetz, 1996). In addition to these subtle modifications, several other reports appeared which resulted in the *3. Stufe der Gesundheitsreform* [i.e. 3rd Health Care Reform Act] being passed and exerting more visible influences[15] (1. und 2. GKV-Neuordnungsgesetz, 1997; Sozialgesetzbuch Fünftes Buch, 1997; Bundespflegesatzverordnung, 1997; GKV-Solidaritätsgesetz, 1998). All of them can be seen, in retrospect, to have reflected the problems being encountered in trying to overcome the financial deficiencies in health care. However, according to Schneider (1991), cost-containment policies have been primarily 'price containment' policies in Germany (p. 96). While the recent reforms have introduced some elements of competition and effectiveness to the health care sector, the containment of costs has been achieved primarily by 'strengthening capacities for regulation' rather than by 'deregulation' (Freeman, 1998, p. 190).

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funds, and premiums to long-term care insurance plans based on earnings are subject to the same ceilings, of one percent of gross income until July 1996 and 1.7 per cent thereafter (Hinrichs, 1995).

[14] Forced by the Maastricht doctrine to reduce deficit spending, the federal minister of health rated the principles of revenue-oriented expenditure policy and stability of the health insurance fund premiums more highly, and proposals to put a legal cap on both the employers' and the employees' share of the contribution were seriously discussed. In May 1996, the health minister pushed a legal reduction of contribution rates by 0.4 per cent from January 1997 to achieve the overall goal of the German government; i.e. to reduce additional costs on wages for employers (Schwartz and Busse, 1997).

[15] On 23 June 1997, the PPR system was repealed by enactment of the *3. Stufe der Gesundheitsreform*; i.e. *1. und 2. GKV-Neuordnungsgesetz* [i.e. 3rd Health Care Reform Act] and brought about further modifications of the health care reform. The systematic withdrawal of the PPR system reduced the autonomy of nursing services and, once again, the negotiation of matters of nursing resource planning relies on the individual capabilities of the CNE. Therefore, the decision to include the cost of nursing resources into a hospital's constrained budget influenced how the data were interpreted, putting an emphasis on total hospital costs, rather than on the costs for the full-time equivalents required.

Meanwhile the debate about the need for further reform to the German health care system continues; i.e. the *GKV-Gesundheitsreform 2000* [i.e. the Health Care Reform 2000]. Under discussion are, once again, new arrangements for financing hospital investments and structuring hospital planning; (e.g. the replacement of the dualistic costing regime). Furthermore, proposals for introducing 'global' hospital budgets and the whole range of categories of Diagnostic Related Groups[16] have been put forward by the German government. Reorganisation of the ambulatory care doctors is also on the policy agenda, with a view to introducing a gatekeeper role for general practitioners and capitation payments. However, there are signs that these objectives will not be achieved since these latter proposals face the prospect of being challenged by various interests and means[17].

Conclusion

This chapter has been shaped by the importance of the German health care system. In the first section I looked in more detail at the fundamental principles and policies by which the German health care system is organised. In the second part of the chapter I turned from principles and policies to reforms and practices - to the 2nd Health Care Reform Act and the working features of hospital organisations. Following this, I discussed some of the impacts of the 2nd Health Care Reform Act on the health care sector and argued that the governmental attempts to produce solutions to the rise of health care expenditures were partly successful in meeting the financial objectives.

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[16] On 30th June 2000, the German Health Care Office declared that the AR-Diagnosis-Related-Group System, based upon the Australian model, will be implemented in the hospital sector from 1st January 2003 (Bundesministerium für Gesundheit, 2000).

[17] Any reform legislation has to pass both houses of the German parliament. On 26.11.1999 the replacement of the dualistic costing regime and the introduction of 'global' hospital budgets was challenged by the *Bundesrat* [i.e. the upper house] which represents the interests of the Länder. The political sensitivity of the cost of health care has nevertheless driven the federal government further towards intervention, and on 16.12.99 another reform package was introduced, effective from the start of 2000 (Deutsche Krankenhausgesellschaft, 1999).

Chapter Five

The Description of the Setting

Introduction

The aim of the following chapter is to give an account of the formal hospital setting - from which the ethnographic journey starts off. The description of the location provides a basis for the potential reader to understand how the map was laid out. Then the setting becomes populated with people and the researcher gets to know how to proceed - through the act of writing by which social scientists have learned to make sense of the empirical space. Each site of study is always very *specific* (Latimer, 1994, p. 6) and for reasons of confidentiality the name of this hospital will not be disclosed. Throughout this thesis it is referred to as *Jo-care* as a guarantee of anonymity. While every effort is made to ensure that Jo-care can keep up its anonymity, on numerous occasions I present the apparent but also some of the hidden features of this particular setting.

First of All...

Shortly after World War II the former military barracks and US clinic[1] of the International Refugee Organisation (IRO) for displaced people with chronic diseases was transformed into a general hospital for acute care and cure. Jo-care is owned by the German branch of the Church's global aid agency[2] and, if necessary, generously subsidised by its local ecclesiastical authority but administered by a CEO like an independent hospital trust. Jo-care is a Roman Catholic hospital and therefore a private voluntary institution[3] but also one under contract to a businessman, who owns

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[1] In this part of the country the role of stabilising order fell to the U.S., whose economic and military intervention was required to restore the old world.

[2] The entire association employs more than 450,000 people and is one of the largest employers in Europe. In addition 500,000 people are contracted on a honorary basis to enhance the capacity of this welfare organisation. There are 25,000 institutions with 1.2 million places for people who seek professional help; the main interest is shown for hospitals, nurseries, nursing and residential homes for elderly and disabled people.

[3] The Weimarer Constitution (11.08.1919) separated state and church and granted churches the right to run private voluntary hospital organisations. In 1948-49, the creators of the *Grundgesetz* [i.e. Basic Law] adopted the relevant articles of the Weimarer Constitution [Art. 136, 137, 138, 139 and 141] into the *Grundgesetz* as Art. 140. Together with Art. 4, Abs. 1 & 2 of the *Grundgesetz*, this guarantees an ecclesiastical autonomy in official matters regarding the employment of secular people; i.e. private

a consulting company, which specialises in turning ailing hospitals into profitable health care enterprises.

The hospital is a 331 bed, acute care facility offering an array of specialist services in the following medical areas: general medicine, surgery, urology, nephrology and dialysis, plastic surgery, gynaecology and obstetrics, anaesthesia and intensive care. In particular medical areas Jo-care has contractual links to the Medical School of the local University and is one of six public hospitals in a city with approximately 130,000 inhabitants. The hospital is located in a lower-middle class area within a community composed of a large Roman Catholic municipality. In the early 1990s, the city within which Jo-care is located included immigrants from Eastern Europe, as well as refugees from other developing countries, among its residents. The community has something of a reputation as the major centre of working class people but it is not merely the immediate district's inhabitants who constitute Jo-care's patient population. Also, the image of the hospital as a Roman Catholic institution may be theoretically misleading; however, Jo-care provides medical and nursing care, through its regular in-patient departments, for approximately 12,000 residents of the larger city. While in official reports Jo-care quotes this overall amount of patients, about 21 per cent are emergency and casualty cases. Calculating with these figures, the ratio of emergency and casualty patient to all patients visits is 1 : 4.8.

Once admitted to the hospital, a patient is interviewed by an administrative secretary or a nurse of the emergency and casualty department, whose task it is to ask for the bill-covering authority, which the hospital administration will charge on the basis of the general fees accepted by health insurance funds. As already noted, many 'walk-ins' occur during the day-to-day practice; i.e. people who arrive at the hospital of their own accord without ambulance delivery (Sudnow, 1967a, p. 15). Additionally, there are people who do not plan their admission to hospital and they have no warning about the fact that they would soon find themselves in hospital. They are all

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employment contracts, non-unionisation, wage-setting powers (Grundgesetz, 1949, p. 37 and pp. 84-5). However, even when hospitals are administered by the church, they tend to be responsible to the federal state because health care institutions are part of the public domain.

admitted via the emergency and casualty department and according to the documentary evidence the process of gaining access to a bed can take up to two hours. On their arrival, people are seen by the medical doctor on duty and if it is appropriate they are referred to the senior doctor for his/her opinion. Otherwise, it is up to the medical doctor to decide if the person is to be admitted to a ward or whether the patient would be more appropriately sent home or referred to another clinic. There is currently some development concerning the appropriateness of the practice of admissions and a so-called patient management service centre is being introduced.

The Hospital Complex

The physical layout is a 'network of different places' and something of a feast for one's eyes (Law, 1994, p. 40). The main house of the white hospital building shines because of the use of lots of glass and it is situated along the edge of a park area, bounded by houses and a military base as well as a busy street. The surrounding residential neighbourhood comprises traditional building blocks from the post-war period. The main entrance can be reached from the streets, from two directions. Either from the back, where a parking area provides space for a limited amount of cars, or from the main street where people arrive by bus or on foot. The whole hospital complex contains four different buildings.

The main hospital building consists of parts of the former military barracks, together with newer constructions. One can see the strong inclination towards centrality, and the re-development brought about spacious, functional and aesthetic surroundings. At the main entrance, there is a visitors' eating facility and gift shop in the form of an Italian bistro which includes a terrace garden. The other part of the main hall is an elegant open-plan reception area at which a receptionist and a telephone operator work five days per week. During the night and at weekends the reception is manned by one member of staff who performs tasks of both positions at the same time. Opposite the reception is the admission office in which approximately 50 patients get questioned and clerked by three full-time administrative secretaries on each working day. The registration of approximately 700 births and 250 cases of death in each year

is also performed in this administrative space. Apart from all this, visitors and new patients quickly detect a range of coloured lines and signs which lead them to different departments and units. This additional guiding system is for general orientation within the setting. Further, the entrance hall has two different banks of lifts - two smaller lifts for people and three others for the transportation of patient beds, goods and food trolleys.

There is a clinic section adjoined to the main entrance area by a large, open and airy hallway with a first-floor half-surrounding catwalk. Most of the Departments of Diagnostic and Therapy such as ECG, laboratory, endoscopy, X-ray, the emergency and casualty department, etc. are placed within this zone. In addition there are some offices and examination rooms of various medical consultants and senior doctors. Within the centre of this open hall is a well-maintained waiting area, appointed with plants and anthroposophical[4] colour constructions around the columns. Both of these creative arrangements can be found all over the hospital main areas. Around the examination rooms and offices are regularly changing picture presentations from different nation-wide artists. Moreover, there are rooms used by social workers and nurses for transitional and community care, as well as the in-house scientific library with an adjoining conference room.

The main building has four floors and on each floor there are long single corridor or U-shaped wards, from which, adjacent to each other, the private and semi-private bed rooms as well as the nursing offices and rooms for ancillaries and equipment storage branch off. Altogether, there are ten different wards across all floors, and in most cases there are two per floor. As previously mentioned, the hospital has the usual range of divisions such as general medicine, surgery, gynaecology and obstetrics, etc. and some of the wards are interdisciplinary in their character. This comes about because of a small amount of beds in plastic surgery or patients who can afford to go

[4] The word derives from anthroposophy which is related to the spiritual and mystical teachings of Rudolf Steiner (1861-1925) (Steiner, 1992). The *anthroposophical philosophy* was found at the turn of the century and is based on the belief that creative activities as well as colours and their particular combinations are psychologically valuable (Caldwell, 1996, p. 260; Collins English Dictionary and Thesaurus, 1993, p. 46).

private. Additionally, there are nine allocated beds on one ward on the ground floor which are used for admissions between the hours of 20.00 and 10.00. On the general medical wards, patients suffering from diseases ranging from diabetes to cardiac infarct to cancer can be found and patients of the same gender are assigned to the same rooms. One of the ten wards is an intensive care area with 12 beds and approximately 1,400 seriously ill patients each year. This unit is placed on the first floor next to the open hallway and beside the main operating theatre, anaesthetic department and labour unit.

In the basement are those places which are set aside for use by the people of the departments for supply and disposal, such as the goods depot, linen storage, bed cleaning unit, recycling, central heating, etc. There is also the department of physiotherapy as well as the kitchen and cafeteria for hospital staff. The latter is a self-service restaurant with breakfast and lunch buffets and provides free access to coffee/tea and soft drinks. This open-plan canteen is furnished in the typical style and the attached terrace garden is carefully planted and tended which means that on warm days, the out-side area is regularly used. In its overall physical structure, this locality appears considerably attractive. Additionally, there is an under-ground garage which is mainly used by VIPs such as the most senior doctors but also by the various services on call; e. g. midwifes, paramedical staff, medical technicians, pharmacists, etc. Some spaces are occupied by vans which are owned by Jo-care.

The administration building could be said to date from the time after World War II and accommodates the personnel and financial departments, conference rooms and the offices of the CNE, CEA and CEO. The two-storey houses' corridors are poorly lit and badly ventilated even though all the rooms are airy and brightly re-decorated. There is another adjoining four storey building. This part of the building is used by the small convent which still exists and is home to five nuns, young conscientious objectors who do social civilian service, staff changing rooms and medical doctors or theatre nurses who are on-call during the night or at weekends. All of the aforementioned groups use a separate entrance from the one used by those people

occupying the administrative and finance offices. There is a link in the form of a tunnel between the main hospital and this building in order to give people of Jo-care direct access to each other's space. Down there in the administration building, at the beginning of the tunnel, the in-house pharmacy is located.

There is also a light green coloured and very modern pavilion in the grounds of Jo-care. Within this, there is an additional above ground garage and the dialysis unit[5] is accommodated on the first floor. This unit is organised in a co-operative form between the department of nephrology in Jo-care and an independent association which has centres for dialysis in 160 different places all over Germany. Most of the clientele in this section are treated on an out-patient basis which means that they come in for a considerate amount of time in order to get their blood filtered and leave soon afterwards.

The last site on the overall complex is the apartment house of Jo-care which has a seven-storey structure. This building block was erected in the early 1970s and the incorporated studio flats accommodate most of the nursing students and other staff of Jo-care. On the ground floor and the basement the lecture rooms and offices of the school of nursing are established. Since 1993 the Department of Further and Post-registration Education has been attached to the school of nursing and is established as one single Department for General, Further and Post-registration Education in nursing as well as other disciplines. Eight members of the organisation work full-time within this interdisciplinary department. The unit is made up of six nurses acting as nursing teachers. Before they were appointed to their current position, they completed a two-year teaching training course in nursing. Another nursing teacher is in charge of the department as a whole and there is one medical doctor involved in this team. The doctor is included to introduce first-hand medical knowledge into nursing education and various post-registration and staff development courses; e. g.

[5] There are 300 dialysis patients in the larger city where Jo-care is placed. At this time Germany has 44,000 and has to expect an enhancement up to 70,000 patients for dialysis service in the next couple of years. There are 2,000 kidney transplantations only each year; to serve those in need 3,000 to 4,000 donations are needed.

theatre nursing, renal nursing, anaesthesia and intensive care nursing. In addition, there are further educational courses for medical doctors from various disciplines, medical technicians, paramedical and administrative staff constantly on offer which are sometimes interdisciplinary in their nature. Before new employees join the day-to-day practice, an orientation seminar, arranged by this department on the first days of each quarter, takes them through the important features and processes of Jo-care. In this sense, learning is not a 'do-it-yourself' matter in the organisational world of Jo-care (Sudnow, 1967a, p. 25). Because of its interdisciplinary status the department and its subjects are directly accountable and linked to the hospital's management board.

Each of the four buildings are part of Jo-care's layout as a whole and in between them are well-maintained garden grounds or parking areas. Overall, the hospital is not designed as one clustered building but spread pleasantly over a larger site. It is hard to remember that this hospital was constructed as a military barracks in the year 1936 and used by the American allies for different purposes after World War II. Re-developing the old hospital into a modern and elegant health care centre was very costly, with costs exceeding the anticipated budget, but Jo-care received 153 million Deutsche Marks [78.23 million Euro] funding from the representative state of Bavaria (i.e. the ministry of work and social affairs, family, women and health) so that an overall total of 175 million Deutsche Marks [89.48 million Euro] was spent in the last 11 years. However, the 45 different occupational groups within Jo-care provide high-quality and excellent health care service to patients regardless of their social background. There are also contracting links to local suppliers and services; the capital expenditure in this respect is not less than 20 million Deutsche Marks [10.23 million Euro] per year and stimulates the regional economy. In this sense Jo-care does not merely provide contracts to their employees but also safeguards employment for others within the larger city area.

The Ward Area and the Subjects

Wards are the primary space in which Jo-care's clientele are served. The wards are medium sized with a capacity ranging between 32 and 38 beds. The wards branch off the central corridors where the different lifts are placed and consist of private, two-bed and three-bed rooms. Overall, the patients' spaces do no longer have the traditional character from the past but are well-appointed rooms. Aside from the modern beds, there is a mobile bedside table and a built-in wardrobe per patient. A small dining table with some chairs in one corner and a fully-equipped bathroom with a separate toilet is one of the standards in each room. Additionally, each bed site has access to a telephone and one TV is located on one of the walls in the middle of the room. The indirect lighting is covered by two high-tech steel constructions which are placed on each of two opposite walls. There, the supply of an overhead light, a radio with earphones, the patient call system for nurses and direct access of oxygen as well as pressure air is guaranteed. There are transparent curtains and opaque blinds in front of the two windows but none which can be drawn between the beds in order to provide privacy. The ward and rooms are clean and freshly painted in white so they appear tidy and sterile. There is a common day room for the patients on each of the wards. It is a place where a visitor is able to interact and communicate with the patient apart from the patient room itself. All the doors of patient rooms are closed and no-one on the ward corridor can witness anything which goes on in the patients' temporary private spaces.

At the time of the field work, there were 179.35 full-time staff equivalents which resulted in 239 nursing members working on the wards. This was due to the fact that there were nursing staff working 38.5 hours per week and part-time nursing staff working between 4.75 hours and 30.00 hours per week. The majority of nursing staff on the wards (i.e. staff nurses, charge nurses and ward sister) has been fully trained and educated; i.e. 99 per cent of the nursing staff have had a three year education in nursing and have been recognised as registered nurses according to the *Krankenpflegegesetz* [i.e. Nursing Act] (1985). Few health care assistants or nursing auxiliaries were employed on the wards at this time. Additionally, the ward sisters

and their deputies had a formal 12 weeks theoretical training in ward management conducted at an external, but local, college of nursing. The average allocation of student nurses to one ward was four to six to cover a 24-hour rota and there were two domestic workers permanently attached to each ward. The gender balance on the wards was largely female with few male members of nursing staff. Moreover, the age profile showed the bulk of nursing members as being between 21 and 45 years old, with the highest proportion within this range being under 30 years of age.

Nurses work a 7.33 hour day[6] on early and late shift. This means in terms of workforce planning that if the basic working week is 38.5 hours for a full-time employee, then one nurse has to work 5.25 days per week. Nurses on night duty have a 10.0 hour day which leads to a reduction of working days per week. Sometimes, the minimum of qualified nursing staff per shift can't be maintained because 'unplanned absence' occurs (Beil-Hildebrand, 1996, p. 11). When unplanned absence occurs, the hospital may send an external replacement or a nurse or student nurse from another ward offers some help. Another cover option is that one staff nurse splits up her/his scheduled working day at short notice; i.e. s/he does not work the early shift until the end and comes in for additional hours in the evening.

The Office Area and the Subjects

The world of management is another part of the hospital that I became most familiar with and some members of the directorate and chief executive management were involved in this study. All the senior managers have large offices, with accommodation for a secretary in an adjacent office. These spaces are designed to encourage communication and are equipped with modern status-bearing furniture. In contrast to this prints, photographs, plants and other material are displayed in an effort to personalise these areas of work. For most of their time at work senior managers use these offices in order to talk: they talk of orientating their service towards the patient clientele; of efficiency and financial success by various organisational practices; of the day-to-day conduct of medical and nursing care; of

[6] On each working day nurses are granted 10 minutes for changing in and out of their uniform.

attempts to do better public relation work; etc. While the CEO, the CEA and the CNE occupy offices which are located in the periphery of the administration building, the chief medical executive's (CME) office is placed within the clinical section of the main building. The reason for this clinical accommodation can be found in the CME's function of also being an active member of medical staff in the department of anaesthesiology.

As already mentioned, the hospital's legal affairs are handled by the CEO. To a limited extend this is undertaken by two other businessmen of the consulting company, who all serve as legal advisors in areas of budgeting and accounting as well as many matters of hospital policy. This means that the people within Jo-care's chief executive management are in charge of the administrative-managerial function and are the main budget holders. Moreover, the CEO follows the promulgation and achievement of the hospital authority's policies, the corporate responsibility for advising the authority on its responsibilities, the implementation of policy directives from the German Health Care Office and has the direct responsibility for all services so that key decisions can be made. There is also a corporate obligation to implement activities of charity in the Christian sense and organisational work processes with a persistent control. According to the official rules the CEO is not the sole decision maker in Jo-care but acts as *primus inter pares* [i.e. first among equals].

On the basis of the obtained data several issues will now be discussed with a primary focus on the CNE and his deputy. Both people working in the directorate of nursing are nurses educated as described above. Additionally, before both were appointed to their current position within the directorate of nursing they attended a two year full-time theoretical and practical management programme in nursing administration at an external college of nursing. This kind of non-academic education has been widely accepted and is still quite common all over Germany. However, in the early 1990s a first step was taken towards academia with the implementation of a four year study in

nursing management[7]. For a detailed and critical discussion on this topic see Appendix Four.

The CNE acts as head of the whole nursing service, which involves membership of the tripartite hospital management board. The CNE's full representation on the management board is in accordance with the first published recommendations of the *Deutsche Krankenhaus Gesellschaft* [i.e. German Hospital Association] of the late 1960s (Deutsche Krankenhausgesellschaft, 1969, 1989; Bayerische Krankenhausgesellschaft, 1983)[8]. Since then, the CNE's integration into senior management has found widespread acceptance and been put into hospital management practice all over Germany. In some representative states the legal basis of the CNE's position and function is stipulated by law and is anchored in the hospital legislation (Küpper, 1996; BALK, 1990; Zeuleis, 1982). According to Streckel (1994) this legislation can be found in the ruling laws of Baden-Württemberg, Berlin, Bremen, Hessen, Nordrhein-Westfalen and Saarland. The remaining five representative states, as well as the ecclesiastical hospital authorities in general, are free of any legislative constraints. In this sense, all organisational members in nursing, those working on clinical wards as well as nurses acting in the Departments of Diagnostic and Therapy; i.e. anaesthesia, theatre, emergency and casualty, endoscopy, ECG, EEG, etc. are led and managed by the CNE and fall within its responsibility and accountability.

In Jo-care, shortly after commencing field work, it became clear that the human resource manager and the deputy CNE did not explicitly know the number of

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[7] There are four year programmes available in order to educate nursing managers, nursing teachers as well as so-called nursing scientists in various curricular forms.

[8] Due to the above mentioned recommendations in management structure, the CNE of Jo-care sits alongside the CME and CEA on the management board of the hospital which acts as a trio of management. The consequence of this is that the nursing service's special interests and issues can be directly represented by the CNE's expertise. According to the *Bundesarbeitsgemeinschaft Leitender Krankenpflegepersonen* (BALK) [i.e. German Association of Nurse Executives] (1997) the core functions are: nursing-medical product controlling, budget steering of nursing personnel, progress and future demand of nursing, maximum performance by quality assurance as well as controlling, marketing as well as service guarantee by co-operation, communicating and net-working and economic personal management in accordance with social as well as professional competence.

personnel accountable to the CNE. I therefore began to ask the CNE how many full-time equivalents and nurses are employed in Jo-care.

At the time of my field work 179.35 full-time staff equivalents, which came to 239 nursing members were contracted in nursing, working on clinical wards. Additionally, 47.5 full-time staff equivalents, which was in effect 56 nursing members, were employed in the Departments of Diagnostic and Therapy. Moreover, there were 23 full-time equivalents, which was in consequence 29 nursing members, contracted in the dialysis ward. 15 organisational members were working full-time within the patient management service centre. As already mentioned there was no direct subordination of the 64 students of the school of nursing and eight employed full-time lecturers in the Department of General, Further and Post-registration Education.

The CNE is also in charge of the department of domestic services within Jo-care, which involves one senior domestic officer and 48.50 full-time staff equivalents, or 60 domestic service members. In all there were 314.35 full-time equivalents and 399 organisational members of staff accountable to the CNE. At the time of data collection an overall total of 500 full-time staff equivalents, or 701 organisational members, were employed in this hospital organisation. Therefore, as head of all these different occupations within Jo-care the CNE is responsible for the largest service within the hospital, in terms of human resources (i.e. 56.92 per cent). In monetary terms the overall personnel budget of Jo-care is 42,070,375.00 Deutsche Marks [21,510,241.00 Euro] which includes 23,406,129.00 Deutsche Marks [11,967,363.00 Euro] for the CNE's area (i.e. 55.64 per cent).

Conclusion

In this chapter I introduced the reader to the general, architectural and personnel background picture of Jo-care. Such an account of the setting consists of descriptions of the location from which ethnographic material was collected. These descriptions were aimed at familiarising the reader with some places, names and

figures in use by the social actors in the setting. Still, there are endless different locations, terms and modes of figures available in this hospital organisation and I could easily talk about many other things in Jo-care: there are, for instance, places for the medical doctors, medical technicians, paramedics, administrators, accountants, cooks, cleaners, gardeners, etc. This means there is a network of different places and worlds and this is why an official definition of what Jo-care 'really' is does not help (Law, 1994, p. 43). The following chapter constitutes the representation of Jo-care, and through this representation I aim to locate people's behaviour and their social relations as an aspect of day-to-day conduct: as situated in a historical, social and cultural setting and as constructed by people through their everyday actions in the presence of others.

Chapter Six

The Sounds and Actions of Jo-care's Life

Introduction

The central focus of this thesis is on the day-to-day practices and their implications for people's performances and social relations in one hospital. Research data include observations, interviews and documentary sources. Three distinguishable groups - student nurses, staff nurses, charge nurses and ward sisters; a smaller group of CNEs and executive managers from various departments in Jo-care are included in this research. While acknowledging the important role differences among these groups, this research project, for the purposes of brevity, concentrates on these general areas of expertise.

In the last chapter I broadly outlined the general, architectural and personnel context, describing the location as an independent Roman Catholic hospital. This chapter focuses on the visual impressions of the organisational culture which mediated through the 'eye/I' of the researcher (Kondo, 1990, p. 3). An ethnography requires a delineation of social, political and economical considerations in relation to the working conditions of the organisational population at various historical periods. This chapter is primarily based upon documentary material as well as fieldnotes taken during various events (e.g. official openings of new wards and sections, celebrations, presentations, etc.) commemorating Jo-care's foundation, history and recent developments.

Jo-care's Founding Ethos

In most countries hospitals are owned and managed by a higher authority, such as local, regional or national governments, religious or lay orders, private organisations, etc. Some hospitals are run for profit from client fees, others may subsist on fees supplemented by public or private donations. Even when hospitals seem to be theoretically autonomous, they may actually be the agency of a more powerful authority which leads the hospital through regulations and subsidies (Glaser, 1963).

In Germany, where Catholicism and Protestantism is strong, the private voluntary authorities run about 35 per cent of all hospital institutions (OECD, 1992, p. 61). Like congregations or fraternal organisations, Christian hospitals are agencies of identification and maintaining them is a way of maintaining health and religious identity (Vogel, 1980, Gärtner, 1994). However, the theory and practice of hospital organisations has also developed around bureaucracies, deriving partly from the work of Max Weber (1864-1920), who, at the turn of the century, was most responsible for drawing people's attention to the significance of large-scale organisations. In relation to this Berger (1973) refers to the progressive bureaucratisation of the religious institutions:

> Internally, the religious institutions are not only administered bureaucratically, but their day-to-day operations are dominated by the typical problems and 'logic' of bureaucracy. Externally, the religious institutions deal with other social institutions as well as with each other through the typical forms of bureaucratic interaction. 'Public relations' with the consumer clientele, 'lobbying' with the governmental and private agencies, multifaceted involvements with the secular economy (particularly through investment) - in all these aspects of their 'mission' the religious institutions are compelled to seek 'results' by methods that are, of necessity, very similar to those employed by other bureaucratic structures with similar problems (p. 139).

Statements such as these quoted above, reveal that political considerations and religious values were pre-eminent in the development of the hospital called Jo-care.

The conceptual beginnings were modest and the creation of Jo-care addressed governmental concerns of its time because the emergence of this charitable institution for care of the poor and infirm represented their welfare policies. In the late 1940s there was an enormous and escalating demand for health care services because of displaced people, prisoners-of-war, and the public responsibility to care for the health of the growing population in an industrial world. This hospital was established with certain aims in mind: an elimination of the social and political problems uncovered by World War II and the provision of cure and care to patients regardless of their social and cultural background. By that time, the American economic support and military interventions were less intensively required and the powerful allies aimed to re-construct Germany's autonomy.

The military barracks was the earliest institution at this location; later a U.S. clinic for displaced people with chronic diseases appeared. In both cases the guiding motives were military and in the latter they were related to the structure and purposes of the allies. Other values underlay the creation of hospitals by Christian communities and Jo-care's culture did not start on the drawing board nor did it come into the organisation by accident. With the help of some economists, the people of the ecclesiastical authority established the cultural life of this hospital organisation through the articulation of their basic assumptions and beliefs. As a result of these early efforts by the clerical founders, Jo-care has been able to develop a substantial history of its own. That is, organisations are created by people and the culture of Jo-care is underpinned by its 'foundational myth' (Casey, 1995, p. 94). This myth and its creators comprise the primary narrative of cohesion and organisational distinction, standing for an ethical code which embodies the essence of Jo-care and establishes the principles of identification with the organisation.

Documents are one source of data which give insight into this discussion and the mission pertaining to this hospital setting indicates its deeper assumptions and founding beliefs.

> The aim of the Jo-care hospital is to cover the health care needs of the population as laid down in its care mandate. Besides trying to heal the sick and alleviating their suffering, the hospital sees the active administration of Charity in the Christian sense as its own special mission. As a Roman Catholic hospital, it declares itself to be an embodiment of Christian values and way of life.

The above excerpt gives a detailed image of the religious and social considerations which were pre-eminent in Jo-care's development. The ethos within this coherent set of beliefs is a complex narrative, embodying the Christian values of the founding association and its ecclesiastical authorities. That is, Jo-care established itself primarily as a general hospital, based on strong Christian beliefs, and since then its main purpose has been to provide health care, comfort, aid and protection for all people, Roman Catholic and others. Some of the retired employees still remember from their own experiences that this ethos evoked for them images of heroic strength and vocational virtue provoked by rich paternalistic care and responsibility. The

motive of charity enabled Jo-care's people[1] to lead a form of Catholic life within the organisation because pastoral concerns provided the frame for spiritual and material domains at work.

One aspect that may have contributed to the path of Christian ethos was the availability of skilled personnel by the *Barmherzigen Schwestern* [i.e. Sisters of Mercy] - a Swiss religious order modelled on the objectives of the Holy Cross. Given this background it is unsurprising that shortly after Jo-care's founding, the Sisters of Mercy were enormously active in establishing religious pastoral duty[2] as their devotional and altruistic practice. As an expression of their devout existence these Roman Catholic nuns devote their lives to the service of charity and have taken on board the vows of poverty, chastity and obedience. Because of that attitude, the underlying motive to care for the sick may have been for religious rather than for functional purposes (Freidson, 1963, 1970, 1994). In adapting the Christian regimen set up by the ecclesiastical authority, these ambitious women made a substantial contribution to the development of the hospital called Jo-care. That is to say, the contracting of religious nurses to hospitals like Jo-care brought the application of high standards of hygiene, cleanliness, supervision, diet, surgical and medical procedures to the patients' bedside.

Within a short period following the foundation as general hospital, the nuns had been established in different areas of work, such as nursing and medical technical care, laboratory, administration, laundry, kitchen, etc. In fact, by the end of the 1960s, there were 60 Sisters of Mercy alone throughout the whole hospital which had 440 in-patient beds at this time. The success of the hospital was demonstrated by these nuns, dedicated to the religious idea of doing good, and working more than 10 hours, split up over the day. The Sisters of Mercy managed the business of caring for the sick because of their religious obligations, while at the same time attending their own

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[1] I will use the term *Jo-care's people* to refer to all the staff nurses, pool nurses, charge nurses, ward sisters and student nurses employed by the hospital. See Chapter Five for a discussion of the various categories of senior and executive managers.

[2] The strict enclosure of nuns is based on the Tridentine profession of faith which was set up by the Council of Trent in the years 1545-47, 1551-52 and 1562-63.

spiritual development. The nursing nuns acknowledged no authority except that of their ecclesiastical superior, but, at the same time, there was no escape from the subordination to medical authority (Müller, 1997; Steppe, 1996, 1997; Katz, 1969; Freidson, 1963, 1970, 1994; Schloßmann, 1907). In these days, the matron lived with 60 nuns together in one part of the administration building which had been prescribed as their home. Five of these nuns are still employed and live in a small convent in Jo-care. They speak fondly of this time as *die gute alte Zeit* [i.e. the good old days], a phase of Jo-care's history.

The devotional pragmatism which this success story demonstrates, without any reduction of spiritual purpose or influence, is what sets the secularised nurse apart. That is, the *weltliche Krankenschwester* [i.e. secular nurse] did not have to live within the spiritual domain, rather they were settled in a secular world while they were working in the Roman Catholic hospital world (Steppe, 1996, p. 35; Hummel, 1986, p. 27). The 'feminine virtue' and 'sphere of duty' of the secular nurse required for Jo-care is here distinguishable from that of the religious nurse she tried to imitate (Nelson, 1997, p. 10). It is also argued by Küpper (1996), Steppe (1996, 1997), Robert Bosch Stiftung (1992), Murken (1991), Wanner (1993), Hummel (1986), Bischoff (1984), Sticker (1984) and Schmidt-Meinecke (1981) that this kind of nursing practice took place already within a wage-earning system and provided the opportunity to demonstrate the value of skilled nursing care. In this sense, the organisation of nursing care in Jo-care developed its own order because it became dependent on paid labour. That is, the ideals of religious nursing were challenged by the expectations and traditions of the older classic professions. As a result, a highly secularised and occupational strata emerged in the immediate proximity of the hospital's religious processes. Where possible, the traditional codes, schemes and formulae were retained to legitimate Jo-care's founding ethos; where this was no longer possible, it was modified in order to permit such legitimation.

By 1952, nursing was still something of a devotional and idealistic practice for young pious women and/or women of good birth and not long after Jo-care was taken over

by the present hospital authority, there was the foundation of a school of nursing. By that time the devotional nursing care of *weltliche Pflegeverbände* [i.e. secular nursing associations] (e.g. the German Red Cross) and their excellent educational system was not unknown to people. According to the traditional genealogy, the young pious women and/or middle-class women felt nevertheless dedicated to the nursing work of religious congregations. The hospital-based nursing school also provided a virtually free source of labour for Jo-care at a time when the major service dispensed by the organisation was nursing care.

Religion played a significant role in the establishment of nursing as an occupation. That is, the education was a broad pastoral mission and took place in the manner of character development and moral worthiness which encompassed the ethos that the educated nurse dispersed health care for the sick as their sacrificial vocation, in return for a modest income. The matron acted as nursing mother and took all the characteristics into consideration, important for the education of a female workforce at this time and an emphasis was placed on the elements of discipline within a 'definite religious conviction' (Caldwell, 1996). This specifically religious emphasis also derived from Jo-care's basic assumptions and the overwhelmingly Roman Catholic population of Bavaria.

By the end of the 1960s, the advances in medical technology and diagnosis brought about new challenges and this points to the suggestion that Jo-care had begun to appreciate the merits of skilled nursing more than a decade before the beginning of modern hospital care. Nevertheless, this movement began to chart a course away from the traditional intuitive role of the nurse towards a more educated form of nursing (Lister, 1997). That is, the primacy of nurses' character development was challenged as they expanded their role and took over work activities which had been at one time the province of medicine (e.g. the measurement of blood pressure; the administration of intravenous therapy). However, the religious tradition had given meaning and direction to the people in Jo-care and the move towards modern nursing was not without its critics. The hospital was larger then, with up to six patients in

one room and a handful of medical doctors, medical technicians and paramedical staff who worked in the hospital.

For example, the task allocation system in nursing was a typical paradigm of work and the essential duty for the working nurse was to complete the allocated routine. A patient-centred view was seen within a different concern in this system and the work was organised hierarchically according to the ward sister who set up the general dictation of the day-to-day practice. Levitt and Wall (1992) point out that the hierarchy placed the ward sister as 'the agent of the doctor and the trainer of the probationer nurses' (p. 226). The matron had the primarily symbolic role of being the leader and was in charge of the whole nursing service and most of the domestic duties (Steppe, 1996; Wanner, 1993; Zopfy, 1989; Bischoff, 1984; Schmidt-Meinecke, 1981). Consequently, the matron was responsible for all the nurses and keepers of the ward and she was the housekeeper who looked after laundry, bedding, kitchen, etc. The matron visited the wards twice a day and her interests had been based on the behaviour of the secular nurses and the direct control of patient care according to the norms of health care at this time. As Abel-Smith (1960) has put it:

> If the new matron was to undertake what she considered to be her duties, she had to carve out an empire of her own. She had to take over some responsibilities of the medical staff and some of the responsibilities of the lay administration. In addition, she had to centralise the administration of nursing affairs (p. 25).

The general administration of the hospital was in the hands of a staff consisting of two bodies. Ecclesiastical officials from the higher authority were concerned with the business management and administration of the institution. In addition to the above officials, the hospital had an administrator who focused on bookkeeping. Moreover, the participation and contribution of medical doctors in management was a major theme and arose from the fact that they were able to direct the use of resources with varying degrees of autonomy (Levitt and Wall, 1992; Freidson, 1963, 1970, 1994). However, the sort of managerial problems medical doctors might have considered were mainly concerned with the organisation of out-patient and in-patient resources. They were chiefly responsible for deciding which techniques and items of

medical knowledge were safe to use - safe for the patient and for their own reputation and the reputation of the hospital (Katz, 1969). To this day, representatives of each discipline come together in the hospital as a medical executive committee and provide a link between nursing and administration.

To restate the perspective taken in this section: Jo-care is an expression of Roman Catholic Christianity, but at the same time it underwent democratisation, becoming a community responsibility. In the beginning the hospital was essentially an instrument of society to alleviate suffering, to diminish poverty, to eradicate mendicity and to help maintain the public order. By that time the deeper assumptions and beliefs of the higher authority influenced Jo-care's foundation, and charity as the basic ethos motivated the cultural development of this hospital organisation.

The Time of Flux

From the mid 1970s onwards, health care in general became an object of increasing governmental observation and intervention. This is illustrated by the mass of data and reports that began to emerge. With and through this data, health care came under scrutiny in terms of the costs to society of its provision, and it became apparent that the increased costs could in part be attributed to hospitals. The introduction of the *Krankenhausfinanzierungsgesetz* [i.e. Hospital Finance Act] and the *Bundespflegesatzverordnung* [i.e. legislation of a retrospective costing regime] represented a significant shift in the federal government's involvement in the provision of hospital care. Both reports received positive attention because of the possibility of financing re-developments and medical technology from public money. In this respect it is argued by Foucault (1979a) that the art of government should not merely be thought of in terms of the enactment of laws, but in terms of distribution from a distance. However, hospital statistics from the German Hospital Association and research done by the *Deutsche Krankenhaus Institut* [i.e. German Hospital Institute] and others predicted a crisis in health care because hospitals were paid in advance for whatever they claimed as reasonable costs. This means that even when the federal government started to limit the individual payments to a prospective

hospital budget and initiated audit techniques to review the health care providers, the stage was already set for a time of upheaval.

Another influential factor was the increasing recognition of the medical value in hospital care. This aspect grew out of profound changes in medical technology and in social expectations of what medical care could do. Laser, micro-surgery, ultrasonic and X-ray scanners, magnetic resonance imager, other computer diagnostics, transplantation, etc. are all innovative procedures which have increasingly enabled medical doctors to do what was once unimaginable (Herzlinger, 1989). Because of these medical advancements there has been a trend to promise safer diagnosis and better therapy for people, while at the same time permitting the prevention of particular diseases. The ethical and promotional considerations of medical doctors lead to the fact that this equipment has to be replaced on a regular basis in order to monitor, diagnose and cure patients more accurately than ever before.

An overriding concern during this time of flux were the costs and quality of health care. As described above, the matron made herself accessible to the medical and administrative staff in many ways. The roots of this tradition lie in a good-natured working atmosphere, with a lot of freedom given to the nursing service as a whole. But the governmental and medical objectives applied led to various conflicts and tensions in Jo-care because administrative problems were increasing and the most powerful doctors in charge of the medical side wanted to have their interests fulfilled. On a large scale, the development and organised deployment of economical and medical knowledge became a major feature of Jo-care's existence. The role of the matron, long seen as pre-eminent, and the purely charitable considerations responsible for Jo-care's traditional culture began to change.

In the mid 1980s there was a remarkable decline in the number of the Sisters of Mercy and the romantic picture of Jo-care was disturbed. The Sisters of Mercy working for Jo-care had a specific way of acting and interacting which set them apart

from people working for secular health care organisations, even within the same region. The traditional religious nurse accepted the matron or medical doctor's bidding with 'unquestioning, unknowledgeable-but-always-reliable dispatch' (Katz, 1969, p. 59). But the secular nurses were less willing to accept the legitimacy of clerical and medical authorities and to view work as their central interest. However, a high level of commitment could be taken for granted because the formerly established ethical code for skilful and intelligent execution of health care was not abandoned or questioned.

At this time nursing began to redefine itself, establishing theoretical constructs, and the purposeful 'nursing process' was introduced as a way of structuring nursing activities (Arbeitsgemeinschaft Deutscher Schwesternverbände and Deutscher Berufsverband für Krankenpflege, 1991; Fiechtner and Meier, 1987). Anglo-Saxon, American and Swiss nursing models (e.g. Henderson, 1966; Orem, 1980; Roper, Logan and Tierney, 1980, 1996; Juchli, 1991) proved to be a pervasive influence and various attempts were made to articulate the underlying structure of different activities in nursing. Since then, according to Lister (1997) nursing theorists have been trying to express 'the effects exclusive to nursing' and set up a framework within a 'highly rationalised discourse, rooted in the same ground as the scientific aspects of medical practice' (p. 40). That is, there has been a significant attempt to build nursing's own body of knowledge through new forms of training, education and research and a reinvigoration of nurses' claims to have something special to offer the patient clientele in the care that it provides (Walby *et al.*, 1994).

By 1984, Jo-care's nursing service became an independent department of which the secular head - the CNE - had a position of authority between the chief administrative and medical executive. There was the creation of three lines of command in which the CNE has become the highest nursing authority in Jo-care. As mentioned before, this structural reform took place according to the recommendations of the German Hospital Association (1969) and aimed at reducing opportunities for structural conflicts within hospital management. This management orientation has been

described elsewhere as 'custodial management' and involves active co-operation between occupational groups to decide and deliver health care services (Ackroyd *et al.*, 1989, p. 614).

Many employees in Jo-care can remember a period in which the hospital, after years of considerable success and expansion, suffered a sudden disorientation. It was during this time that Jo-care found itself in an unfamiliar competitive situation with other health care suppliers, especially with a large teaching hospital which was due to open in 1992. The debates were not so much concerned with issues of access and quality as with the amount of in-patient beds and costs of health care. There was enormous pressure not only in financial and economic terms, but also in a political respect which resulted in a decline of in-patient beds and the re-development of Jo-care. Faced with these political and economical problems, Jo-care's nursing staff began to suffer a considerable crisis at the same time, which resulted in a shortage of skilled personnel in nursing. While hospital patients became 'sicker and left quicker', the caring staff was left with more paper work and tasks which were not directly connected with caring for patients (Kramer and Schmalenberg, 1987, p. 39). Herzlinger (1989) goes on to reflect another concern when she argues that

> [i]n many segments of the health care industry, those employees who are at the most critical point in fulfilling the purpose of the organisation - that is, in close and frequent contact with the "customer" - are often given the lowest pay and the lowest status (p. 100)

The shortage of nurses was widespread all over Germany and it was therefore not a case of human resource mismanagement. In general, nurses were desperately trying to develop a greater autonomy and to maintain their health care values[3] while finding a place in the new order, in which they were still relatively powerless. Thus, the role of the hospital nurse was rather unclear and nursing work had become increasingly difficult (Deutsche Krankenhausgesellschaft, 1989, 1991; Bayerisches Staatsministerium für Arbeit und Sozialordnung, 1990). While nurses reported increased

[3] According to Salvage (1995) the values nursing espouses at its best are 'altruism, compassion and social justice' (p. 274).

dissatisfaction with the quality of care which they were providing to patients, they also claimed that there had been a substantial change in employment composition and interdisciplinary co-operation over the previous few years. Much of this was undoubtedly due to poor organisation and led therefore to lower productivity and morale and generated an apparent nursing staff shortage.

Thus, the intimacy of Jo-care's traditional nursing culture was no longer guaranteed. Charity - the basic value that motivated the creation of this community, was no longer the primary objective. There was also the fact that nursing superiors did no longer live together with their nursing employees, nor did they take their meals together. In the past, nurses used to work for the organisation for a very long time which created a personal presence on the ward floors. No longer was this the case. During a number of bad years in the end of the 1980s and early 1990s, these problems gave managerial officials reason for concern. A number of strategies[4] failed to work and the hospitals' reputation within the wider city area decreased. The people in Jo-care's management tried to counter these problems with an active lobby, press campaigns, organising public visits to the hospital, etc. but their success was by no means certain.

The Emergence of the economic Perspective in Jo-care

At some point in the late 1980s there was a growing realisation that the organisational forms and accounting procedures, prevalent in German hospitals for decades, were no longer appropriate. On 21 December 1992 the 2nd Health Care Reform Act became law. This report made a number of general recommendations concerning the reform of existing management structures and aimed at producing a more efficient and effective delivery of health care. In the past hospitals were reimbursed in full for necessary and reasonable costs expended in service provision. Generally speaking, there had been a lack of flexibility because of a certain cost structure and the reforms in health care brought about the recognition that patient

[4] Attempts were made to reduce the medical, administrative and domestic workload of nurses in hospital wards and to rise their income as well as offer career opportunities.

cure and care could not be provided at any price. The increase of people's health insurance fund premiums and health care costs in general had to compete with all the other demands on Germany's resources. Organisational changes introduced under the auspices of the 2nd Health Care Reform Act were implemented in Jo-care during a period of political and cultural stringency and gave rise to additional pressure.

As a result of capital outflow and a financial deficit of 3.5 million Deutsche Marks [1.79 million Euro] in 1991, fundamental changes took place in Jo-care. The financial figures spoke for themselves and the forthcoming 2nd Health Care Reform Act brought about environmental challenges manifested within competitiveness. Like other health care organisations, the hospital authority introduced in 1992 an extensive change programme with the intention of ensuring Jo-care's survival. There had been some attempts at reorganisation in the previous decade, but nothing as extensive and elaborate as the new programme had taken place. The CNE reports how the change process was initiated:

> Mr. Fawkes: Well it was like this - when I took over from Mrs. [name of former CNE] it was all very difficult for me, not at all easy. Mrs. [name of former CNE] was totally different from me not only from the point of view of personality but also with regard to her whole style of leadership. Uh (2.72) so I was sort of up in the air for about six months, nine months. There were no clearly formulated goals and basically none of the staff in any of the professions in the hospital knew really what was going on. The whole thing was disorientated, and without leaders. We [directorate members] then thought about getting in touch with an outside firm. We also said to ourselves that the hospital had to be looked at closely from all sides.
>
> Maggie: You mean from the economic point of view?
>
> Mr. Fawkes: In the first place, yes, from the economic point of view. The administration, X-ray department, laboratory, all the departments of diagnostic and therapy, nursing service, medical service - well all these departments and areas within the hospital. Uh (2.25) and because at that point in time there was a deficit of 3.5 million Deutsche Marks [1.79 million Euro]. And uh that demanded a lot from us [directorate members] and it took a lot to get that idea [contact to outside firm] accepted in the hospital because the hospital authority wasn't actually prepared to accept the idea at all.
>
> Maggie: You mean by hospital authority [name of ecclesiastical association] or do you mean the chairman of this organisation =
>
> Mr. Fawkes: = Well, Mr. [name of the ecclesiastical chairman] but also the whole board of directors including the bishop. They said that people from [name of a consulting company] had already worked out a kind of organisational work

process for the hospital when everything was being built and that programme should be put into practice. At that time 150,000 Deutsche Marks [76,693.78 Euro] had already been paid for an expert's report regarding organisational work processes of the hospital. But that wasn't really what we needed, but uh what we needed when it came down to it was a detailed verdict of the whole hospital.

Then we heard about [name of consulting company] in [name of city]. They got in touch - Mr Tate and [name of other leading consultant] then got in touch themselves with [name of ecclesiastical director] and the bishop. That's how it all got started. They then presented their optimisation report and a strategy catalogue. They offered to put the points in the strategy catalogue into practice within the next two years. And so then they were given a two year contract by the hospital authority, which was transformed after the two years uh (2.56) into a permanent contract.

Maggie: And how did hospital staff react?

Mr. Fawkes: Well if you look at what's said in the expert report and in the catalogue. These are all measures which in principle, ye::s uh you could have thought of that yourself, really, when it comes down to it. But because of all [the problems with] the various professions not communicating with each other and working away from each other well, we couldn't get a handle on things.

The decisive factor was the fact that the [name of consulting company] presented a diagnosis. I mean the hospital wasn't ill but was ailing. So the [name of consulting company] arrived at their diagnosis and prescribed the relevant therapy. And uh this therapy was being prescribed by someone outside the hospital. And uh the prophet in his own land - as you well know - they don't enjoy the same standing as a stranger. Uh for me it was a real phenomenon how all these things - which were in the expert report we'd already discussed - all of a sudden, overnight, were able to be put into practice. (...)

The above interview excerpt gives a detailed image of the reforms which followed the recommendations of a commissioned report from management consultants. In the past, Jo-care could be visualised as a geographical site where people drawn from different backgrounds came together to carry out their respective purposes. A set of charitable rules and bureaucratic arrangements laid down at the foundation of Jo-care ensured that people knew how to act and be in the organisation. But the rules that should have governed these actions as people performed their tasks were far from clearly stated or clearly binding. In the early 1990s, new people were introduced from the outside and designed a modern management strategy. They convinced the ecclesiastical officials that the hospital's vast bureaucracy was hampering information and communication processes, limiting creativity and service orientation and that 'decisions at the top were too frequently of a political rather than a business nature' (Casey, 1995, p. 97).

What has been established in Jo-care is a system of hospital management in which tactics and techniques of other industries and services have been brought into the health care organisation. Significant here is the altered status of people's responsibility and accountability towards others. There was a transference of the primary responsibility from the tripartite management board, working as a consensus team, to a more or less independent hospital trust, chaired by a single manager. This formal priority led to the provision of new managerial roles for the tripartite committee structure and a remaining advisory role in professional terms, rather than in direct responsibilities. However, consensus management in some form continued to be an inescapable feature of the complex hospital organisation because the CEO depends upon the input of managers who have contacts to and knowledge of the organisational world. The tripartite directorate is also important to the hospital service as such and plays a vital role in making sure that the 'bred and butter' things within Jo-care have been done.

The re-organisation of Jo-care had reversed the position of the tripartite management board while reinforcing a so-called central management structure to a decision-making process which has become more finite and decisive (Anthony and Reed, 1990). At the core of this reform strategy lay a proposal which intended adopting business values and associated behaviours. Such a concept is relatively new to health care organisations in Germany and involves the aim that the business of hospital administration and service quality should become better. The whole ecclesiastical board did not know exactly in which way but they just wanted a change from the old ways since the maintenance of charity and bureaucracy could no longer be the over-riding priority. Additionally their focus on the quality of health care may have been attributable to the fact that it was part of the 2nd Health Care Reform Act (see SGB V - §§ 135, 136, 137 and also §§ 115b, 112, 108, 70 Abs. 1) and it was claimed that this aspect became an increasingly important feature of effectiveness and competitiveness. Therefore, the organisational reforms were based on the vision of a costly and efficient service, driven by the provision of quality care to clients.

A new managerial control system was established as an organisational basis to simplify, rationalise and professionalise this hospital organisation. Kunda (1992) and Zuboff (1988) argue that such a system consists of a structure, which divides the organisation into different units responsible for carrying out the work, and an accounting system that continuously records, controls and evaluates their day-to-day performance. Such a framework for operational administration can be regarded as a critical component of any for-profit or non-profit organisation and serves as a blue print for particular activities. All these technical modes of ordering created effects on patient care, albeit less directly than on the management of the organisational setting, and these were introduced as a means of making clinical and financial decision-making more visible through contracting, standard setting, audit mechanisms, design procedures, etc. In line with the broader health care reforms initiated by the German government, this shift accelerated the pace of organisational change and is part of the overall story.

Leaders, Heroes and Chief Executive Officers

That a hospital is being 'reformed' is not an altogether straightforward notion, given the possibility that it can be said of all social organisations that, from the moment of foundation onwards, they change for the better each working day and are, in a sense, continually 'reforming'. On the way, reforms bring about or ultimately involve organisational uncertainty but also people who make the choice and influence the circumstances of an organisational setting. By implication, it is frequently argued that the CEO of an organisation is the master of his/her own destiny and the creator of meaning through symbols, ideologies, rituals, beliefs and myths. This means the guiding members' behaviour is associated with change in organisations and much of their influence is believed to depend upon the character of successful *Leaders, Heroes, and Chief Executive Officers* (Pettigrew and Whipp, 1991, p. 139). Therefore, the context of the CEOs introduction is greatly instructive in appreciating the dynamics involved as Jo-care's culture began to change.

In the early 1990s the hospital was under immediate threat and the competence of Jo-care's tripartite management was called into question. Faced with governmental pressures for operational effectivity and efficiency, they were charged with not knowing what was going on. However, there was some recognition of the fact that the old traditions were not proving adequate and that they needed to be extended in some way. The rhetoric and skills the consultants brought into the day-to-day practice had a certain image of novelty, enabling Jo-care's management to throw off the possible charge with mismanagement, and were thought to be a useful supplement to Jo-care's tradition. In fact, the CEOs created a broader notion of 'collective leadership at the highest level' and seemed to fulfil the needs which were fundamental in bringing about a successful managerial strategy into Jo-care's day-to-day practice (Pettigrew and Whipp, 1991, p. 145). The CEOs were not expected to disrupt the traditional patterns of authority but to co-ordinate and control the complex relational networks involved in modern hospital activities. Commenting on the way in which they operate, one of the CEOs reflects upon his role and relations with the hospital board:

> Mr. Tate: (...) Well, being the CEO means basically having the responsibility for uh. the whole hospital. According to the articles of procedure the hospital is part of an association - and within the framework of the association - articles of procedure were put into effect giving us [consultancy company in charge of the main chair] room for manoeuvre. The rules are laid down quite clearly - I don't know if you've seen them - in any case they're similar to the articles of a private limited company.
>
> Maggie: Mhm.
>
> Mr. Tate: As far as authority goes, on paper - and this is actually not intended for publication - we have <u>more</u> authority as is usually the case in a [hospital trust that is similar to a] private limited company. I would say de facto not quite... or, or in another way. It's based on, and depends very much on the relationship between the people involved. Put it like that.]
>
> Maggie: [Depends then on you, actually?
>
> Mr. Tate: Yes. But also on [name of one of the partners of the consultancy company]. You can... but it's certainly more to do with me. Uhm the church run institutions are very reliant on power structures, very hierarchical.
>
> Maggie: Mhm. Well, the contract, as you have just said, is one thing and what you actually do here in the hospital is another. (...) Where do you see your priorities? What do you want to see functioning here? What is important for you?

Mr. Tate: Well, various things. First of all I try ... and for that reason we have the OD process and all that =

Maggie: = You mean [name of organisational development programme] process?

Mr. Tate: Yes, yes. Organisational development basically. I want to develop things here with regard to work content, according to our set goals. These are shared by the [name of the hospital authority] and that's my task as well as being in accordance with the organisational philosophy. That's more related to a meaningful work contents and I play a big role in that. Also as regards management strategy, to keep people toeing the line. (1.19) Moderating. Getting something through or across, sometimes. That's the part of a meaningful work content and it's often very solid and concrete stuff. And I think that's the main part of my work here because the economic, the financial side of things gets taken care of by [name of one of the partners of the consultancy company]. .hhh Whereas it is also the case that when basic, fundamental decisions are to be taken then I'm involved too.

The second thing is of course seeing that the hospital uh let's say flourishes financially. The work content aspect is one of my main tasks. So the second area is finance and the third is - if you like - trouble shooting. That's what I mean when I say problem solving. We have regular meetings with the management board and closed seminars in seclusion too. They take place every two months, and we discuss projects in the offing, set up timetables, keep a check on what's been put into practice already, see where there are problems and where something has to be changed. In actual fact to set up and structure new things. And then when I'm here I have a look and ask the CNE or the CEA "How far on are things? What's happening?" Or they come to me themselves and tell me about any difficulties encountered. So if you like it's a kind of moderator role.

In this account, Mr. Tate cites the formal lines of responsibility and describes himself as being attached to the hospital organisation. He knows what he can do and to whom he provides account because the rules are laid down quite clearly. But, Mr. Tate also suggests that his relations with the hospital authority are more open than usual in terms of his official competence and responsibility. This becomes apparent as he remarks '[i]t's based on, and depends very much on the relationship between the people involved'. That is to say the nature of the CEOs introduction was rather extraordinary and it was up to each of them to build up their influence. It seems this chief executive figure's role is all about personal relationships and this profound challenge to the existence of Jo-care has led to spectacular changes. However, focusing on formal relations may prematurely disable research into other elements such as 'the personalities and backgrounds' of senior executives (Dent, 1991a, p. 716). Mr. Tate and his partners are appreciated as charismatic people and transformational leaders, and all of them had at some time worked in nursing and/or

hospital management. This means that the appointed CEOs are looked on as the embodiment of certain personality traits and therefore, as a guide to a particular behaviour. Additionally, all of them worked their way up the managerial ladder and they were promoted into these chief executive positions. Thus, the CEOs grew up with the knowledge and insights of a hospital organisation, and were therefore able to understand the culture and speak its language-in-use.

Following their evaluative report, they developed a zeal to convert Jo-care from a charitable service institution into a modern health care enterprise. As CEOs they argued that it will be a 'long haul' if financial balance and service quality are to make 'a real difference to the way that things are done' (Ferlie and Pettigrew, 1990, p. 197). They proposed a series of reform packages to the ecclesiastical authority and were able to use the institutional environment and their visions to Jo-care's advantage. This means the CEOs introduction was to have far reaching consequences because they brought about a different interpretation of Jo-care's reality. Therefore, the focus of attention in the pursuit of a new managerial rhetoric and in response to the environmental pressures was the chief executive function.

The Creation of a 'new' Culture

Like a number of other executive managers in large service organisations, Jo-care's CEOs introduced an extensive 'new culture program' with the intention of ensuring the hospital's survival in a competitive health care market (Casey, 1995, p. 97). The formula to be employed was similar to that in contemporary programmes of cultural or human resource management and was linked mainly to the heavily prescriptive literature on the management of meaning. As I have noted in Chapter One, a common theme in much of this literature is that if all the members of an organisation share common values and beliefs there is less need for complex organisational mechanisms to exert managerial control, since employees will direct their energies and enthusiasm towards the organisations willingly. Thus, the attitudes of Jo-care's people were to be changed because employees were to be intrinsically motivated and the external coercion of bureaucratic control was to be rejected as inappropriate

(Anthony, 1994). Significant here is that these strategies were not aimed at undermining the traditional value-system which had been built on the charitable and professional ideas. Rather, what the CEOs wanted to do was to refine and underpin these well-established values and to create a behavioural and deep-rooted response to the complex social, political and economical circumstances. Therefore, reshaping the values and meanings within the organisation to the goals of senior management became a central focus for attention and concerns.

For the CEOs, it was important to understand what Jo-care's employees valued at work and hence what they had to do in order to engage in effective organisational change programmes. For instance, it was useful to have an understanding of the implications of the medical and nursing work flow in Jo-care in order to design cross-functional structures and processes at work. The chief concern here is with the values and behaviours the organisational culture exhibits because the basic assumptions are shared and made visible by the performances of a large group of people. Altogether, the CEOs wanted to use consensus support among the key power groups in Jo-care and initiated the mobilisation of employee-participation as their major strategy to improve and revitalise Jo-care's health care service. The cultural emphasis which was encouraged aimed at an open involvement of Jo-care's people and the pursuit of 'excellence, leadership, customer satisfaction and a team-family atmosphere of caring involvement and commitment' became the central feature of day-to-day practice (Casey, 1995, p. 97).

Toward this end, the CEOs introduced extensive seminars for most of Jo-care's employees. People from different educational and social backgrounds participated and had varying values, vocational interests, work habits and outlooks. This means the employees came from all sections such as chief medical doctors, staff nurses, medical technicians, domestic workers, physiotherapists, cleaners, administrators, conscientious objectors, nursing students, etc. Despite the wonderful seminar environment in a luxury hotel, more than half of the participants were there on hospital orders. On the first seminar day psychological exercises and a series of

games were used to break the ice and help people to get to know one another. The seminars took the form of workshops and turned out to construct a 'regime of "truth"' and expertise (Kondo, 1990, p. 77).

Apart from the promotion of Jo-care's traditional ethos and the recognition of different professional values, there was the provision of knowledge-based skills that organisational members require. In an effort to establish these policies, the chief executive management encouraged employees, who had been in close and frequent contact with patients, to spend a great deal of their time articulating what they wanted to do. Organisational themes emerged from the repeated statements of a number of delegates as they were allowed to plan what they always wanted to change. This means organisational members perceived that in these seminars they could influence Jo-care's reality. In relation to this, a ward sister reports how the seminars changed her working life at Jo-care:

> Ruby: (...) That's really important (4.87) and there was a lot of support given by the chief executive management. =
>
> Maggie: = Was given - or are they still giving support?
>
> Ruby: Was given - when the chief executive management was brought in, and it became obvious during the interdisciplinary seminars. The first time I went to the seminar I wasn't even ward sister, but deputy ward sister. (3.89) I had the feeling then that they were doing some kind of self-awareness training with us. It was in part really totally co-operative and my eyes got opened really wide [accompanying gesture]. How much you had been influenced by others up until then and how you let yourself be put down, you know kept in place. It was really fascinating observing all that and being able to see what had happened to me, personally. Well what had been drummed into us for generations on end. Us [nurses] are just helpers and have to obey orders from the (doctor).
>
> Maggie: Mhm. That's what nursing used to be like and the nuns didn't want that role to change at all. Well. You mentioned the interdisciplinary seminars. What's "left over" from them apart from your own personal insights?
>
> Ruby: Well I don't want to get into my increased self-awareness any further, but really I saw the light as far as questioning, challenging things went. I'm sure for a lot of people then something snapped. And they started thinking "Is this how things should be?" Uh. you ask WHAT'S BEEN LEFT OVER from these seminars. Uh (7.13) .hhh hhh. I realised then for the first time that it's great when employees from all departments of the hospital get together. It didn't matter where they were from, the technical department, the kitchen, whatever. There was at least one person there [from each ward or department]. The interdisciplinary group had to ask itself questions and arrive at a result. Although everyone was able to contribute his/her own aspect we had to agree on one result

only. In moments like that you experience the dynamics of a group quite a bit [laughter] and it was clear to me that as soon as there was a common goal we all really stuck together. The whole group was very mixed and there were occasionally arguments. But as soon as we were in little groups we were able to talk to each other in quite another way. And in my opinion that's something that we've kept up in the hospital. (2.25) (...)

The CNE remembers it similarly and refers to the so-called *patienten-orientierten Tagesablaufrahmenprogramm* (POT) [i.e. patient-oriented day-to-day programme] in an interview with me.

Mr. Fawkes: (...) And what triggered it off actually - the thing that sent [positive] shock waves through the staff - that was definitely the [interdisciplinary] seminars in [name of town]. At these seminars common goals were set down. For instance the POT, which co-ordinates the work of the various different professional groups in the hospital. And uh we came away from these seminars with definite, concrete arrangements. And straight away on the very next day - or as soon as you were back at work - you tried to put these things into practice.

For instance .hhh for a year in the nursing service it wasn't possible for doctors and nurses to do a medical round together. Yes. No-one had time - above all the nurses didn't. And uh it stemmed from that feeling of being overworked and that feeling of - how can I put it - where are we going to. Well, where are we headed? And uh that was due as well to the fact that there weren't any clear decisions and agreements there. And from that [point on] when everything got defined, written down and taken note of - from then on things were clear. The goals were clearly defined and step by step you started putting them into practice.

What becomes obvious here is that the approach of employee-involvement appeared to meet the needs of Jo-care's people. It was also fed into the organisational perspective to improve the performance of health care and facilitated Jo-care's transformation because of its practical nature. The efficacy of the seminar programme emphasised "the skills of group and team building, of problem-solving processes, of inter-personal communication, of facilitation of meetings and the building of diverse and creative workplace cultures" (Casey, 1995, p. 97). This means the seminars took place on an ethical basis to enhance information, communication, co-operation and to improve the effects of health care services. But they also intended to make the participating people become committed to the goals of institutional excellence and feel an enthusiasm to do more and better work in Jo-care.

The seminar delegates wanted to put these things into practice by working together happily within an interdisciplinary world and by throwing their full energy into work. Working in this way involves a very co-operative attitude towards others in the workplace and towards the content of work itself (Kondo, 1990). On the face of it, the new organisational context seemed to cohere very well with the nursing service's overall strategy in Jo-care because it does in itself guarantee that the nursing staff, which is close to the patient clientele, gain greater control over decision-making. However, it was obvious that employees were merely allowed to do those things the CEOs expected. Sally, another staff nurse, complains about the seminars because she found that she was regimented:

> Sally: When the chief executive management came we went to interdisciplinary seminars in [name of town] the first two years. In the first seminar we threw everything out, started from scratch and really wanted to change a lot and we did end up changing things. And by the time the second seminar took place they were already saying that there would be no more seminars in future because everything was going so well. (2.72) You know it was said that there were to be no more patients on the corridors and no more overcrowding over bed occupancy so we we'd have less work.
>
> Maggie: But that's what we've got, isn't it?
>
> Sally: Exactly. In the end none of that happened. (...) It wasn't like that (in the past) and we didn't have beds on the corridor. It's only now that the amount of work has increased. (...) We really felt that this was a step back. And the (whole hospital's) talking about it.
>
> Maggie: I know, I heard about it too. So did anyone really expect things to get better, easier after a chief executive management was introduced? Did that get discussed at the interdisciplinary seminars?
>
> Sally: They really sold themselves good. (1.34) With the chap [CEO] you really had the feeling he can talk. If you said something he'd answer you using your own words, but so that everything seemed totally clear and logical. And you really think he's a kind of deity in white. And with the other CEO it was better because we were in the same workshops together. It was pretty confrontational. And I really thought that I'd be able to feel more at ease from then on. That I could go back to work and be involved in changing everything. But what really got changed? (...)

Statements such as these quoted above, reveal that the organisational seminars were an effective way of tapping people's ideas. These seminar days were presented as highly successful just at a time when things appeared to be going badly wrong. They were also intended to help people communicate more openly together in a spirit of

honesty and co-operation. People came away from these seminars with definite, concrete plans and these change agents reinforced the new dedication of Jo-care's organisational world. Certainly, if people like Sally expected to throw everything out and to start from scratch with new working conditions and better quality service then these seminars turned out to be something of a disillusion. In Sally's case, the seminars appear in an obscure twilight as she suggests that there have been little new or few improvements.

The pedagogic rationale behind these seminars was to build on specific cultural themes and to encourage webs of occupational relationships. The method-in-use was concerned with 'explicitly teaching a vocabulary and a set of values which encapsulate understandings perceived to be appropriate' for Jo-care's organisational world (Anthony, 1994, p. 41). This means desired values got passed down to those who work in Jo-care's day-to-day practice, but also to some change agents who were able to reinforce the value-driven message. As a crucial element of their managerial strategy the CEOs directed a behavioural process in which people's general attitudes and values were determined by persuasion and education.

For example, the cultural rhetoric was built up by numerous references to the old charitable and health care motives which underlay Jo-care's foundation. The continuity of this code, embodying the Christian and professional values, was made visible and ensured. The revival of this inherited tradition was strategically related to the fact that Jo-care is an agency of identification and is owned by an association of the Roman Catholic church. This means the religious and specific professional considerations which were pre-eminent in the hospital's development were applied to renew the underlying motive to care for the sick among Jo-care's employees. Additionally, the seminars were conducted in an environment where high quality service is regarded as the norm; i.e. the luxurious hotel, which encouraged employees to think differently about what they do on a day-to-day basis. All this led to extensive and continual discussions between the different occupational groups about establishing a negotiated order in Jo-care. Therefore, the identification of different

forms of institutional excellence was used to signify the values people were expected to aspire to.

Another major theme at these seminars was the effort to encourage Jo-care's employees to participate in decision-making structures. The delegates were treated in an open, flexible and informal manner and they learned to become participants in Jo-care's cultural playground. Several attempts were also made to establish high trust relations which create a particular kind of sensitivity among employees. While the employees were associated with the patient, 'caring involvement' became the form by which people identify their place within this hospital organisation (Casey, 1995, p. 97). Of course, not every person joined Jo-care's newly established 'culture club' (Thompson and Findlay, 1999 p. 171). In Sally's account, just a page or two back, it is clear that her experiences and response were somewhat different and she did not experience the mobilisation of commitment and identification.

What becomes significant here is that the utilisation of people was dependent upon their underlying values and creative ideas and whether or not these themes were compatible with the wider transformation of Jo-care. The managerial strategy was aimed at gaining people's commitment and enthusiasm by instilling a new work ethic in them so that their values and behaviours become 'concomitant with the organisation's view of itself' (Anthony, 1990, p. 4). Therefore, one of the goals of these seminars was to establish a creative, dynamic and energetic employee, sensitive and united with others in Jo-care. Here the focus of attention is given to a normative project which works less through 'formal structures and mechanisms than through informal processes, value-systems, and management of the emotions' (Thompson and McHugh, 1995, p. 214). The point at issue is therefore much more related to aspects of people's sense of self, creating 'an exchange that is more than economic' (Kunda, 1992, p. 209). Instead of looking at structural patterns of control another perspective was taken which ensures that employees become compliant with and enthusiastic about the demands of the organisation. Jo-care's re-launch into a relatively stable period of political and economical balance facilitated this trend.

The Expansion of Knowledge and Commitment

Jo-care's previous emphasis on charity and its negotiated bureaucratic order has been challenged by its chief executive management and by subsequent events arising from the managerial rhetoric. The reorganisation prior to the CEOs' introduction was never intended to move Jo-care's services coherently in any managerial direction. In the early 1990s, financial de-regulations and changes in health care legislation posed serious challenges to which Jo-care's management was incapable of responding. A planned managerial strategy was set up by external consultants and aimed at achieving a 'unified, central and accountable direction' of the whole organisation's resources (Anthony and Reed, 1990, p. 28). In a quick succession of moves, the appointed CEOs established new corporate structures and promoted a strategic framework which guided the change process generally. One element of this enormous attempt to change was helping Jo-care's people to develop a shared diagnosis of 'what was wrong' and 'what can and must be improved' (Beer *et al.*, 1990, p. 162). Here, the initial mobilisation of commitment was achieved by the organisational seminars which were set up to reveal the attitudes and expectations of Jo-care's people. Additionally, there was a focus on values and meanings within this hospital organisation and people's concerns became strongly influenced by what they were taught to believe, value and think.

The CEOs, with the approval of the hospital authority, certainly proceeded with real interventions which were created to change the ways in which Jo-care's people did their work on a day-to-day basis. Once again, there was a considerable effort to get the strategic vision and missions across, which means that the purpose of change was 'communicated, and employee-involvement and commitment secured' (Coulson-Thomas, 1992, p. 81). But, by that time, the scheme for Jo-care depended on the creation of cross-departmental conference and meeting structures which implied 'the necessity for greater co-operation' between employees and 'the increased exercise of responsibility' (Anthony, 1994, p. 9). These needs were met by the creation of an

organisation-wide communication network[5] which sought to be a response to the fact that 45 distinct occupational groups were employed within Jo-care.

A number of loosely linked communication teams were set up and directed to improve cross-functional co-operation while at the same time removing departmental barriers to its achievement. The interacting people within the groups are supposed to review the work done on a day-to-day basis and to discover and act on cost, quality and service development processes. Once again, people, drawn from various echelons and sections of the organisation, started to gather information on specific topics. As observed by Casey's (1995) critical research of Hephaestus - a world leader in the development and manufacture of advanced technological machines and systems - the purpose of the meetings is "to share information, discuss and assess on-going problems, to make decisions about these problems and to develop strategic options" (p. 120).

A remarkable vocabulary was developed to give the different communication groups a name. Since then shortened or contracted forms of words have been in use and these names created effects in particular ways. The strategy behind this was aimed at developing shared vocabularies of justification and a new framework of language to manage the identification with this hospital setting. These words portray the hospital's world where the conference and meeting structure appears to be explained to Jo-care's people.

[5] In Jo-care, the conference and meeting structure, which includes all people from the adjacent levels in Jo-care's hierarchy, is composed of the following committees, groups and teams: Das *Jour Fixe zwischen Geschäftsführung und Direktorium* [i.e. the meeting between Jo-care's CEOs and the members of the tripartite directorate]; *die Direktorium's Sitzung* [i.e. the tripartite hospital management board]; *die Führungskräftekonferenz* [i. e. the committee of the leaders of the different occupational groups]; *die Krankenhauskonferenz* [i.e. the meeting between executive managers and hospital staff]; *die Chefarztbesprechung* [i.e. the medical executive committee]; *die Leitungsbesprechug des Pflege- und Funktionsdienstes* [i.e. the nursing executive committee]; *die verschiedenen Gruppen der Leitbildorientierten Organisationsentwicklung* [i.e. the different organisational development groups]; *die Arbeitsgruppen für Abteilungs- und Stationsmanagement* [i.e. the project groups of the different departments and wards]; *die einzelnen Teambesprechungen der Stationen und Funktionen* [i.e. the different ward and departmental groups].

The CEOs made it clear that they encourage such high involvement relationships and each of the communication groups in Jo-care was allowed to manage their general concepts of co-ordination and apply them to their particular situation. The participation in one of the self-managing groups enabled Jo-care's people to re-examine long-term goals and to question operational initiatives in particular ways: What does it mean for the client to stay in Jo-care? What implications arise for the medical and nursing staff in terms of patients' shorter length of stay? What kind of initiatives improve the quality of health care? Which kind of services and procedures can Jo-care afford to offer to its patient clientele? The redesign of their in-house co-operation was seen to have a symbolic value for Jo-care's people who became eager to appear 'progressive, modern and having a good public image' (Alvesson, 1990, p. 38). For those people who embraced the idea that their corporate integration was a source of organisational advantage, it created a feeling of upward-directed power on operational, financial and personnel issues like the departmental work flow, diagnostic and therapy scheduling, labour costs, etc.

For example, at the Department of General Medicine, a large project team became one of the organising vehicles in Jo-care. The group, composed of the medical chief and his staff, ward sisters, staff nurses, physiotherapists and various staff of the Diagnostic and Therapy Departments, got the task of examining the department's strategic direction and developing plans for specific actions. As the new organisational concept unfolded, the members of the team got to the roots of the department's problems while they were sharing information and debating quality as well as cost problems. In the event of an overall consensus on a particular topic, the next higher group from different levels and functions and/or particular people commissioned were asked to support and/or refine these ideas and obtain everyone's commitment to it. The creation of this organisational initiative was based on enhanced communication and creative thinking and gave each delegate an understanding of the 'interconnectedness' of Jo-care's entire service delivery process (Hart *et al.*, 1990, p. 154). In fact, it was the most up to date and effective way of developing a 'caring, sharing world' in which the CEOs only kept a broad guiding

function on financial matters and long-term policies (Newton and Findlay, 1996, p. 43). On the whole, it made sense to Jo-care's people because they got a feeling of integration into the management of change and could question the logical grounds of decisions regarding the quality of patient care and cost effectiveness. As the leading CEO reflecting on Jo-care's co-operative redesign describes it:

> Mr. Tate: (...) Let me put it like this: single projects, now run by a project group and all the committees we have here - we [CEOs] started all that. We ran little work groups, moderated them ourselves and were ourselves involved in putting things into practice. Uh that's another way, a more structured method and above all a very controlled procedure. If you want your organisational philosophy to be an instrument to run your concern; or as aims regarding how to run the concern. Although you mustn't regard it as something static. You have to uhm adapt it sometimes. Now we're... well from our experience after two or three years at the latest, when people realise they have a certain degree of freedom but also certain responsibilities - it's then at the latest that you need an organisational philosophy to give people a feeling of security. Even if some of the staff on the wards don't understand why. But others do understand, it varies a lot.

Commenting on the way one of Jo-care's organisational development groups is working, one staff nurse explains:

> Paula: The project group then has to try and find new ways of putting things into practice. These suggestions are presented to all the different kinds of staff in the hospital and, actually, it all works out perfectly. Maybe even it really works out perfectly. For instance about dying in hospital - accompanying dying patients and an extra room for them, whatever. A lot has been done.
>
> Maggie: And a nun took a special pastoral course in religious welfare and so can approach patients now and offer support in that particular area.
>
> Paula: But that was before. YES. That was before. (...)
>
> Maggie: And that's true about the extra single room for seriously ill patients, isn't it?
>
> Paula: YES. And loads of other things got put into practice too. For instance now we have soup bowls which don't spill. OK these are little things and you laugh about them because it all sounds so stupid. But when it comes down to it, it's the little things that really annoy you, you and a few hundred others. (2.55) And now everything's great because problems get talked about. A responsible person is chosen who has the level of competence necessary to change something. And so it gets done, the person [chosen] sees to it. (...)

The introduction of Jo-care's new co-operative alignment was described as successful, both by members of chief executive management and Jo-care's

community. The responsibility for this success may be found in the redesign of co-ordination patterns and the systematic use of Jo-care's people who engaged in the new cultural rhetoric. This means the favourable outcomes may be epitomised through the participants because they create their organisational reality by their participation and want to make Jo-care's world as they visualise it. In this context Anthony (1994) refers to 'directed autonomy' in which employees are trusted because they will be brought to share the same values and meanings (p. 20). The principle here is like that in other human resource strategies and requires responsibility getting pushed down the hierarchical lines. According to Thompson and O'Connell Davidson (1995) this implies a dynamic very different from the day-to-day practice and 'puts into reverse the historic trend towards vertical integration' (p. 18). In the hospital's traditional set up one of the main sources of discontent was that Jo-care's employees were not consulted and had no right to take part in the managerial function of decision-making. The new network allows people at the bottom of the organisational chart to apply a set of resources to which they have access and to use their personal judgement to act. The rhetoric of team and family, succinctly expressed by Casey (1995) also emphasises this point:

> Knowledgeable and skilled employees are now invited, and required, to have a substantive role in the design and management of production. The rewards to the employees for participating in this new function are feelings of greater involvement and a sense of "empowerment" in a partnership with a caring and committed employer, and a close-knit team of colleagues who share a passion for excellence and customer satisfaction. Hephaestus promotes the team concept as the way for employees to perform their utmost, to feel valued and to have their resources of knowledge and skill more deeply tapped and utilised (p. 112).

What Casey (1995) addresses in her study on Hephaestus' culture is how the team concept was effected by the delegation of tactical responsibility. The culture of participation is thus about 'people learning about themselves' and 'working together in order to help themselves and the organisation' (Newton and Findlay, 1996, p. 43). By implication, people need a lot of 'autonomous judgement' because there is no longer any reliance on central bureaucratic directions (Anthony, 1994, p. 20). Huczynski (1993) argues that 'commitment, responsibility, creativity and putting people ahead of bureaucracy' are now associated with the new movement of

organisational development (p. 43). That normative influence is now deemed to be appropriate and open, involving and participative relationships would empower employees to accomplish their own personal goals while at the same time attaining the goals of the organisation.

From 1993 onwards, Jo-care's people began to operate within delegated decision-making power structures and it would seem that their contributory understanding was required to identify and solve problems for successful management of change. Most of the organisational members - no matter how senior - had the skills and competence to make the new hospital organisation work and the cohesion to move Jo-care's organisation along. As already noted by Casey (1995) knowledge which was previously kept from ordinary hospital staff was communicated and departmental boundaries between specialist fields were breaking down.

As Jo-care's team concept extended, a considerable amount of de-centralised planning and co-ordination took place in everyday affairs. Jo-care's people spent hours thinking about what might happen and debating and planning for possible consequences. Meanwhile, Jo-care's chief executive management consulted an organisational psychologist and used role playing with simulated real-life situations as another part of its own re-orientation. On a retreat away from the workplace, some project groups suggested that an organisational philosophy should be prepared that should underpin the behaviour that Jo-care's people were trying to achieve in its cultural rhetoric. Commenting on its development, a staff nurse explains how the organisational philosophy emerged:

> Paula: .hhh Well, here's one example which I find pretty obvious: the organisational philosophy of the hospital here. (2.15) It's all very democratic and has been from the start. Or generally speaking it was a very democratic concept. Everyone - really <u>every</u> employee in the hospital - could write down what they thought was important and what ought to be included in the organisational philosophy. Then there was a jury, or rather a committee, made up of all kinds of hospital staff, not only management and doctors. The whole concept was continually being revised and revised and revised. And after all that time - I can't remember exactly how long it was now, maybe a month or a year or even longer - when it was finished at last, I'm sure the result everyone arrived at was what had been planned right from the start. (2.53) But of course everybody had the feeling

that they had developed the organisational philosophy of the hospital [tentative laughter]. OK that's all right, why not [tentative laughter] but I think it's interesting.

Maggie: And how did you arrive at the conclusion that everything - the result - had been planned beforehand? Had the employees' suggestions been all changed? Or was the completed organisational philosophy couched in such abstract language that staff couldn't find their ideas and contributions in it any more?

Paula: Simply because of the fact that in another hospital run by the same consultancy company running Jo-care they have an almost identical organisational philosophy, [sneaky laughter] that's why. And I think the whole organisational philosophy was a bit contrived, [I mean forced on us from above]. Or at least I still do. (2.66) Uhm (2.41) I think it's something new for a hospital to have an organisational philosophy. As far as I know in business or wherever they've had that kind of thing for a while, it's perfectly normal in industrial or service enterprises and probably also necessary. But I think somehow in a hospital there's not the same understanding there for the whole idea of an organisational philosophy, for the point of it all. And hm. Of course that's the idea behind an organisational philosophy, it should contain guiding principles on a higher level rather than on a lower level.

Maggie: Goo::d, but when do these guiding principles get applied, what kind of processes? The organisational philosophy's here - what does it actually get used for?

Paula: Yes, it does get put into use, it's really great. For instance the whole (2.38) thing with the [name of the organisational development programme]. The organisational development programme [project teams working along the lines laid down in the organisational philosophy]- hh. I mean the idea of that is to put that organisational philosophy into practice. And it's also the case that everything's very democratic. Everyone can say what's annoying them and back up their arguments using the organisational philosophy. (...)

I've said such a lot about the organisational philosophy now, how great it all is. But actually - that is, my feeling is - well I don't feel good about it. [tentative laughter] No:, not a bad feeling. More a feeling of scepticism, that something could result from all of this that we don't want. YES. Somehow that the time was not yet right for any kind of organisational philosophy. I mean at the time it was introduced most of us were quite simply out of our depth with the whole idea. Actually no-one really had a clue about what was going on.

As this statement suggests, the presence of interacting teams advanced the co-operative attitudes and common understanding in particular ways. This means the appreciation of employee participation created a particular framework for organisational action and led to new patterns of 'authority, responsibility and incentives' (Hart *et al.*, 1990, p. 155). The above interview excerpt also traces the emergent process through which cultural knowledge was constituted and coupled to organisational activities. As Paula suggests, this move led to the construction of an organisational philosophy in order to mould understanding and recognise the

organisation's needs. Actually, this staff nurse's response to the creation of Jo-care's key resource demonstrates that she is eager for organisational development but less than enthusiastic about the process of its achievement. For her, the discovery that outside Jo-care this organisational philosophy found another existence led to a betrayal of her expectations. Paula's own considered verdict is that her intention to create an organisational philosophy has changed, that her initial spirit was naively conceived and that at the end of the day everyone did what they were told.

What becomes significant here again is a managerial focus which makes use of people's intellectual capital, knowledge and skills rather than systems or structures (Thompson and O'Connell Davidson, 1995). Of course, there was an emphasis on educated and more integrated employees, whose enthusiasm and commitment shaped the perception of Jo-care's reality. But this reality was constructed by the CEOs strategic conceptions and they discovered the need to encourage employee involvement as a crucial component of their overall strategy. Additionally, the complexity of Jo-care's development was built on some values of its corporate culture and there was a general change in practice consistent with the hospital's new vision of institutional excellence. This trend led to a change in the management of work but did not change the character of the employment relationship. In Jo-care, the management of culture was presented as an alternative but the immediate problem lay in its consequence: apart from shifting behaviours, there was an establishment of normative practices which were deployed as a 'free-way' to intensify control. This means the actual practice of management continues to deploy the conventional 'rationale pursuit of goals supported by an apparatus of control' (Anthony, 1994, p. 65). The indication of that traditional tension was displayed in some of the interviews which took place at the time of collecting my research data. After all, Jo-care's culture is still in place; initially built on the charitable, professional and bureaucratic idea and newly re-established by changed day-to-day practices and the spirit of a new realism. Unless this is appreciated, it is difficult to understand the peculiar relationships between the investigated rhetoric and Jo-care's day-to-day practice.

To restate the perspectives and arguments stated in this section: the new cultural programme, assisted by various organisational concepts, has not led to a cultural turn but an emphasis was put on the state and quality of people's hearts and minds. Additionally, a remarkable vocabulary has been developed to structure and communicate the organisational arrangements which strengthened this hospital organisation's singularity. These visible sources and outer expressions constantly remind the reader of Jo-care's corporate culture and echo the language and styles of employee inter-/action. All of them stand for the beliefs, values and meanings of Jo-care's people and are manifested in the day-to-day practice of this hospital organisation. The cultural image of Jo-care is the topic of the next part of this study.

Conclusion

In this chapter the reader encountered some of the visible impressions and oral expressions of Jo-care - a hospital organisation. As an ethnographic writer I reflected on different issues and trends regarding the economical, political and social considerations and investigated Jo-care's organisational culture over various periods of time. Here, I sought to place the hospital and its organisational members within a wider cultural context and began to address some aspects of the managerial rhetoric involved. The complexity of a behavioural renewal became visible in Jo-care's day-to-day practice as I presented some of the key concepts which were virtually embodied in the managerial message. Throughout the whole chapter an emphasis was placed on human resource strategies, managers and people who were taking the process of value-shaping seriously.

Chapter Seven

The Cultural Image of Jo-care: Representing Practice

Introduction

In the previous chapter the culture of Jo-care was identified as a key element of this corporate organisation. I have shown how, over different time periods, Jo-care's people took up and acted out various aspects of their cultural life. Despite the winds of change in economical and political respects, Jo-care's social life has been the most influential factor at its corporate system. It became obvious that a set of shared values and the transfer of authority, responsibility and incentives outlined in the contemporary cultural rhetoric provide the foundation and context for the reorganisation of Jo-care, its management and people. This chapter lays out the complex issues of how people picked up the new language and modes of practice in this health care enterprise.

Service-orientation towards People and People's Needs

The realisation of a new spirit was carried over into the day-to-day practice through the adoption of key attitudes. There was an establishment of the values of creativity, optimism, honesty, openness, empathy, fairness, readiness to help and an attitude of cheerfulness and brightness. As the organisational transformation took place, it appears that most of the nursing members manifested these cultural values in their language and in their immediate personal inter-/actions. This means the notions of institutional excellence may have began to permeate the cognition of Jo-care's employees and brought about improved performances, greater concern for patients, and the promotion of quality service.

A number of employees in Jo-care demonstrate and communicate different patterns of understandings, obligations and expectations which have not been actually stated in written materials but which are compatible with the features stated above. Many of these accounts are given by brief, anecdotal stories which provide meaning for,

and instil a sense of purpose to, the members of this organisational world. Here, for example, is an interview extract showing a staff nurse's perspective:

> Esther: [C]ommunication u:hmm has improved. About three years ago it was terrible (...) each ward complained about the other, but now somehow =
>
> Maggie: = between wards?
>
> Esther: Between wards and also with the Departments for Diagnostic and Therapy and then people began to realise what they were fighting about and with whom. And what kind of problems the Departments of Diagnostic and Therapy have and what difficulties the wards have. And that no-one does it on purpose to deliberately annoy the other, or because s/he's stupid. But that everybody had problems to cope with. And (before) nobody had realised this or had just complained about the different departments, and the Departments for Diagnostic and Therapy complained about the wards. I think it's got better.
>
> Maggie: And why has it got better? =
>
> Esther: = Why:::? I think due to [name of a town] seminars everybody got together more. Unfortunately we don't have that any more (2.28). And, (1.62) that was good for communication. You can really see that now if you look at the [name of the organisational development programme] - the written forms which initiate an examination in the Departments of Diagnostic and Therapy are much better now. Not so:::, they used to be really awkward. Every [department] had a separate form for each examination. Sometimes you could just get so confused (...).
>
> Maggie: And understanding between wards - e.g. that you help each other out, like it was today, or with other departments. Do problems get discussed? Or is the mediator or mediating group the [name of the organisational development programme]? Or did the CNE arrange everything? Or the doctors who were interested in improved communication and information flow? The [name of a town] days were just single seminar days, weren't they? That's relatively short.
>
> Esther: Yea:::s. But they were very intensive, because you really (...) well when do you see each other the whole day long? Never!]
>
> Maggie: [Especially that combination =
>
> Esther: = that combination. But you work out the whole process of work together, because (...) the old process of work was more or less arranged around the Departments of Diagnostic and Therapy. Patients were often collected for examinations at midday when they actually wanted to eat, or straight away in the morning when they weren't washed. And that wasn't particularly pleasant for the patients because they actually shouldn't have had to wait so long with an empty stomach or have a cold meal. There didn't use to be a break for the patients (...), now between 2 and 3 o'clock they have a break so they can have a nap or rest. That wasn't possible before, everything just went on through the day and the patients had to put up with it. And now the telephone switchboard arranges everything I think.
>
> We realised there was a problem when we saw the high turnover and bad atmosphere in the whole hospital. So then the CNE and CEO got together to

improve things, that aspect. And the people in the hospital wanted something to change too (1.72) so they got together. And (1.78) in any case things got better (2.19) and stayed better too (1.85). Now you don't get snapped at, on the phone. You yourself feel motivated to =

Maggie: = So the nursing care as well as service enjoys better status in the hospital?

Esther: Exactly.

Maggie: In comparison now to the Departments of Diagnostic and Therapy?

Esther: Mmhhmm. Nursing care and service has an improved status and the patient is now the focal point. And not only diagnostic and therapy is important but other things. This is made clear in the organisational philosophy and all that, it's really the patient who is important and not the functions, therapy and diagnostics. All that trouble and then another x-ray and then this and then that, no matter how the patient is feeling or whether he was asleep or was needing a rest. Now we have the situation that it's the patient who's important and not (...) a particular occupation (2.34). The main thing is to take care of the patient, not to fit him into the [hospital] work process.

One of the key concepts in this interview extract is that of service-orientation towards people and people's needs. The notion includes not just the patient clientele but also Jo-care's employees themselves. This means employees regard each other and themselves as people with individual needs and expectations in their workplace which others have to take into consideration (Casey, 1995). Further, this elaborate corporate value in itself has been designed to increase the satisfaction of clients within an integrated health care service. Putting patients first has led to various considerations in different professions and focuses on the 'how' and 'where' clients interact, which in turn focuses on the employees who actually create or deliver the work that patients value (Schlesinger and Heskett, 1991, p. 77). Moreover, Heskett *et al.* (1990) claim that this policy requires that as much attention is given to those people who serve as to those people who get served in service organisations.

In this perspective, Jo-care's Diagnostic and Therapy Departments exist to serve the nurses and medical doctors on the ward floors who have direct patient contact for 24 hours a day. To a great extent the same factor became evident throughout the whole hospital because it is now everyone else's responsibility (e.g. the people in the personnel department, medical technicians, senior managers, etc.) to serve front-line staff who actually transfer their service to the patients. Formerly, in typical hospital

conditions, nurses were regarded as the ministering helpers with their work experience and their own attitudes, sharply marked off from the more mundane world and all the other functions (Nelson, 1997; Küpper, 1996; Wanner, 1993; Whitston and Edwards, 1990; Hummel, 1986; Bischoff, 1984). At this time it made sense for offices to be closed between 12.00 noon and 2 p.m. because the traditional system recognised and rewarded the completion of paperwork rather than employee satisfaction. The service-oriented response is now that Jo-care's front-line people are considered, and must consider themselves, both as clients and servers.

In fact, the more that nursing care becomes an important part of delivering better quality service, the more important personal interactions are in satisfying patients and in becoming better than any other health care organisation. As Schlesinger and Heskett (1990) remark:

> These front-of-the-house jobs cannot be done by incompetent, uncommitted workers. They require men and women who can take responsibility and manage themselves, respond well to pressure from customers - in short, the kind of people who rarely come to mind when most service managers think about candidates for frontline service jobs (p. 78).

Most people in Jo-care regarded the new concept as an effective approach in shaping the behaviour of employees with each other and in achieving a greater patient orientation. Indeed it is suggested that the policies of people orientation are unique to Jo-care and all organisational members ensure a congruence in their day-to-day practice. In such an environment, changes, like the POT which co-ordinates the work of the various different occupational groups have stimulated marked improvements in Jo-care's work flow and employee morale. A deputy ward sister reinforces this point:

> Ina: (...) Uh that [POT] was all exactly worked out at some point. We were all involved, that is the nursing staff, medical doctors, medical chiefs, the whole caboodle. The people from Departments of Diagnostic and Therapy too. A:nd (4.38) the more streamlined this is and the better it's kept to the quicker everything gets done.
>
> If there's uhm yes (2.32) how can I say this best (2.34) uh uh mistakes or (2.50) uhm. (3.85) gaps or offences against it [then that has some kind of effect on the

> occupational groups]. It causes a problem somewhere else. And I think that I personally am encouraged to stick to it so things flow in the right direction and I remind people of this as I see fit. (1.82) And for the most part it works out OK with the doctors, but sometimes it doesn't. That probably has to do with the persons involved and (for that reason things) don't flow like they should.

Accounts such as those stated by Esther and Ina may stand as indications that cross-functional work systems flow and the process of self-formation occurs in their day-to-day experiences. They are both concurrently in sympathetic relations towards others and in respectful relations to them as people with needs. Additionally, both nurses consider their job not only to understand others and to work hard, but to influence and shape the organisational performance of other people in Jo-care. Especially Ina's remark on the POT suggests that the language of people orientation encourages her 'to stick to it so things flow in the right direction'. In this way she describes the purpose of the new rhetoric and promises an emotional link in the form of a high degree of loyalty to this hospital organisation. Such a perspective of the relationship between Jo-care's employees and the organisation ultimately involves the argument that there are no inconsistencies between personal and corporate objectives.

One prerequisite for changing from the old model to the new, service-centred, model is an intensive programme to train and communicate with existing employees. For example, the senior executives regularly talk to employees and they emphasise how crucial it is for everyone to be informed about Jo-care's reorganisations. In doing so, they add to the employees' stock of knowledge as well as to their pride in themselves and the importance of their work (Schlesinger and Heskett, 1991). In addition to talking to people, training sessions typically provide the context in which employees commit themselves to this hospital organisation and its service-expectations. New employees take part in a two-day orientation seminar in which the underlying theme of service-orientation towards people and people's needs is communicated. During these sessions, they work through exercises to identify and adapt their attitudes towards Jo-care's organisational philosophy and engage in role-playing to build their enthusiasm for the hospital organisation. Throughout, the focus is on teaching new employees social and technical skills and helping them to think and act

autonomously. Moreover, continuing development in the form of further and post-registration education pertains to everyone, not just Jo-care's newcomers. The rationale for this comes partly from the need to set higher performance standards and expectations and partly from the need to enhance the knowledge and skills people must have to meet those expectations (Schlesinger and Heskett, 1991). As a result, Jo-care wanted to create a generation of people who became interested in relevant information and were properly prepared to recognise the hospital's needs. That is, the cultural message was very straightforward and related to the needs and interests of Jo-care's audience. Indeed it is suggested that Jo-care become truly service-oriented and the CEOs redesigned the business of health care to support the efforts of the front-line people and to maximise the impact of the value they create. As the philosophy of this hospital organisation suggests:

> We encourage fe-/male employees to develop their skills and expand their knowledge. Professional training, courses and further education are accorded great importance. We orientate ourselves according to the demands practice makes on us and are preparing ourselves for future developments in health care and the hospital itself. One major aspect here is inter-professional co-operation and the development of interdisciplinary, patient-oriented concepts.

A close examination of the concept of service-orientation towards people has led me, as a participating observer on the ward and hospital floors, to some kind of uncertainty and unexpected ground. The contradiction embodied in the rhetoric is crucial here and illustrates one of the difficulties I faced as a researcher. At first glance, it might seem that the circumstances at work enabled people to make something of that happen, but there were limits to such a self-fulfilling freedom. At the time I was collecting my research data there was a full utilisation of the nursing service's capacity. By implication, most of the nursing staff could not say when their work was done because of the intensification of their day-to-day workload. That is, it was difficult for them to get their own interests fulfilled within the day-to-day practice when patients felt sick and needed constant care. Commenting on the way in which the concept of service-orientation towards people is practised, one staff nurse reports:

Laura: (...) I have to say that after I started work there was a introduction day for new employees. The organisational philosophy of the hospital was presented and uh. I really have to say that what was said then was not necessarily put into practice, or still doesn't get put into practice. Especially with regard to the hospital philosophy (...). For example we still have beds in the corridors or patients in the common day room. But well that's meant to stop now. Or that dying patients are only seldom alone in a room. It's always difficult in practice to decide where to put patients or how to organise things. And it really (...) is a time problem if you want to do holistic nursing care. It's just not possible to do it the way you want, you always have to sacrifice something. Because of not having enough time. Just like activating nursing care. Esss. I can't take an hour for direct care or to bath a patient completely quite simply because there are other patients on the ward too. You just can't do everything.

Maggie: Did you get the impression that this was made clear in the nursing philosophy? Or in the organisational philosophy of the hospital, that this could all be possible?

Laura: Well as regards the nursing philosophy (...) that should all be possible. Yes!

Here, Laura emphasises that it was far from clear that the reality of health care work has actually changed in the ways that Jo-care's rhetoric suggests. That is, there was a wide gulf between the rhetoric of service-orientation towards people and the reality on the ward floor. For example, the same theme of disparity between claims made and the evident facts resounded in people's comments about the employee involvement groups that were established as part of the new cultural rhetoric.

In any case, many employees reflected on the language and practices associated with the concept of service-orientation towards people and people's needs. They confirmed Jo-care's reputation was a progressive and modern health care organisation in which the implementation of innovative actions and employee-involvement has taken place. The same cultural rhetoric also served useful for public relation interests and managerial functions. It depicts Jo-care as a health care organisation with a history, an ethical code, and a set of shared values - a hospital soaked in the 'belief of harmony' (Anthony, 1994, p. 62). In short, the service-oriented movement arose out of the necessity to become a more management and patient-driven service organisation. The exploration of this cultural policy is a critical component of the organisational development programme which Jo-care's people have developed.

The Generation and Utilisation of Knowledge

The managerial message in Jo-care was very straightforward and was related to the needs and interests of the participating audience. Right from the start, there was a systematic attempt to familiarise Jo-care's people with the business of health care and the logical grounds behind the hospital's managerial strategy. In meetings and seminars, executive and senior managers could be seen translating financial terms, operational data, health care concerns and mediating other useful information to nursing personnel in understandable terms. The new forms of information technology available in Jo-care played a determinant role in facilitating good cost-accounting data and the managerial rhetoric was used creatively to appeal to people's concerns. The CEOs promoted the idea that as the hospital becomes more competitive in the German health care market, a general body of knowledge and analytical skills would be essential for nurses to cope with the diverse efforts that co-ordinated action demands. A ward sister reports how the cultural doctrine of equality between people and the policy of support are promoted in Jo-care's day-to-day practice:

> Ruby: I remember very well how it was before the present CEO came to the hospital. The ward sister we had then used to fight and fight like crazy, arguing with everybody and I was absolutely convinced that I never ever wanted to take on a management position. Never - I'm not daft. However I soon became deputy sister and after I saw the changes in chief executive management I allowed myself (to be talked into it). It was very hard to begin with but I know that it had to do with the situation [that the leading CEO used to work in nursing]. Yes, things would be different here. The doctors had their wings clipped quite a bit after the change in management. Definitely! OH YES they had to get used to a whole lot of things.
>
> Maggie: On the other hand the doctors with their budgets - based on the prospective calculated bed occupancy - have quite a degree of autonomy. (...)
>
> Ruby: When I started working here no-one had a clue about bed occupancy or the financial system. You didn't know the first thing about all that. Maybe the chief medical executive heard about it through the directorate but as to how far information like that was passed on I've no idea. I wasn't sensitised for things like bed occupancy, length of stay, patient figures and frequency at all nor was I aware of what part they played in things, not for a long time. Until we got involved a few years ago. Then it became clear to me how important all that is for funding a hospital. (3.03) Uh I consider this information very important and it's always fascinating, all these millions that are involved. (3.72) But I'd also like to know how many people who know about the accounting figures really understand them. [tentative laughter] I suppose anyway that the length of stay and bed occupancy are the two most important aspects at the moment.

Similarly, the CNE explains how the policy of support and involvement is promoted in Jo-care's day-to-day practice:

> Maggie: What surprises you when you go through the hospital? When do you experience that AHA feeling?
>
> Mr. Fawkes: What surprises me? (6.53) For instance when the hospital is really full and a lot of staff despite that still are willing to cope with overcrowding.
>
> Maggie: Do you know why?
>
> Mr. Fawkes: I can imagine why. Because we really go on the offensive with the hospital financial figures. They [employees] have enough information at hand to actually know why we have to act in a certain way in a certain situation. I think that's an effect of our offensive information policy - especially with regard to finances. Through that everyone's involved in the process - above all our managerial and leading personnel. Yes. (...) They have to have keep sight of the whole hospital. (2.03) And they need that so that they don't see themselves isolated on their ward but instead keep sight of things. At the ward sister meetings we regularly inform staff about the hospital accounting figures and about current developments during the present year. And about the financial situation and developments so that they know what's going to happen in the next few months. That's very economically-minded, of course, looking at it that way. But you almost don't have a choice because the pressure from the governmental authorities is very great.

The above interview excerpts give a detailed image of the organisational scene and describe the striving for decentralisation and the production of knowledge in a very general sense. On an intra-organisational level, it appears that Jo-care's senior managers provide the right kind of support and that the provision of 'accurate and up-to-date information' on operational issues is ranked as an important requirement (Callan, 1993, p. 70). In particular, Mr. Fawkes' remark that 'they [nursing personnel] have enough information at hand' to know why Jo-care's management has 'to act in a certain way in a certain situation' appropriately describes the purpose of the new rhetoric. Here, the logic relies on innovative data which traditional accounting and measurement systems were not able to provide; e.g. to accumulate, monitor and analyse comprehensive data reflecting each component of the service process. The new information technology system is networked in ways which 'informate' the workplace and provide a reliable and up-to-date orientation regarding the situation in Jo-care (Zuboff, 1988, p.358). Apart from communicating the core values of the new culture, the hospital's CEOs make sure that there is a disclosure of

information at all levels and there is a heightened awareness that Jo-care's people learn about what they are doing. As a result they are able to make informed decisions about the use of resources and similar to Casey's findings (1995) Jo-care's nurses 'know much more about the elements of production than they previously did' (p. 105).

Another way to think about this organisational challenge is that the hospital's 'horizontal co-ordination' has to be ranked as important if Jo-care's people are to discover and act on cost, quality, and service development opportunities (Warhust and Thompson, 1998b, p. 3). The implementation of innovative, high quality and low cost health care services depends upon close co-ordination among medical, nursing, and administrative departments, as well as between labour and management. More and more employees, particularly those at the lower end of the organisational chart, are now able to participate because like in Casey's practice locale (1995) they "possess previously specialist knowledge and perform in wider functions of the corporate work place than their predecessors" (p. 106). Consequently, Jo-care's people see clearly the organisational roots of the hospital's ability to compete but, even more important, they share a common understanding of various organisational matters (Beer *et al.*, 1990). The new organisational form appreciates these multiple functions of Jo-care's people and encourages employee commitment to this hospital organisation. This process was seen most clearly in the department of nursing because Jo-care's nursing service was the area which was most enthusiastic about the organisational change effort. A ward sister relates how Jo-care's nurses come up with new ideas and how they create better ways of doing things in their day-to-day practice:

> Ruby: (...) Uh (1.81) on our ward new things have always been tried out which were then put into practice. We started using alternative nursing care procedures, like for instance poultices and compresses. Although we did that more intensively, at the moment not so much. But generally speaking starting something new isn't that dramatic. Well of course there are teams who'd be more likely to say, "God, something else new". But that's not the case on this ward and it'll stay that way, I mean new staff will be influenced by the rest of the team so that they end up wanting the same. That is, wanting to try out something new. Whereas I must admit that the newly-qualified nurses are mostly highly motivated. So they really enjoy trying out something new.

I::n teams where this doesn't work out as well; I've worked in a team like that before, mostly there are a lot of people in the team who did their exam years ago and who don't like changes. And when newly-qualified nurses come along they get pushed in a certain direction. The kind of people who say "Oh leave me alone with your new ideas". We've never had that kind of attitude on our ward, it wasn't like that either before I became the ward sister. That is to say, again and again something new came along and we always accepted it.

A year ago at the time of the discussion about nursing assessment talks I spoke to Ms. Sterne [deputy CNE] and said to her that I would find it good to discuss everything with the team. I would not have wanted to decide alone whether or not to introduce it [nursing assessment talks]. And I think that would have been quite damaging to the 'fertile ground' we've been cultivating on the ward. Uh. I said too [to the deputy CNE] that I wasn't keen on increasing the staff's workload. To insist on their making time in order to improve nursing care even more. At the same time performance appraisal interviews were introduced and (2.22) I really didn't want to make too many demands on the team. But since they decided themselves, everything was clear. And then we started to think about how to put things into practice.

There were several workshops with staff nurses, ward sister, charge nurses and the CNE where we talked about how to do things. We worked out criteria, procedure criteria etc. and this was presented to the whole team. This went on until we got as far as being able to fix a starting date. Then we really did start and discovered that the forms were not at all adequate for our purposes. There were a few points which made the conversation with the patient totally confusing. So the forms were revised in a new workshop, taking the special requirements of our ward into consideration. Ms. Sterne didn't take part in that workshop. We managed fine, working till we were able to present the new form to the team. Since then we've been using our new form and Ms. Sterne said just recently that it's going to be printed for the whole hospital. Because I showed the new form to everyone at a team briefing and the team was really pleased with it.

Maggie: The staff on the ward or the ward sisters of different wards?

Ruby: The ward staff. I showed it to the other ward sisters in the hospital too, but the reaction was not overwhelming and most wards haven't been doing nursing assessment up until now.

Maggie: I find the way you developed it interesting. (...)

The above interview excerpt is a good example because the liveliness and vitalisation of this particular ward can be described as highly successful. The organisational form of participation underscores the fact that new ideas are first communicated within the team and then put into practice according to the apparent logical connections. For example, the nursing assessment tool was designed specifically for this ward by members of the team and it seems that the process of participation encouraged high levels of group commitment. The reservoir of available experience and knowledge of specific cultural figures was used to identify and solve problems at

hand and enriched the skills and experience of each member of the ward team. Such a process underlines the fact that this ward found a new way to achieve continuous improvements in quality and service provision and all this happened with almost no formal involvement. That is to say, the members of the team were put into a new organisational context which favoured autonomous roles and imposed responsibility and particular relationships upon them, which in turn created a situation that has encouraged the adoption of new attitudes and behaviours.

At the time of the fieldwork more than 700 people who care and/or treat patients, perform clerical work, cook meals, clean wards and offices, regulate supplies or provide some other forms of labour in the hospital's day-to-day practice were employed in Jo-care. Jo-care's re-organisation was perceived by many of those interviewed to have allowed for improved communication and good quality service. Most of Jo-care's employees appeared to be keen to go along with the new organisational culture and to experience the community it provides. An organisational development programme was founded in 1995 and was given an acronym - LORE. In full this meant *Leitbildorientierte Organisationsentwicklung* [i.e. philosophy-oriented organisational development] and its primary goals were to put the organisational philosophy into practice, to train employees in the new cultural ethics and to let them participate. This means Jo-care's people start new projects and put things into practice, and their knowledge is required to be deployed and directed in ways by Jo-care's management through the teams in which they work. As the philosophy of this hospital organisation suggests:

> All fe-/male employees contribute towards success as a whole, regardless of their profession and status. They all earn therefore the trust and care of the organisational community. This is true also of the psycho-social and spiritual care sectors. We know we are dependent on each other in order to fulfil our tasks; we therefore treat each other with respect as partners. We are polite to each other. We respect the personality and achievement of our colleagues. Personal and professional commitment is acknowledged and appreciated. We encourage independence and initiative by allocating responsibility and competence in clearly-defined areas of work. The needs of each area of work interests us and we support each other if and when necessary.

On the surface, it appears that Jo-care's CEOs share 'a certain faith in human nature' and do believe that many employees want to do good work (Schlesinger and Heskett, 1991, p. 80). That is, they wanted to help Jo-care's people to achieve this and have consciously constructed an organisational environment in which employee learning, as well as organisational development, is facilitated. Similar to Schlesinger and Heskett's observations (1991) the new managerial logic is built on capable employees who feel integrated and are well informed to provide 'a better service, need less supervision, and are much more likely to stay on the job' (p. 72). At the heart of this approach are Jo-care's nurses who are enthusiastic for organisational development and, according to Anthony and Reed (1990), the generation and utilisation of knowledge enables them 'to hold their corner, to understand better the working of committees and the operation of the auditing of clinical performances' (p. 24). The cultural rhetoric not only advances horizontal collaboration and enables the hospital's CEOs to trust Jo-care's people, but it also enables Jo-care's nurses to feel great and perceive themselves as being important.

For example, Jo-care became a WHO health promoting centre committing itself to continued collaboration with the WHO's programme and the development of hospitals both in Germany and internationally. Jo-care was accepted for several reasons: First, its connection with other health care organisations places it in a strong position to respond to WHO's aims. Further, Jo-care's cultural rhetoric speaks of a considerable freedom to act and that it is the charitable and human factor which adds value to the provision of health care services. Specifically, Jo-care supports health promotion work in diabetic and parental education as well as in patient information. However, there are also innovations in nursing and medical practice and co-operation in the organisation of meetings between different WHO hospitals. The current WHO project focuses on helping hospitals to respond to new demands of health care reforms, encouraging the development of a competency-based and holistic rhetoric, preparing involved people and developing a portfolio of innovative practices in primary health care organisations. As an important link in the chain of collaborating hospitals, Jo-care invites other health promoting centres to take part in specific

projects or joins them on projects, and develops close relationships whenever possible. Being a health promoting hospital extends people's accountability and provides a challenge for each member of this hospital organisation. Here, as Dent (1998) argues, the key accord is the 'external audit' which ensures that an internal system of quality assurance is in place and is working well (p. 214). This reflects the rationale of Jo-care's rhetoric which relies on a quality approach and could be one reason that review practices are in place, and that different project teams - which are sometimes multi-disciplinary in its nature - are actively involved.

Below the surface, however, 'things were not as tidy' and there was considerable evidence that people were not treated as well and did not feel so committed to the hospital's rhetoric (Zuboff, 1988, p. 352). Shortly after commencing my field work I heard tales of how everyone got involved, creating a feeling of understanding, togetherness and mutual participation. This means an emphasis was placed on organisational transparency and co-operative, high trust work relations to reach consent and to transform 'what and how people think and feel' (Thompson and Findlay, 1999, p. 168). In retrospect it became clear that somehow I had expected to find marked changes in people's openness as a consequence of their participation, actively contributing to the reproduction of social relations at work. In reality, however, no such sensational transformation occurred and the nursing members were complaining about feelings of uncertainty and ambiguity.

People's Awareness of Expenditure and the Implications

In Jo-care, the implementation of the 2nd Health Care Reform Act took place in an atmosphere of unease. Jo-care, like other hospitals, relied upon a combination of models which were underpinned by the three principles of efficiency, effectiveness and economy and could be used as norms against which 'systems, processes and services could be evaluated' (Thomson, 1992, p. 33). However, the history of this hospital institution, its external and internal relations, and the relative autonomy of Jo-care's employees have left a mark on the cultural context.

One element in this enormous attempt to change was that the appointed CEOs had to respond to the context of the hospital's economy and its services. Within this sector, as Mr. Tate describes it, they are expected to see 'that the hospital uh let's say flourishes financially'. That is, to establish Jo-care's 'input mix' and to agree on 'output levels' with a variety of health insurance funds with whom they would establish and draw up general contracts (Bartlett and Harrison, 1993, p. 70). It is in the light of such a responsibility that the CEOs have to manage Jo-care's capital scheme effectively in order to retain the hospital's efficiency and/or to reinvest financial surpluses. This managerial aspiration has led to a particular search for health care expenditures and there has been a strong emphasis on tighter planning and spending controls.

From 1993, when the nation-wide block of all hospital budgets began, until 1995, the CEOs were no longer able to specify the hospital's income and expenditures. Beyond the planned time span, this legislation was extended to contain costs while a form of prospective payment was introduced in return for access to a defined range of services (Stabilisierungsgesetz, 1996; Beitragsentlastungsgesetz, 1996). All this led to enormous tension between service planning and capital spending, and Jo-care moved from a clinical and *cameralistic*[1] model, which characterised it since the early 1950s, to a management-driven service organisation, where what has to be done governs who works with whom and who leads (Beer *et al.*, 1990).

For example, one of the tasks of the CEOs in Jo-care is to allocate the hospital's budget internally across various departmental units. According to Bartlett and Harrison (1993), this managerial task involves a high degree of risk for the hospital, given that under a blocked budget the overall income is fixed, even though the health care delivery costs are variable and therefore only partially controllable. This means that the change in the hospital's fee structure represented a move away from a costing system that 'averaged patients costs across all patients' (Arnold and Oakes, 1995, p.

[1] The word derives from its Latin origin *cameralius* and means that the budget is based on a written report which involves an accurate book keeping in terms of expected as well as actual revenues and expenditures (Deutsches Universal Wörterbuch A - Z, 1989, p. 803).

116). The introduction of a prospective costing regime, in the sense of specifying a separate price per case, influenced how cost-accounting data have to be collected, and it was the beginning of placing emphasis on the marginal costs of hospital care. Thus, the new system of hospital finance has led to the fact that Jo-care's CEOs now feel obliged to talk in terms of financial targets and cost improvements, even if their affinity for such terminology is sometimes only superficial and opportunistic (Pollitt, 1993).

One of the immediate outcomes noted by a large number of nursing staff at all levels was the increased cost consciousness. Re-developments, equipment, screenings, supplies, waste as well as employees' working time cost money and cost consciousness was an inevitable effect of the economic forces that shaped the working relations of Jo-care's employees. With regard to matters of efficiency, effectivity and economy the people within this hospital organisation became actively involved, and participated in cost-cutting exercises which were used as programmes for quality-assurance at the same time. The decentralisation of decision-making power enabled them to evaluate operational issues and to improve performances in health care in general. These activities were related to the explanation of costs, the mix of the workforce, the conditions at work, the control of work volumes, the consumption of material, etc. Commenting on the way health care material is consumed, a ward sister reports:

> Maggie: What about costs of material and supplies and being economical with them? That's very important too.
>
> Ruby: That's also a very important point but in my opinion things here aren't done right. (...) What we really need is for every single employee to develop an awareness for material s/he uses and for what gets wasted. I don't mean counting every glove. But it does happen that you contaminate a sterile silicon catheter, it's dirty so it has to be thrown away. Or if a faeces collector which costs between 15 and 17 Deutsche Marks [7.67 and 8.69 Euro] doesn't fit the patient straight away a new one is taken. I think about occurrences like that and believe that staff should develop more of an awareness for what everything costs.
>
> For instance I was talking the other day to somebody about what student nurses actually learn. You know, hygiene, comfort of the patient - that's important but they never learn about being economical with material or avoiding waste. And where's the interest in saving money meant to come from then? And perhaps a nurse or an employee are angry about something and say "Why should I save

> money for the hospital? I don't care." Or if you think about the good of society in general. There are still people who don't even recycle their glass and don't think about how they're producing rubbish. The only thing that would make these people more aware would be to pay them a share of the surplus left over at the end of a budget span.
>
> Maggie: That's illegal.
>
> Ruby: Yes, but that's the only way this problem can be solved in a hospital. Of course it would mean triple supervision.

What is impressive about change in Jo-care is not that formal relations have changed, but rather the extensive development of people's awareness of expenditure and the implications. It seems that the emphasis on knowing what things cost may have begun to bear fruit and Jo-care's people show some evidence of greater cost consciousness in their day-to-day practice. However, nursing staff did not notice any change in the quantity, quality and availability of supplies in their day-to-day practice but the inventory of supplies kept on wards decreased markedly. In one ward, a charge nurse reported that they became acutely aware of costs when they discovered that a lot of costly health care material was dispersed throughout the hospital in rooms for ancillaries and equipment storage. While nurses generally saw the necessity to become more cost conscious, they were quite resentful of other departments' personnel who were not made to play by the same rules.

Traditionally, the functions of planning, control and costing had a low priority in Jo-care, but this has changed as attempts have been made to raise the awareness of costs (Levitt and Wall, 1992). Indeed it is suggested that the cost consciousness came about because Jo-care's people were regularly informed and placed in autonomous positions, and they perceived themselves as having a significant degree of control. Additionally, the employees were expected to place a considerable degree of trust in the organisation's judgement; i.e. into the expertise of those members who are participating in the cross-functional conference and meeting structure. All this happened in line with one part of the organisational philosophy:

> Our thoughts and actions must also be guided by economic considerations as well as those of quality and ecology. Fe-/male employees are therefore regularly informed about the achievements and economic situation of the hospital. In

> order to cope with the demands our health care mandate makes upon us, we have responsible, competent work groups and an accounting system. Buildings, facilities, equipment and resources at our disposal are treated with care.

What is interesting to note is that only few people understood fully 'the complex mathematics' that created Procedure Fees and Diagnosis Related Groups, and even fewer knew in detail the technical and political requirements needed fixture of these payment rates (Preston *et al.*, 1997, p. 159). Although it is claimed that there is a culture of involvement, there is some indication that Jo-care's people have been poorly prepared to engage in anything more than cost-related conversations. In reference to a concept from cybernetics, I suggest that Jo-care's people look at the complex financial process of capital planning, which involves various revenue calculations, like a 'black box' (Collins English Dictionary and Thesaurus, 1993, p. 111). That is, as Preston *et al.* (1997) argue, they continue to solve such considerations through their belief in Jo-care's culture and 'the neutrality of economic and technical means' (p. 159).

Contradictions of people's awareness of expenditure were easily recognised by the ethnographic presence on the ward floor. The inconsistency embodied in Jo-care's rhetoric is set within a highly constraining framework of financial pressure and an apparent misbehaviour. As in Lee-Treweek's ethnographic study of nursing auxiliary work (1997), the misbehaviour displayed by Jo-care's nurses was based around 'defying the official status and formal definitions of their work' (p. 47). Similar to other industrial or service occupations, the misbehaviour took the form of various overt, covert and contextual acts; i.e. from the scheduled working time to the material Jo-care's people used in their day-to-day practice. This material includes the hospital's food, medicine, screening tests, national telephone line and other health care supplies. Another kind of misbehaviour utilised by Jo-care's nurses was the organisation of their work; this became especially clear in the staff room and its use during working hours. Interestingly, most of the practices were known by those in authority even though they were inclined to overlook these actions deliberately. This was reflected in the difficulties of the CNE and his deputy to explain why they

tolerate these practices and what they mean to them. The deputy CNE, for example, describes the consumption of hospital food in the following way:

> Ms. Sterne: (...) The incident with the medicine cupboards wasn't important. But I often notice things over a longer period of time.
>
> Maggie: Lunch! [tentative laughter]
>
> Ms. Sterne: [intense laughter] For example. Ye:::s. I do notice that. I sometimes don't go round the wards till 11.30 a.m. Or at the weekend, on Sunday, usually they're all sitting there. But that's something which (2.66) is difficult to put a stop to. There would have to be a complete ban or something. Or people shouldn't order so much food so there isn't so much on the ward. It's hard to control and keep a check on it. I think it's just not fair, we've often talked about it. And unfair towards the other staff in the hospital who have to buy their food in the cafeteria. But well, they say "Ms. Sterne the food is left over and it'll get thrown away anyway." These are the arguments you hear, but it also has to do with the fact that too much food gets ordered. If everything got planned better, if the kitchen could be informed more quickly about which patients were being discharged then there wouldn't be so much left over. And I do mention that. Once when I was on the gynaecology ward there were I don't know how many meals left over. And so then I said "You can't do that. You have to phone the kitchen in the morning. If it's two or three meals, OK. But all that other food that's lying about. That's all money being wasted." .hhh hhh.
>
> Maggie: I just read the other day that food accounts for two per cent of the [hospitals'] total costs. And the point is that ordered meals don't get cancelled and that three extra meals are always ordered anyway in case there're any admissions. They're always ordered and if a new patient comes along just before 12 p.m. then another meal gets ordered for them on top of that. So there are always three meals left over, staff know that. And if nothing gets left over then the nurses phone other wards. Because they know after all that stuff gets left over on the other wards too. So they go to other wards, collecting food round the whole hospital.
>
> Ms. Sterne: Mhm, mhm, mhm. Yes, yes. [Ms Sterne stops talking about the subject as such] Yes and another thing that's important for me uh is taking little problems seriously. (...)

The unofficial use of hospital food was also recognised by Mr. Fawkes. His views were similar to those of Ms. Sterne:

> Maggie: Does it annoy you for example too if the employees eat the left over meals? Or if they're sitting having coffee?
>
> Mr. Fawkes: Actually less so. Actually less so. I've stopped stalking through the hospital like a sheriff - that is to say, I never did anyway. People know the rules and they're all old enough and adult enough to keep them. And in all the hospitals in the world staff eat [left over meals] because it's hard to understand that an untouched meal gets sent back to the kitchen to land in the slop buckets [for the pigs]. So (2.44) hhh. that's accepted here. (2.16) But it's definitely another matter

if instead of 35 meals 40 get ordered all of a sudden. But usually it's a matter of two meals for admissions. Sometimes more.

Maggie: It's more!

Mr. Fawkes: Ye::s. but it differs from ward to ward. There are differences.

Maggie: As far as I saw on ward 6 there were always three extra meals and as soon as a new patient was admitted they phoned the kitchen and ordered another meal.

Mr. Fawkes: Yes, they phone again.

Maggie: Least meals get eaten on ward 6 and even there there's five or six meals left over. Urological and surgical wards have most, when patients get operated on and that can mean 6 - 8 meals at lunch time and 10 - 12 meals in the evening.

Mr. Fawkes: Mhm, mhm. That's something I've been meaning to do something about anyway. Away from [name of the ordering system], introducing a new one. There's a new system in Switzerland where everything gets ordered by scanner.

Maggie: You mean the order is fed into a little portable computer and sent on-line into the kitchen]

Mr. Fawkes: [Ye::s, so you can send it directly on-line to the kitchen. I'm planning on doing something about that in 1998. There's a lot wrong with the way things are just now because the system's so sluggish.

What becomes obvious from both accounts is that there were widespread examples of hospital food being 'taken for personal ends' by nurses with the knowledge of their superiors (Dalton, 1961, p. 194). While Ms. Sterne sees the individual actions of people as deliberate attempts to abuse the hospital's resources, Mr. Fawkes believes in 'formalised, organised acts' which are initiated by instrumental reasons and occur systematically over a long period of time (Kondo, 1990, p. 219). The hospital's food was also perceived as being obtained by the nurses with a degree of moral confidence, due to the amount which could go to waste, and the open ordering system. This becomes clear as both interviewees rationalise this popular and complex usage of hospital food in their understanding, and the strategy of 'internal theft' is justified through the statements that scraps from leftovers have to be avoided and an IT-dependent ordering system should be introduced (Dalton, 1961, p. 196). This argument supports Scott's view (1985) that these 'everyday forms of resistance' were intuitively recognised since everyone knew of the Christian virtues and ecological values to feel grateful for anything that provides spiritual, mental and physical nourishment and causes minimal damage to the environment (p. 32). Faced

with the shortage of skilled nursing personnel in the early 1990s, however, the deputy CNE officially protested, but usually looked the other way for fear the nurses were going to change their employer again. The typical internal use of material is also suggested by the defence of Jo-care's CNE who allegedly says that 'in all the hospitals in the world staff eat [left over meals]' and this statement illustrates his 'apparent knowledge of the thefts and reluctance to intervene' (Dalton, 1961, p. 203). Despite the advantages of imposing rigorous controls on the organisational circumstances, the CNE and his deputy in Jo-care chose not to do so.

The volume of materials lost was not exactly known by cost analysts in Jo-care and they explained that the consumed hospital food was not more evident within the budget than it was many years ago when the hospital was larger, the length of days for patients longer, and most of the clinical nurses Sisters of Mercy. In this sense they understood that a discreet theft of hospital food was acceptable as long as it does not become apparent. What was at first a reward in return to the work of the Sisters of Mercy, however, grew in the course of time into an accepted standard of moral and legal behaviour which the secular nurses in turn allocated judiciously as an 'unofficial reward' to themselves (Dalton, 1961, p. 201). For example, Vivienne, a pool nurse, remarks that "everyone hopes that meals get left over because, quite simply, everyone's hungry. And at that time there's no official break. Although everyone takes one". In one way, as Scott's (1985) argues such a behaviour represents a form of 'individual self-help' and Jo-care's people attempt to conceal it (p. xvii). On the other hand, however, one could also say that Jo-care's nurses eat several thousand Deutsche Marks' [a couple of thousand Euros'] worth of food and even misuse valuable hospital time to feed themselves.

As I grew to become more of a participant in these relationships rather than an observer, the nurses on the ward floor asked me to take part in many of these eating gatherings. At the beginning of my field research I rejected all such invitations but the concern shown for my health and welfare occasionally elicited feelings of participation. In other words the situation culminated one day when I received a food

tray from one of the charge nurses on the ward and started to eat quite simply because I could not entirely ignore the fact that I was hungry. Thus, my full participation in this day-to-day practice was a necessary step in the process of understanding, but similar to the matters of interest addressed by the research of Kondo (1990) my active involvement produced a threat to my research as well as to the self. This means that even though some forms of collective practices of misbehaviour were evident in the day-to-day practice, the personal use of materials and services was officially forbidden in Jo-care.

Savings that have occurred in Jo-care in recent years, however, can be regarded as the outcome of people's openness to critical evaluation. For the most part, they have helped this hospital enterprise to grow through the provision of an excellent health care service to patients and continuous cost improvements. Careful monitoring and cost control became an important feature and Jo-care's nurses pay attention to how much health care machinery, material, examinations and tests are used. For the majority of them, the need to decrease and control costs became a primary objective and the hospital's CEOs regularly remark that Jo-care's savings are the sum of individual contributions. This means there has been a freedom of choice to become more efficient, effective and responsive, and team projects have entailed site visits, empirical investigations, and interviews with for-profit service organisations. The rhetoric of holding people responsible appears to have tied their interests to this health care organisation but Jo-care's labour force could also be seen as an 'active subject' (Thompson and Findlay, 1999, p. 173). This movement arose in less than five years in response to Jo-care's general disorientation in the early 1990s. Inspired by the philosophy pertaining to this hospital setting, to give the very best service to their patient clientele, Jo-care's nurses participated extensively in ethical and organisational developments.

Public Relations and the Marketing of Services

In addition to service-orientation, the growth of knowledge and people's cost consciousness, the notion of public relations (PR) became an important component of

Jo-care's cultural rhetoric. This concept includes the essence of Jo-care and is promoted by evocations of its Christian name, its ethos and its values, norms and attitudes. The press frequently describes Jo-care as belonging to the category of high quality and/or service-oriented hospitals and contrasts it with others who do not emphasise that kind of business. Indeed, Jo-care presents 'a carefully designed set of images' of its health care services and of its employees (Casey, 1995, p. 109). Not only does the hospital display its Christian values, it also displays the quality of its sophisticated services and economic success. That is to say, the knowledge and skills of Jo-care's employees, as well as their dedication to good quality service, are regularly presented to the outside world. The image is one which is at the heart of Jo-care's philosophy and which also exhibits the importance of Jo-care's strong co-operative beliefs:

> We are representatives of the hospital and present a positive image in public. We present values, characteristic tasks and achievements both inside and outside the hospital. The most important aspect of our work is our approach and attitude towards the sick, their relatives and fellow fe-/male employees. Co-operation with people, institutions and media connected with the hospital is friendly and constructive. Continual improvement of quality is the yardstick for our daily work.

Central to Jo-care's image is the pursuit of service-orientation towards people and people's needs in which exceptional health care is given as much significance as the hospital's exceptional employees themselves. In the past, Jo-care merely competed with religious and professional values in health care but now it presents itself with on-time services, frequent medical rounds, semi-private rooms, nourishing cuisine, better health care, faster treatments, shorter length of stay and greater effectivity. Here, the hospital offers a concept of service orientation which promises the greatest amount of service effort in the shortest period of time within an environment designed to satisfy the patient's expectations. However, the hospital's brochure raises expectations of its services because the picture of a patient room promises space, modern beds, and private health care, seldom available to the ordinary patient. Regardless of this, the hospital gains considerable prestige through these press campaigns because the enthusiasm of Jo-care's people and the presentation of their results stimulate external interest. This means the ideas of public relations are not

merely applied in terms of various services but in terms of service results produced for Jo-care's clientele (Heskett *et al.*, 1990). To this end, Jo-care describes itself as a progressive Roman Catholic hospital in which managers and employees alike are committed to 'a path of on-going learning' in the pursuit of an ever-better health care service (Casey, 1995, p. 109). Commenting on the various ways in which the hospital presents itself to the public, the CNE reflects upon Jo-care's recent achievements:

> Mr. Fawkes: (...) Or, one of the most recent projects, which was very time-consuming. I already mentioned to start with that I've got to find the way back to the staff. [The last project was] for instance organising March 19th - completion of all the renovation, production of the documentation brochure, organisation of the whole celebration, including honorary people and guests. There were 250 people invited. And then the organisation of the Spring Party in the evening. Above all, though, the brochure and the invitations - everything to do with organising. Dealing with all that was a huge amount of work.
>
> Maggie: Wouldn't that actually be the job of Mr. [name of the CEA] that is as far as he was there?
>
> Mr. Fawkes: Usually, usually hhh. I could imagine that it could be one of a CEA's tasks. (...) I'd like to go back to the point of public relations. For instance just recently we organised something else. A newspaper supplement, twelve pages, to appear in the [name of local newspaper] on 31.05.97. All aspects of the hospital are presented and I took over the co-ordinating role. That is, I arranged appointments, accompanied photographers in various parts of the hospital, went (through the hospital with journalists). These are things which basically someone from the administrative side of things could do too.
>
> Maggie: Mhm, mhm. That makes me think of the TV story about the girl doing a practical.
>
> Mr. Fawkes: Yes, that report done by [name of local TV station] about the school leavers' voluntary year doing social work. That was a really good report, by the way. Did you see it? I liked the 2.5 minute report. And then that panel discussion. For instance about out-patient [short-stay] surgery. It was presented by Ms. [female name] from the health academy in [name of town]. And Mr. [male name] the under secretary was there because he was the patron and he gave a welcoming speech. These are all things we help organise, play a decisive role in and which we attract to our hospital. (5.04) The last big project which was in the newspapers was the social services network.
>
> Maggie: You mean the social service for transitional nursing care?
>
> Mr. Fawkes: Yes. The social service for transitional nursing care. We really did a lot of work on publicity for that.

Even more than at any other time, Jo-care's executives attempt to manage the media and they do their best to create a favourable and up-to-date impression in the mind of the public. Of course, they do not exactly hide critical news, even though they gloss over it sometimes but, as Kanter (1985) suggests, they try to send out the 'information broadcasts in advance of the grapevine' so that the public hears the hospital's version first (p. 236). Altogether, Jo-care's executives are no longer beginners at some of these games and the employees seem to know that representing the image of Jo-care occurs concurrently with representing its health care services. In this way, like in Casey's view (1995), the employees' knowledge may have become 'a new avenue for identification' with the hospital and to control this process is as important as the quality of Jo-care's health care services (p. 110). Of course, it takes a certain amount of art and effort, and perhaps some luck to mount successful PR techniques which attract public attention and hold an audience (Law, 1994). In consequence, the hospital became an attractive place for nurses, medical doctors and other employees, and altogether they make it successful by their representation. In this sense, Jo-care is known publicly not only for its medical and nursing accomplishments but also for having developed a 'strong' professional culture which makes these accomplishments possible. That is, Jo-care's culture represents a decentralised, consensual organisation which favours the collective exercise of responsibility over individualism. That was essentially the message and a huge amount of effort was put into presenting it.

Conclusion

A range of research material has been presented in this chapter to show how Jo-care's image is employed as a shared expression for people in their day-to-day activities in this hospital organisation. Jo-care advertises its organisational culture during face-to-face contacts with patients, visiting relatives and others on an everyday basis. Culture is therefore a major reference point for Jo-care and the four sections in this chapter have specified what might be meant by it. That is, the chapter considered various conditions which Jo-care's people might fulfil if they are to succeed in meeting the criteria of their newly created culture. How, then, can the rise and

expansion of Jo-care's cultural rhetoric be understood? To answer this question several organisational practices are taken into account in the following chapter.

Chapter Eight

The Complexity of and the Response to the managerial Rhetoric I

Introduction

This chapter, and the one which follows it, are concerned with the creative content and purpose of Jo-care's managerial rhetoric; its guidelines, cultural projects and organisational practices to manage this hospital setting. This entails an explication of the various participatory and skill-enhancing schemes and of how Jo-care's nurses experienced and responded to these influential concepts during their day-to-day practice. Such an aim seeks to fracture the appearance of traditional and common sense images at work and it will be shown that various systematic interventions were of significant importance in Jo-care's cultural life.

For its theoretical inspiration, this thesis draws upon the work of labour process analysts, in particular their conception of the study of organisation and work in the state sector, as it links specific managerial efforts to the wider social and organisational context and the predispositions and power resources of people inside and outside the labour process. This conceptual framework has been used to provide a means of critical realist analysis of the rational and symbolic mechanisms that operate in the day-to-day practice of this hospital organisation. While there is a sense that various cultural schemes were introduced into the hospital, contradictory attitudes and behaviours were simultaneously generated by Jo-care's rhetoric and the reality of day-to-day practice.

The Programme of General Change

The hospital called Jo-care has long had a tradition of corporate Christianity and has been associated with a homogenous, largely professional workforce who believed in some kind of moral purpose and vocational obligations. In the mid 1980s, long-term social and economic changes were beginning to displace the existing interrelations between work and religious and/or professional life, and the hospital found it more difficult to maintain traditional forms of management and co-ordination. That is, the

hospital's operation became 'more complex, large scale and dispersed over wider boundaries', as described by Thompson and Findlay (1999, p. 171). It was at this time the conventional hospital structure was first replaced and this improved the status of the CNE by establishing his/her position within the tripartite management board. These structural changes had helped to establish the self-assurance of Jo-care's nursing staff whose influence on decision-making was growing. But, the presence of a variety of professions on the hospital board led to functional differentiation and posed problems for Jo-care's management. From that point of view the directorate's capacity to provide clear and shared views was inadequate to provide an informed managerial decision-making process, and their short-term responses to organisational and economic challenges were not always consistent with the hospital authority's view and that of Jo-care's employees.

By 1992, the hospital authority had introduced a series of organisational reforms in key parts of Jo-care's management and external consultants were brought in to run the hospital as a business organisation. This was a very complex process: First, the reorganisation produced an organisational structure in which the three sections within the directorate reported directly to the CEOs, and the Department of General, Further and Post-registration Education became accountable to the tripartite management board. Additionally, a couple of ecclesiastical and administrative people left, but those who remained and those who came on board have been firmly in control since then. Not everyone was able to help in the redesigning of Jo-care, and even those who did participate quite often did not always fully appreciate what the hospital renewal would require. That is, some people were enthusiastic, others were neutral or even antagonistic.

The development of chief executive management was the initial attempt by Jo-care's authority to undertake a general change programme even though there was a preservation of key relationships, and particular relations of authority. This means the new structural apparatus did not significantly evolve because it was built upon an extension of the chief executive position. What is impressive about change in Jo-

care is, therefore, not that the formal hierarchy has changed, for in many respects this remains much the same, but the 'extensive development of executive powers' of managing directors over expenditure and decisions with social and practical implications, as observed by Ackroyd's research (1997) of the NHS hospital service (p. 4). That is, there was the introduction of 'a secular influence over forms and spheres of activity' which previously were organised by the ecclesiastical hospital authority and/or locally, within the hospital community as described by Alvesson and Willmott (1996, p. 9). As one of the staff nurses has put it:

> Maggie: Who's got most say in the hospital?
>
> Paula: Hhhh. [more a groaning] Actually, the chief executive management. Yes, I think so. Uhm (2.03) I think every thing that happens here in the hospital gets done like they want it. Even if it's not obvious. (...)

A charge nurses says it similarly:

> Maggie: Who contributed most input and who has most say in the hospital?
>
> Ina: Well, the chief executive management. You mean here in OUR hospital?
>
> Maggie: Yes, yes we're talking about Jo-care.]
>
> Ina: [Yes, it's the chief executive management who has the biggest say in things.

What is important is not that the overall appearance of the organisational structure has changed, but that the new structural order on the inside of this hospital organisation has been modified. Thus, the appointment of Mr. Tate and his partners as the chief executives was the driving force in the overall change programme that took place in Jo-care. At the same time, their status as human subjects suggests that Jo-care's CEOs experience similar control conditions more characteristic of waged labour. Of course, they have been given the universal function to execute the highly divisional labour process of this hospital setting, but, what is widely assumed to be an autonomous function of control can be understood, from a Bravermanian perspective (1974), to be founded upon a subordinate employee category. Here, the logic is based upon a '*structurally unequal relationship*' because, when traded as commodities, corporate managers are in the same way sellers of their own labour as

the ordinary wage labourer (Willmott, 1997, p. 1332). According to Braverman (1974) executive managers are part of the labour process and therefore share 'the subjugation and oppression that characterises the lives of the productive workers' (p. 418). Such an argument is echoed by Willmott (1997) who recognises that "[t]hey have only the scarcity of their skills and/or their capacity to combine with other employees to use as a lever to raise their living standards or to improve working conditions and prospects" (p. 1332). These statements support Mulholland's (1998) research findings on management and careers:

> The dilemma for each stratum of management is that there may be a conflict of interest between themselves and corporate management, which arises from their function as contenders for the role of global agents versus their interests as another employee group. At the same time, their status as employees suggests they endure some of the alienating employment conditions characteristic of waged labour (p. 185).

Consistent with this theme, writers such as Thompson and Findlay (1999), Willmott (1997), Thompson and McHugh (1995), Smith and Willmott (1991), Armstrong (1989, 1991), in following Braverman's view (1974), focus on the aspects of managerial subjectivity and control. Managerial subjectivity assumes that managers are subject to the rigours of a governing authority whereas control tends to emphasise the core feature of the managerial function. The object of these aforementioned concepts offers attractive insights, but the problem with that point of view is still that managers' primary responsibility is to manage employees and to behave in ways that are consistent with the ideological and/or capital's interest. Willmott (1997) has described this managerial condition as 'socially, economically and organisationally distanced' from wage labourers because managers are employed to undertake the function of planning and supervision by organising labour processes and controlling the workforce in ways that are deemed to be congruent with the priorities of the employing organisation (p. 1345).

From this standpoint, it would be implausible to claim that Jo-care's CEOs occupy independent positions, however, and for the vast majority of those working in this hospital, such aspirations were not shared or remained unrealised. Even people who

knew the details of Jo-care's recent history were not aware of the CEOs' dispositions and their managerial agenda. Commenting on her experiences, one staff nurse explains what she thinks about Jo-care's CEOs and their hospital-wide change programmes:

> Maggie: And when you think back over your four years in Jo-care, then well you've experienced all the restructuring and re-organising, haven't you? What do you feel about that? Do you like the way things are or not?
>
> Fergie: Well I'm of the opinion that we really can be satisfied with the way things are at the moment. Because when I compare Jo-care with other hospitals then we really are in a good position. Whether it's the pay or anything else. People moan everywhere and you have to complain now and again, otherwise the bosses would have no idea there was anything wrong. But on the whole we're really well off. If I compare things with [name of another hospital in which the consultancy company is in charge of] where my father works and that I know a lot about and hear a lot about because of that. My father says for example that they stop at nothing. (...)]
>
> Maggie: [You mean the CEOs working for these hospitals?
>
> Fergie: I think to begin with things in Jo-care were similar to those in this other hospital. Except that my father has always kept me posted about what's been going on there right from the start. This other hospital was meant to be closed down and the employees signed a petition in protest. And my father always says that they'll stop at nothing. The things that they've cut back on and put an end to - you wouldn't believe it, unreal. A beginning like that - well for instance I didn't experience that in Jo-care. When I started work in Jo-care the situation was already good. I'm in a good team on a good ward. But a few rough edges of mine had to be smoothed down - quite a few, actually. [laughter] (...)

Such claims can certainly not be supported by observation within this research but this staff nurse is suggesting that there are similarities between Jo-care and the other hospital of which the same consultancy company is in charge. While there is much that can be said about this critique, there is also the fact that this staff nurse herself welcomes the programmatic change and perceives positive benefits from Jo-care's managerial innovations; e.g. job satisfaction from the reward and support system. Even though there are some ambivalent comments about the effects of Jo-care's reorganisation in Fergie's account, the advantages they bring about are commonly admitted and generously acknowledged.

Such a view was reflected by many people who had experiences with the traditional management approach as well as with the new managerial initiatives. Similar to the

findings reported in Anthony and Reed's study (1990) people showed a range of attitudes towards Jo-care's managerial rhetoric from 'the positive to a guarded, critical acceptance and, at the extreme, a hostile withdrawal' (p. 24). What was interesting to observe was that most of them did not want to return to the old days and clearly preferred the new corporate programmes, even though the majority of them were cynical and critical of it in some respects. As Jo-care's CNE explains:

> Mr. Fawkes: Uh comparing everything with the 1991 situation - at that time there was a staff turnover of about 60 per cent in the hospital - and there was a really miserable atmosphere in the hospital. The whole thing was destructive and there was no feeling of co-operation there at all - neither within your own profession nor towards other staff in the hospital. And uh to be honest I do have to say that during the last few years one of our main priorities was personnel management. So there'd be uh uh a better atmosphere and more co-operation here. And uh all that was incredibly time-consuming. And you had to be there on the spot a lot - be present, uh to yes]
>
> Maggie: [to pass on values?

On this basis, Jo-care's people were induced, inflamed, assuaged and manipulated to set aside the traditional conflicts of inter-professional relations in favour of 'co-operation to advance shared interest in greater competitiveness and an enhanced quality of working life' as emphasised in Milkman's review (1998) of the American workplace (p. 26). Within this trend, optimistic expressions of the development of Jo-care have been apparent but these have focused upon the quality, economy and publicity of its health care services rather than on the content and purpose of the managerial rhetoric, to which I now turn.

The Programme of Operational Change

One concept supporting the generalised change programme was the increased emphasis on service orientation within a particular organisational workflow. One constant theme was related to the patient-oriented day-to-day programme (POT) for Jo-care's clientele which co-ordinates, intelligently, the work of various and different organisational groups. As previously mentioned on page 192, this popular conception of the hospital's day-to-day process has led to far more attention than ever before being accorded to 'caring for the carers' (Pollitt, 1993, p. 69). However, this

service-oriented movement did not occur spontaneously but was itself constructed by Jo-care's people; i.e. as suggested in the research of Beer *et al.* (1990) it started at 'the periphery and moved steadily towards the corporate core' (p. 159). This programme has a clear strategic purpose in the delivery of health care and penetrated deep into the core of the hospital organisation by fundamentally changing crucial elements of the labour process at work.

The creation of such a working arrangement was achieved by redesigning the service process of various professions into a multi-cellular and flow-oriented layout. The POT appears highly programmed and rigidly structured and, like a consistent schedule, it follows a similar pattern each day. From 6.00 a.m. to the end of the day at 9.00 p.m., virtually every minute is accounted for. Here, the organisational workflow was deliberately simplified and placed into a process chart which meant that the daily organisation became based around the patient clientele rather than functions. Another feature was to build quality into the health care process by establishing - with no human resource shortages - a perfect symmetry between the various functions. That is, the activities of Jo-care's people were thoroughly regulated and their contacts with others carefully evaluated. This physical framework acquired a standardised character and the occupational groups were synchronised on a schedule which, in effect, aims to decrease inter-professional tensions and to be responsive to a patient's needs. That is to say, that the POT works not by directing people's activities, but instead by setting new parameters and time limits within which they must undertake their supposedly autonomous activities. In this respect, there was no attempt to redesign the occupational self-organisation of Jo-care's nursing and medical service and/or to affect the contemporary organisation of nursing and medical work. Much of the day-to-day organisation of their work was left intact which means that Jo-care's nursing and medical profession still retain authority over their own work. For a nursing example see Appendix Five.

Even though the POT has not brought about significant changes of organising nursing work, it has nonetheless gradually influenced several parameters of nurses'

work. One of the main advantages identified by a number of people is the predictability of the organisational process, particularly for those working at the front-line in Jo-care's day-to-day practice. Another convenience is the fact that the pace of work can be varied, which means being able to ensure quality and consistency according to patients' needs. For example, the hand-over at the end of each shift is typically employed to review the shift's problems and to suggest remedial actions.

There were also a few indications that something was being done to advance efficiency and labour productivity by streamlining and rationalising Jo-care's day-to-day operation, and more than one person said that there was an elimination of extreme workloads and/or leeway from the conventional day at work. All this created a flow-line work operation and enforced appropriate behaviours as well as practices. As in the systems known as *Just-in-Time* and *Total Quality Control*, the main element is one of continuous improvement and each person is encouraged to take part in it (Sewell and Wilkinson, 1992a-b). All these managerial initiatives operate on an everyday, ever-present level, and as organisational arrangements they improve existing conditions and solve organisational problems of the labour process at work. Commenting on the extent of how the POT is being practised, the CNE explains:

> Mr. Fawkes: (...) [I]n any case you have to differentiate, depending on whether it's a long-term [or short-term] patient. The longer a patient is in hospital, the more patient-oriented the day-to-day practice becomes. And if a new patient comes into hospital then of course s/he enters that. And I think that's fine and it's in the patient's interest. For instance if I have to go into hospital as a patient for a groin hernia operation. On my first day I don't bother about having a rest from 12 p.m. to 2 p.m., because basically the preparations for the operation are uppermost [in my mind]. But I notice the POT as soon as I've been operated on and if I've to stay in hospital for a while. Then it becomes more obvious.

As previously mentioned on page 208, the satisfaction of patients' needs and expectations is an important area of concern and several other quality initiatives were started to improve the day-to-day practice; e.g. a patient management service centre, a social service for transitional nursing care, etc. All these initiatives required some

level of participation and aimed at a functional utilisation of human resources. In this context, the emergence of different concepts and detailed practices has lead to a collective framework for the reconfiguration of the context of day-to-day work. This central aspect is directly connected to the service process by which quality care is delivered to Jo-care's clientele. Subsequently, however, the deployment of the POT, and maintaining the patient orientation as it was originally planned, became increasingly difficult. Here, is an interview extract showing the perceptions and perspectives of the CNE:

> Mr. Fawkes: (...) It also became totally clear to me that our staff stick 100 per cent to putting what we agreed on into practice. I don't know if that's a characteristic particular to nursing. But I'd like to add to that that if agreements such as the POT are put into practice to a degree of 80 per cent or even only 75 per cent then basically speaking for an organisation this size it's a gigantic success. But to get back to your question, about what the POT is like now. Well, I think we're between 60 per cent and 70 per cent. And that's the extent of how the [POT] is being practised. (...)

One ward sister makes similar claims and adds some other factors as she refers to the POT in an interview with me:

> Ruby: Maintaining the patient-centred day-to-day practice is becoming MORE AND MORE difficult. That is to say really showing interest and consideration for a patient's needs. Uh we're also meant to keep up the same standard. Before we used to have only one or two discharges per day and accordingly only one or two admissions. And now it's up to almost three or four a day. It can't be helped. YES and then we have one staff equivalent less than last year. Uh. under conditions like that you can't carry out patient-centred day-to-day practice, no way. Impossible, because I have one full-time nurse less and more work. There's only one solution - I have a think at regular intervals about the traditional things we still do uh. (2.69) and whether they're still necessary. (4.00) So you wonder about why you actually still do some things. Or someone comes along from another hospital and asks why we don't do things another way. There are things you just don't notice yourself. But I often wonder how things manage to get done at all. [tentative laughter]

As these statements suggest, there is a contradiction at the heart of this POT because it was the very uncertainty that inevitably accompanies the human element which drove Jo-care's senior management to try and '*standardise* the [inter-professional] encounter as a means of ensuring 'quality' or at least consistency' as described by Warhust and Thompson's critical considerations (1998a, p. 5). In spite of the

accountability and professional autonomy of the people at the bedside, the front-liners were faced with the emergence of a routine, with set tasks taking place at pre-ordained points throughout the day. That is, the desired instrumental stability of the organisational process involves control patterns which have as their principle an objective reality and a rational design. Like a traditional electric clock system, the POT was constructed to minimise 'any irregularity in time keeping' and to assure employment of labour in different parts of the institution as reflected by Vogel's (1980) historical analysis (p. 44). As one final year nursing student remarks:

> Ian: (...) well I don't understand why you have to finish the administrative work connected with the medical round [by the time the late shift starts at 1.10 p.m.]. That (annoys) me because if the round was, well, complicated and there were admissions too you should (actually rather be looking after the new patients). I thought that today when I got a new patient with heart trouble, I should have taken his blood pressure and pulse right away. But at the same time I was also meant to be doing the administration after the medical round. So I sat at the desk finishing that off. Only then did I go to the new patient to check his vital signs. And I really thought, wouldn't it be more sensible to take care of the patient first, because most of the admissions come in the morning anyway. The wards empty and fill up again during the morning, that's my experience at least. And that means you're doing all that administration work after the medical round while patients are being discharged or admitted and needing attention. In the afternoon usually all that work has been done by the early shift and if not, usually someone complains. In any case it's very unusual if in the afternoon there's still a signal tab visible [in the kardex].
>
> Maggie: So this isn't just the case on this ward but this is what happens generally in Jo-care.]
>
> Ian: [Generally speaking, yes. That's really one thing which isn't all that important. (...) Well, everything [the whole work process in Jo-care] is in such a rut that if you want to change anything (1.31) then it's just impossible. (...) You're not even allowed to finish what you're doing, but as soon as the food's there you have to get up and abandon everything. Even if you've just been doing something for a patient. Like if you're doing a dressing just before the food is handed out or while it's being handed out then that's bad. You know, in the sense of "he's finishing his job and we've to hand out the food on our own". So that's really true, food governs the daily routine.

There was considerable evidence that this form of regulation can control the way in which nurses work in Jo-care's day-to-day practice and the POT was, in fact, created to continue and extend the control revolution brought about by Weber (1946, 1947, 1982) as reviewed in Ackroyd and Bolton's comments (1999) on Pollitt's neo-Taylorist analysis (1993) (p. 372). The close relationships can be found in the CEOs

responsibility for the control and co-ordination of the hospital's multi-professional structure and context. Like *Just-in-Time*, *Total Quality Management* or *Business Process Re-engineering*, the POT depends on a systematic act of organising which represents an intelligent organisation of the day-to-day work context and the perfect co-ordination of different occupational groups. Thus, if the deployment of the POT were working as originally planned, it would extend the established mechanisms of control. In this sense, the control of the labour process cannot be said to be total because Jo-care's people are able to escape from managerial demands through the 'technical complexity' of health care labour and the uncertainty that occurs in the everyday hospital practice (Dent, 1998, p. 218). This finding supports Ackroyd's research (1997) on health care labour and quality management in the new public service sector. Commenting on the arrangement of his tasks and jobs a final year nursing student explains:

> Ian: (...) I don't know, maybe I'm a bit peculiar or funny. But I arrange all my tasks and jobs according to how important they are, no matter what kind of job it is. Well, according to how important a job is for [the patient's] survival, even if that does sound a bit over the top. So s/he [the patient] can't just go and die on me and so with that in mind I organise my work. When I look through the patient's documentation [kardex] in the morning I set my priorities. For instance if I see that several of the patients allocated to me need Insulin injections then I think about which things are absolutely top priority and don't do things in the usual order. I mean, washing a patient is only important in my eyes as far as there's nothing else more urgent to be taken care of.
>
> And doing things in that kind of order is not the way people work on the wards and it seems to me that it's almost impossible to change. I think if everyone set real priorities in their work then the nursing care practice [here in Jo-care] would be quite different. No problems. I always think how I can't scrub my back myself either unless I use a brush. (1.88) And, well, no-one's ever died because of not being washed , or because they didn't get washed till the afternoon. Of course it's not very nice and, naturally, not very patient-oriented, because the patients also have their own priorities and ideas about what's important for them personally. Maybe an injection is annoying for a patient, while cleaning his/her teeth is much more important to him/her. But (2.03) I personally work according to the priorities I set and (...) whatever I don't manage I have to leave undone. One [colleague] says I just don't want to overwork myself. But why should I if my colleagues on late shift can finish things in peace and quiet.

The POT was seen by the researcher to be well embedded in this hospital organisation and perceived as such by all organisational members in nursing. The indicators for this were the understanding of what the POT wants to achieve and

people's ability to relate to these pragmatic aims to organise themselves and to exercise discretion. Similar to the findings reported in the study of Ackroyd and Bolton (1999) which highlights mechanisms of work intensification in a NHS hospital, the POT appeared to be successful. This was because it was kept simple and clear and operated with the goal of an increase in patient numbers and an improvement in service quality, rather than attempting to re-design the work of nurses, to set direct controls on output, or quantifying performance in the manner that 'scientific management' has deemed necessary (p. 382). However, people's comments as to their work experiences were mixed. Overall there was a sense that working conditions had become more stressful and intense, although this was experienced differentially. One of the staff nurses, for example, clearly indicates that she is not pleased with the operational changes at work:

> Maggie: Let's get back to what you said about things "going back". Well the POT was set up, and central services brought about. This means that nursing staff have more time to spend on patients instead of having to do a lot of non-nursing tasks. Roughly speaking. Except for taking blood samples for blood sugar testing - there's been (quite a bit of progress.) So where do you see things regressing?
>
> Sally: (3.97) From the point of view of quality, because you always have so much to do. So if things go on being as intensive as they've been the last six months then there will be quite a drop in quality. At some point you ask yourself - when you're mobilising a patient - why are you doing this because you have so little time as it is. New patients come continually and others are discharged. But at some point the patient loses out and quality suffers. (...) I'm not sure they [senior management] really want to change that. I've heard they do <u>want</u> to change things. Someone's meant to have said that there won't be any more beds on the corridor. But of course now and again there are. (...)

Another staff nurse says it similarly:

> Maggie: If you think of nursing practice, what would you say still remains of the POT?
>
> Vivienne: Well. OK. Examinations now also take place during lunch time like before. [tentative laughter] It just happens that a patient gets summoned at lunch time or that the medical round takes place then. All that's happening again. Otherwise...
>
> Maggie: What about undisturbed periods of time devoted to nursing care?
>
> Vivienne: They're not undisturbed any more either, because plastic surgery patients are admitted in between times and patients have to be taken to theatre at 7.30 - 7.45 a.m. As I said, it depends on the ward. =

> Maggie: = Between 7.30 and 7.45? I always thought they didn't start operating till 8.30 a.m.
>
> Vivienne: No::, the patients have to be in theatre then because they start operating at 8 a.m. So you're really kept running. But these aren't the only patients you've got to take care of. There's always loads of work.

Both nurses explain that the conditions at work have become more stressful and intense rather than satisfying, as the POT advocates would have them believe. While Vivienne may perform some work quicker to cope with what was a collective shared work experience, Sally explains that having 'so much to do' will result in a reduction of quality which means that 'at some point the patient loses out'. Paradoxically, the POT was created to avoid precisely such a drop in quality and/or decrease in Jo-care's services. Thus, both comments reveal the contradictions and tensions between the rhetorical claim to deliver better quality service and the real experiences of Jo-care's people. It is here then that the rhetoric of Jo-care's POT falls short, and is contradicted in practice. Developing a similar argument Knights and McCabe (1998b) describe the experiences of *Probank's staff* under a business process re-engineering work regime:

> This brief selection from a case study on BPR suggests that it may lead to a more intensive rather than satisfying work experience which lends support to the fears of some critics. (...) The bulk of staff suggested that rather than a more enriched and satisfying working experience, work was often less enjoyable and was indeed more stressful (p. 184).

With the introduction of Jo-care's rhetoric, however, the emphasis on service orientation towards people has become a much more central issue than in the past. Even within a highly scripted hospital system, the skilled and knowledgeable employees have to be seen to be delivering good and individual nursing care to their patient clientele. This argument is in line with James' research results (1992) on emotional labour:

> No nurse would have felt happy about complaining that a patient wanted too much 'care', but it was legitimate to complain about an overload of physical tasks, or tasks inadequately carried out (p. 499).

However, another critical factor of this in-house approach is that despite its patient focus, it keeps the hospital costs per patient down by marked improvements of the organisational work flow. What is interesting about this concept is, with its emphasis on getting more patients through fewer beds at lower costs and improving the quality of health care, is that problematic issues of co-operation which may have needed appropriate improvements on an organisational level were not tracked down. By some measures, Jo-care's efficiency of service delivery has been improving throughout the 1990s: Firstly, the reported level of bed occupancy and length of stay for in-patients decreased from 92.44 to 88.74 per cent and from 10.68 to 8.6[1] days over the past five years while the number of in-patients increased from 9,597 to 11,429 between 1992 and 1996. In the same period there was also an increase of childbirth cases from 382 to 731. Secondly, the complexity of patient flow into and out of Jo-care, and between different parts of the hospital increased; i.e. changes in admitting practices are evidenced by the increase in out-patient care given to Jo-care's patient clientele. There was also an increase in in-patient discharges to nursing homes and community health care services. Thirdly, changes in staffing patterns have been reported as people cope with the degree of flexibility required. The result of all these figures is a very high level of activity in caring for patients at a higher level of acuity. Combined, these effects have led to a different interpretation of the work place even though the difficult notion of work intensification and rationing has been deliberately avoided. This echoes, for example, the hospital study on Business Process Re-engineering by Leverment, Ackers and Preston (1998) which suggests that

> this intensification of work **had not** occurred as a result of a downsizing or new technology initiative as is so often reportedly the case in re-engineering, but merely because of the reorganisation of the work process, together with problems inherent in today's health service - staffing difficulties, and ever expanding patient demand in terms of both resources and expectations (p. 134).

In short, the intention of creating the POT brought about wide-ranging organisational improvements in terms of quality and efficiency. Nonetheless, there was also the

[1] The length of stay for in-patients decreased nation-wide from 12.9 to less than 11 days over the last couple of years (Bundesministerium für Gesundheit, 1997a, 1997b).

idea that labour forces could be controlled through planning and execution mechanisms. In many ways the POT was a logical and realistic development which derived from the idea that the day-to-day operations of a hospital organisation could be planned, controlled and monitored. In this sense, the re-organisation of the hospital's work flow was not a result of more employee commitment and ever-expanding patient demands in terms of both resources and expectations, but much more instrumental and technical. In other words, the system caused complex effects on various facets but these were not dependent on the internalisation of new values from the managerial rhetoric.

The Initiative of Resource Allocation and Management Systems

The arrival of chief executive management in the early 1990s coincided with the introduction of a new accounting system and the use of advanced information technology. The concrete rationale behind this 'accounting entity'[2], as it is called by Horngren, Harrison and Robinson (1996), was to support the efforts of these executives and to provide pragmatic, immediate and technical information about the pace and direction of organisational change (p. 9). This quantitative practice was seen as an instrument of observing organisational processes and therefore new accounting principles entered Jo-care primarily as "a means of analysis - as a seemingly objective technique for monitoring costs or for measuring the impact of reform proposals" (Arnold and Oakes, 1995, p. 105). In essence, the accounting system collects data and permits comparisons of financial profiles for similar departments, variances in patient or service profiles over time, and mixed profiles to develop department-specific per diem rates, Procedure Fees and Diagnosis Related Groups for particular units and/or departments. As in other organisations, these procedures were regarded as neutral and technical, and there was a belief that the strategic change process could become more linear and rational if better information were available by enhancing managerial knowledge (Wilson, 1992).

[2] According to Horngren, Harrison and Robinson (1996) an accounting entity is 'an organisation or a section of an organisation that stands apart from other organisations and individuals as a separate economic unit' (p. 9).

In addition, the introduction of standard costing and financial planning was intended to operate within various departments of this hospital organisation and meant that principles and norms of what quality, effectivity and efficiency might mean had to be constructed. Here, an attempt was made to decentralise the financial operation of Jo-care's services and to involve the medical chiefs and departmental and ward managers. Their broader involvement was seen to be essential for the success of the whole initiative and it was in this context that attention was being paid to 'accounting boundaries' and departmental and/or ward performances (Arnold and Oakes, 1995, p. 108). Like in the critical research done by Broadbent, Laughlin and Read (1991) such a strategy was also regarded as an exercise to 'renew the involvement' of these people in the executive process of management and again this was dependent upon the existence of good cost-accounting data (p. 17). Thus, a suitable system with accurate and up-to-date information was relevant for managing resources in Jo-care's day-to-day practice and this 'resource management system', as named by Bloomfield, Coombs and Rea (1992), was also a prerequisite for the enrolment of managerial people (p. 1997).

The pattern of involvement on the part of these senior people overlapped with the aim to make managerial decision-making more visible to Jo-care's people, and on a regular basis accountancy values and/or statistical results were communicated as a portfolio for particular activities. Here, the emphasis was on creating a process of organisational transparency and the aggregated information was based on monthly details of expenditures and variances; e.g. bed occupancy, full-time equivalents, diagnostic and therapeutic activities, etc. The message is framed in a number of modes. For example, it is supported by the philosophy of this hospital organisation:

> Our decisions are transparent; we take fe-/male employees' objections seriously. By means of a regular/punctual and detailed flow of information we create an open, trusting atmosphere. We uphold agreements whether verbal or written. If agreements have to be changed we inform all those affected and make decisions together. In the case of a difference of opinion we try to understand the other point of view and attempt to find a solution together.

Commenting on one important aspect of his work, Jo-care's CEO explains:

> Mr. Tate: [Yes, yes. That's perhaps another important aspect of my work. I think that through our work here we've improved communication and the information flow vastly. And that's certainly a hu::ge part of my but also our work, passing on - transporting - information of all kinds.
>
> You know yourself, it starts with the monthly accounting figures, the regular meetings with heads of departments and wards. Passing on information there, making the decision making process as transparent as possible. That is also one of the CEO's tasks. One of the most important ones. Communicating in other words.

As these statements suggest, corporate and individual concerns were embedded in the day-to-day operation of a resource management system and the distribution of information throughout Jo-care. It was hoped that the available management information would enable Jo-care's people to understand the business of health care and to commit themselves to the corporate process, which was necessary if the desired change was to be achieved within this hospital organisation. As Peters and Waterman (1982) remark:

> Bringing the financial information down to the shop floor is a major step in bridging the gap between management and labour; more than any other single act, it makes the goal explicit and the nature of the partnership concrete (p. 267).

It was the new resource management system that was able to provide the necessary information and to enable the heads of departments and wards to become accountable for their budget allocations. In this way, the complex results generated by such a computer system provided good arguments for organisational change and most of Jo-care's people accepted their apparent certainty and rationality. The creation of such an acceptance was conveniently achieved by the continuity of what Miller and O'Leary (1987) termed a 'calculative apparatus' that is central to develop a cumulative information base (p. 254). Such a modern cost system does not, however, "reveal or objectively represent the world as it is, but rather, make visible a particular or partial view of activities" (Bloomfield *et al.*, 1992, p. 209). That is, the expansion of computerised information represented a significant shift in the provision of financial and human resource management because accounting 'constructs' rather than simply reflects Jo-care's reality (Arnold and Oakes, 1995, p. 105). In this context Zuboff (1988) remarks:

> Who does what and how well they [people] perform can be translated into "objective" data, along with hundreds of variables that describe the production process or other business functions. In many cases, this means that managers' subjective judgements and personal sources of influence lose some of their force, while the intellective skills required to competently address the electronic text become more important (pp. 355-6).

Such an electronic system does indeed allow Jo-care's managers to monitor, record and tabulate organisational processes, in addition to service or business-related processes, and by that means they are increasing control while apparently providing employees with information. Within such a framework, the managerial task can be associated with "the emergence of Fordism as a regime of accumulation and with the establishment of a new regulatory apparatus of co-ordination and control" as described in Webster and Robins' critical review (1993) of Sewell and Wilkinson's account of the 'panoptic gaze' (1992a, p. 247). It follows from this that Jo-care's information and communication technology depends upon regular acts of organising which can be interpreted as an essential component of organisational introspection and reflection. Alongside the central interests of the federal state, this does, of course, imply various forms of surveillance, information gathering and data management as imperatives for governing complex social structures (Foucault, 1979a; Rose and Miller, 1992). In relation to other studies where these themes are discussed (e.g. Hogett, 1996; Dent, 1996, 1991b-c, 1990), such an extension of established mechanisms of information control protects and preserves systematic principles which are integral components of any corporation and institution within modernity. Thus, the managerial imperative to move towards a greater regulation of affairs could be one of many explanations as to why this hospital can be regarded as an effective and efficient place for organising health care work.

Moreover, the managerial instrument of standard costing and financial planning brought about issues of accountability for various professions in Jo-care's day-to-day practice, where "clinical freedom has previously been used to ensure a primary responsibility to patient care rather than patient care with a limited amount of resources" as reflected in the critical analysis of Broadbent *et al.* (1991, p. 17). Of course, the planning of resources has always been an implicit aspect of the role of

directorial and/or clinically based people within Jo-care. Nonetheless, the introduction of financial and resource allocation has displaced their sphere of activities quite radically and challenged existing structures and power relationships. As Jo-care's CNE remarks:

> Mr. Fawkes: (...) The blockades, the barricades individual people in management had had - whether it was the upper management level or the middle level - they were all gone suddenly and they joined in and gave their support. Certainly also because uh individuals in management became involved in financial responsibility and when it comes down to it in the continuing existence of the hospital itself.
>
> So there was pressure there, wasn't there. Like "If you don't join in then the hospital deficit will grow. As a person on management level you have to make your contribution." So in that way a lot happened. And another thing that helped me a lot - and which consolidated my position bit by bit - was the fact that we were given quite a free hand. We were given a goal and freedom of action. We were given authority in all areas - contracting employees, budget accountability, yes uh and uh and we were able to grow, to develop within that framework just great. (...)

Here, Mr. Fawkes' account emphasises the advancement of organisational efficiency through the use of moral involvement, financial controls and resource targets which in turn created specific norms in a variety of ways. As in other organisations, responsibility and accountability were integrated into the job of various budget holders and the implanted norms provided 'the basis for observing deviations from expectations' (Miller and O'Leary, 1987, p. 252). Clearly, the emergence of this form of organisational decentralisation involves some elements of self-control and flexibility but the available information can be viewed as providing the potential to identify the inefficient use of material and/or human resources. As a consequence, Jo-care's senior people were able to retain operational control over their own work but they were no longer able to organise additional material or human resources as a result of their decisions alone. They had to execute their work dependent upon predetermined budgets and, as outlined by Dent (1998), this reconfiguration does not reflect "the success of the occupational groups' own strategies to gain control over the work and who is qualified to do it" (p. 207). It was in this sense that the medical chiefs and all the heads of other skill based occupations lost ground to Jo-care's CEOs over the control of their work environment. This is a form of workforce

management and budgetary control which had not been historically cultivated in Jo-care's day-to-day practice. In other words, the resource allocation have actually led to 'a fundamental loss of autonomy and status' for people in senior positions by giving them less latitude in their everyday practice (Dent, 1998, p. 205). For example, directorate members and departmental heads are required to anticipate their objectives and expenditures over a given period of time, which are then approved by Jo-care's CEOs, who then monitor and evaluate the targets set down in the plans. This view is sharply articulated in the following comment:

> Maggie: So a lot of tasks have to be taken care of by [name of CEA] or by members [of the directorate] =
>
> Mr. Tate: = by the directorate. The whole thing is structured so that the management board takes care of the day-to-day business, which in fact it does. And we [CEOs] only get involved in that - even if it's, personally speaking, difficult for me - if there's a special reason. And that can be something positive or negative. Um I also actually wanted to say that when I'm here 80 per cent of the problems which arise can't be solved by the directorate.
>
> Maggie: They [directorate] can't or don't want to =
>
> Mr. Tate: = I'll leave that unanswered for now.
>
> Maggie: Mhm.
>
> Mr. Tate: Can't be solved because of the people involved. Or because they [directorate] think they can't decide alone. You do have to ask yourself sometimes if you really do enough delegating. (1.91) I actually think I do. Here we've delegated quite a lot, but there are still structures left over from the church tradition which are simply out of date. They like to have a safety net, so to speak [not be responsible on their own for decisions] (2.22) And (1.59) well, when I'm here what we discuss most has to do with bigger problems which have arisen.
>
> Maggie: You offer solutions or advice? =
>
> Mr. Tate: = Mostly solutions and decisions.]
>
> Maggie: [Decisions. Aha. Mhm.
>
> Mr. Tate: Day-to-day business includes the task of creating and establishing overall structures so that aims and goals for the whole year can be set, the budget monitored and that (1.59) a certain degree of communication with the management level takes place during the appropriate meetings. (...)

Clearly, the implementation of these far-reaching principles can be regarded as being partly motivated by the nation state wishing to exert greater organisational control

and quality assurance[3] over medical doctors and health care services in general. As previously mentioned on page 219, an important reason behind this interest was that the expenditures on health care could systematically be controlled at an organisational level (Foucault, 1979a; Rose and Miller, 1992). However, these concrete governmental arrangements not only benefited the health insurance funds, the federal state of Germany and/or the representative state of Bavaria (i.e. the ministry of work and social order, family, women and health) but also CEOs of general hospitals as the 'purveyors of change programmes and efficiency drives' (Mulholland, 1998, p. 184). From the standpoint of Jo-care's executive management, the budget allocations (for general medicine, surgery and professional staff, for example) decentralised some resource allocation decisions to the level of the directorate and below, while the CEOs were able to maintain centralised information control over performance evaluation and accountability. It was in this way that they were able to make faster decisions and to gain more control over the structure of work, and, according to Bloomfield *et al.* (1992), the availability of an accounting and information system enhanced the CEOs power to develop 'individual or collective efficiencies' within this hospital organisation (p. 206).

Despite of the increased control over staff, Jo-care's executive managers were not able to secure total control or eradicate the spaces in which misbehaviour took place. That is, there were numerous occasions upon which Jo-care's people were able to create some personal space in the world in which they work. One example was the active subversion of managerial control through the manipulation of statistical figures. This is illustrated in the following data extract:

> Sally: (...) We are <u>the team</u>. The doctors always say that too, loud and clear, because they can really rely on us. I worked for a day on another ward and saw the doctors take every single ECG out of the medical files and submit it for the diagnostic results. (...) On our ward that's a routine thing. But you know there is the very real possibility that we'll just give up. If you can't see any progress. Because you're always giving and getting nothing back. One day it will have gone

[3] The convention was that an external audit would only be to ensure that the internal system of quality assurance was in place and not the quality of health care in itself; i.e. the expectation was that hospitals would set up 'internal audits' which would identify appropriate criteria and guidelines for good practice as occurred in the Netherlands (Dent, 1998, p. 216).

> so far that we don't want to go on any more and aren't motivated any more. Like for example we'll do the nursing assessment talk [with the patient] but not fill out the forms.
>
> Maggie: You mean the statistics forms?
>
> Sally: Exactly. Don't you think we're really (fed up) hearing Ward 6 (will do it)? For instance if Ms. Sterne comes and asks us again to help out on ward 7 or wherever. Don't you believe that doesn't piss us off. But not everyone notices. Ruby doesn't notice so much (...) because ward sisters never do. They don't have access to that kind of information in their positions. I used to be the go-between, between nurses and (the ward sister). But at some point I asked myself why I should be the mug, the trampoline for the others. [laughter] (...) (6.41) So I'm still hoping things are going to get better again. I'm hoping, in any case.

This example demonstrates one form of misbehaviour that was concerned with the politics of concealing information and producing false impressions of the work situation for those in authority. Central to this practice is the technical and social knowledge of Jo-care's people which enabled Sally to restrict the flow of information within the hierarchy. That is, her specific form of knowledge was a crucial source and medium through which workplace misbehaviour could be mobilised. The manipulation of statistical figures, in particular, became an important *Weapon of the Weak* through which Sally could obtain a certain degree of power and autonomy even though she failed to question her subordinate and uncertain organisational position (Scott, 1985). This argument is in line with Collinson's research results (1994) on *Resistance through Distance*:

> In seeking greater control over job and self, workers sought to manipulate the commodity status of their labour by using their knowledge of the labour process to appropriate and privatise 'public' space, time and production on the shopfloor. Their oppositional practices were intended to exploit the interrelated material and symbolic spaces that were available as commodified labourers (p. 34).

While the new resource management system has generated practices of misbehaviour among Jo-care's people, this behaviour may have reinforced the desire of executive managers to introduce further control strategies. For example, the introduction of new rules of acceptable conduct with regard to information and communication, the careful exercising of observations concerning the breaking of these rules and the application of penalties for those who break them, has probably cut back people's misbehaviour in its existing forms. Clearly, however, this impact on behaviour is not

to be confused with a reduction in the tendency to find new forms of misbehaviour, or, more generally, to resist managerial controls. As Ackroyd and Thompson (1999) explain the matter:

> It is undeniable that we are in a period of significant organisational change, and that the alteration of organisational structure is also helping to reconstruct the conventional forms in which misbehaviour finds expression. In our view, however, misbehaviour has by no means gone away; still less is it being eliminated. Much of what is now being claimed about the removal of misbehaviour is tendentious or simply wrong from a factual point of view (p. 5).

The impact of horizontally integrated forms of managerial control was felt in different departments and wards at different times and the loyalty that existed among Jo-care's people took on a new character. This means that the introduction of competition to various areas within Jo-care brought about a major change in the way in which staff and departmental managers behave. Here, the old bureaucratic and clinical motives which had underlain Jo-care's foundation were no longer contained within the wider hospital community but had become reconstituted as incorporated and interdependent business motives to co-ordinate the activities of decentralised sections. To some extent, Jo-care's people had to accept the promotion of competition within the new enterprise culture as the following quote from a pool nurse indicates:

> Vivienne: There are favourite wards - take Wards 6 and 4, they're obvious examples. I'm sorry about saying this, but Ruby [ward sister of Ward 6] gets on very, very well with Ms. Sterne [deputy CNE] and [name of the ward sister of Ward 4] isn't somebody who's always prepared to accept the latest innovations. And so you can see a difference between the two wards; Ward 6 often gets help when they're short-staffed, whereas Ward 4 gets left out in the cold no matter how short-staffed they are. So there are subtle little differences about who can do what, etc.
>
> Maggie: You mentioned Ward 6 as an example because on that ward a lot of things happen which are introduced by Ms. Sterne, or the CNE in general. Why do you think it's the case that things work better on that ward than anywhere else? Of course it's obvious that the personalities of the ward sisters are very different, but does that mean an advantage right from the word go? One of the ward sisters is very motivated, and the other tends to say BUT.
>
> Vivienne: [name of ward sister on Ward 4] is quieter and the kind of ward sister whose first priority is to stand up for her staff. And who tries to make sure that her staff does not get landed with additional tasks. Sometimes she exaggerates a bit. But she was more or less against (4.38) and critical of these nursing

> assessment talks, which were one of Ms. Sterne's ideas. Ward 6 went for the idea full tilt while Ward 4 refused. And as far as I'm concerned I still think the whole thing's a load of rubbish. (...) I think a lot of things end up being less use than you thought they'd be at the start. And [name of the ward sister on Ward 4] is the kind of person who tends to say "Maybe it won't be any use". Perhaps she's not always right about that, but she's just more one for saying NO. (...)

At first sight this description seems to fit neatly into personal sympathy and antipathy, but a closer look reveals that fundamental changes have taken place because of managerial strategies which reflect Ms. Sterne's central role within the division of labour. What emerges from this interview extract is an increased pressure to control costs and to improve the quality of nursing care in Jo-care's day-to-day practice. These elements have led Vivienne to argue that there is some competition between wards and she is illustrating that competition as she refers to the availability of human resources and nursing assessment talks within two health care provisions. Vivienne's account also depicts the configuration of Ms. Sterne's 'regulated autonomy' to implement the latest innovations so that principles and norms for quality care and better efficiency could be introduced (Hoggett, 1996, p. 26). What is of concern here, according to Webster and Robins (1993), is 'the relationship between management and control' and 'the shaping influence of information and associated technologies on the texture, pattern, organisation, and routines of everyday life' (p. 244). In the case of the former, what is on the agenda is the monopoly of modern managers who rely on the principles of close observation, analysis and planning in order to control the workforce as well as the labour process. The latter is based upon the micro-politics of power and it is in this context that an accumulated knowledge base can be generated in order to intensify routine sustained control.

In following such a perspective, Ms. Sterne's managerial approach can be interpreted as an example of a more comprehensive planning and monitoring process than Vivienne, a pool nurse, has been able to discover. It is in this context that the control of costs (e.g. allocation of human resources) has become the dominant managerial concern even though the introduction of nursing assessment talks was built upon the assumption of the changing nature of high-quality patient care. For the nurses on Ward 4, however, the notions of commitment to efficiency and quality care fly in the

face of their experience of increased workloads and inadequate nursing cover. The argumentative disposition claimed here suggests that Jo-care's nurses were expected to follow clear rules and shape their behaviour according to the central and rationalised interests even though this purposeful process became particularly distorted by the 'heterogeneous, rivalrous and recalcitrant' environment as described by Reed's critical observations (1995) of managing total quality (p. 61). What becomes clear is that Jo-care's nurses were under constant pressure to achieve further cost reductions and the hospital's day-to-day operations became increasingly contested.

Another result was that senior people of Jo-care reported an increase in work loads as an effect of the 'wider range of responsibilities' as outlined in Mulholland's research (1998) on management and careers (p. 198). For example, the issues of quality management and efficiency in human resource and monetary terms have greatly increased their duties to monitor and tabulate Jo-care's day-to-day practice. That is, the supervision of various human resource variables (i.e. full-time equivalents, organisational members, the measure of planned and unplanned absence) and other programmes in general (e.g. performance appraisals, descriptions of qualification requirements, workforce planning, etc.) have increased the bureaucracy and work load for people with line responsibility. The following comment is illustrative of the typical response:

> Ms. Sterne: (...) And then the work here [in the office] just piles up so I have a lot to catch up with. Or I have to look through [files], do other office work. Quite a bit piles up. And so then I maybe go to the wards one day less in the week than is usual for me. But the day after that I make sure I can go round the wards [so it's not two days in a row]. Sometimes [I go] every day. When I come back from my holidays for the first few days I've got a lot more to do here [in the office]. Although I always look and see if I can't leave it for a bit. I only glance through things quickly and then like to go to the wards to re-establish contact. Or if I've been away for a while then [I go right to the wards so] people notice I'm back. (...)

Other senior managers talked about similar experiences but their work loads became even more complex due to other programmes, the aims of which were to enforce quality service and to achieve conformity among Jo-care's people. In each respect,

the enormous efforts of senior managers were geared towards all the concerns of an effective and successful hospital organisation, towards what had been called by Jo-care's CNE the creation of a *Schmuckkästchen* [i.e. a real gem] rather than just being concerned with the regulation of human and financial resources. As found in the research of Mulholland (1998), senior managers were able 'to gain *some* control over change projects' in order to justify their relative freedom of action even though the initiative of resource allocation and management systems indicates that Jo-care's people, managers and staff alike, have become objects of control in the interests of the hospital's goals (p. 192). As I have noted earlier, however, it would be inappropriate to argue that senior managers have not had any choice regarding the strategy of close observations, or, alternatively, what Hoggett (1996) calls 'regulated autonomy' (p. 26). This is confirmed by Ackroyd and Thompson (1999) who see this argument not so much as a strategy of control, but as a product of a disposition to act and a policy adopted by management:

> Making choices, within a range of parameters, is actually central to the managerial role. What we have to note, is that what is appropriate to do in order to remain profitable will vary from time to time and place to place (p. 86).

Although Jo-care was just the site for the collection of my research data, my role as a participant-observer generated important insights into the way in which middle and senior managers appropriated time, goods and other covert reward systems to themselves. My understanding of people's behaviour was enhanced by the very detailed observations and analyses of particular work situations which demonstrated that misbehaviour was integral to the functioning of the hospital. Thus, this study suggests that middle and senior managers were active and innovative in their attempts to survive in their role, recurrently breaking rules and actively abusing them on a regular basis. Most of them were not aware of their managerial wrongdoing because they justified it by reference to their superior position in the workplace, hierarchy and the enormous amount of activities provided by them.

To conclude, in this section the importance of the new resource management system in Jo-care's day-to-day practice was highlighted and some of the interconnections

between information, power and subjectivity were explored. As I have shown, the initiative of resource allocation and management systems does not only reflect and reinforce managerial and hierarchical control, but also intensifies material and symbolic uncertainty for those in subordinate positions. What made the labour processes I have been examining in this section similar to others were people's efforts to pursue a certain degree of autonomy and/or to organise themselves in Jo-care's day-to-day practice.

Conclusion

This chapter is the first of two examining how the CEOs seek to manage people and exploring the way in which the managerial rhetoric was embedded in the culture in Jo-care. Concerned with avoiding abstract ideas and romantic ideals, I have tried to describe and deconstruct the various managerial practices by applying a critical realist analysis of power and subjectivity to the analysis of Jo-care's culture. My argument is that people's subjective experiences of organisational conditions of bureaucratic and normative control reinforce their material and symbolic uncertainty. Against this background, Jo-care's people invest in language and practices that seek to redefine their identity as health care professionals and dignified, worthy human subjects thereby challenging and/or rejecting the rhetorical view of self. This argument will be continued in the following chapter.

Chapter Nine

The Complexity of and the Response to the managerial Rhetoric II

Introduction

In this chapter I continue the exploration of the creative content and purpose of Jo-care's rhetoric started in the previous chapter. Having examined in Chapter Eight the programmes of general and operational change as well as the initiative of resource allocation and management systems, in this chapter I introduce the reader to the managerial creation of high trust work relations as well as the programme of participation and staff development. The data examined below explicates the design of these managerial interventions and demonstrates how Jo-care's people experienced and responded to them during their day-to-day practice.

The Creation of High Trust Work Relations

Attempts by senior managers to improve their staff relations through better communication channels were explained by the correlation of service orientation towards people and people's needs. Using the notion of service-orientation towards people was in some respects a comfortable and comprehensible way of viewing the importance of human beings, and patient-driven health care was given as much attention as the hospital's employees themselves. Many of the managerial actions were modest but very well chosen, such as the regular personal appearances of the divisional directors in Jo-care's departments and wards. Most visible manifestations of this effort were their random visits to the hospital's floors and the promulgation of the new cultural rhetoric among Jo-care's people. Here, the managerial focus increasingly switched to negotiating on an individual basis, developing informal contacts with people at their work place and trying to create allies within Jo-care by giving individual compliments and/or agreeing to people's proposals. That is, there was a considerable effort to introduce informal communications and to remould the relationships between senior managers and the rest of Jo-care's people. As the hospital's reorganisation has progressed, this people-oriented strategy has come to be seen as a way of building bridges between management and staff.

This precise process of co-operative, high trust relations is discussed by Peters and Waterman (1982) as they analyse the key criteria of the most successful organisations, organisations which were assumed to have magical qualities. Their first principle *A Bias for Action* involves a certain degree of action orientation which means that an organisation has a degree of fluidity and informality that allows for communication and exchange of information quickly and easily at all levels (p. 19). Both authors were captivated by the wandering around approach carried out by Ed Carlson of United Airlines, Bill Hewlett of Hewlett-Packard and Big Jim Daniell of RMI who rode around the factory in a golf cart, waving and joking with his workers, listening to them, and calling them all by their first name - all 2,000 of them. Peters and Waterman (1982) characterise these wandering about events as a '*technology of keeping in touch*, keeping in constant informal contact' (p. 123). This technology, they argue, can be seen as an innovative method that pays attention to employees, not to working conditions, and they identify the process as one which gets the desired interests of one group across to others by *Management by Walking About* (MBWA) (p. 122).

This example also echoes management and academic writers[1], following Peters and Waterman's (1982) view, that is: management leaving the office, moving around, talking to employees, discussing and sharing with them organisational problems as well as new ideas. According to these authors, this is all done in a highly visible and very informal way, on a spontaneous basis and can happen at any time during organisational operation. Ackroyd (1997), in organisational and management literature, also discusses MBWA in terms of nurses' autonomy and managerial control, but he makes it explicit that

> [i]t would be difficult to imagine a senior NHS manager walking around the wards to see that that patients were being treated appropriately, and the work was being done in a satisfactory way. In industry, this kind of management, called management by walking about (MBWA) is often advocated. It would be

[1] For accounts on this subject see Peters and Austin (1985), Powers (1986), Simmons (1987), Volland (1987), Peters (1988a), Kramer and Schmalenberg (1988a-b), Kramer and Hafner (1989), Townsend (1991), Rakich, Kuzdall, Klafehn and Krigline (1991), Sims (1992), Campbell (1992), Thomson (1992), Davidhizar (1993), Dunham, Fischer and Kinion (1993), Kinchen-Singleton and Nail-Hall (1995), Ribeiro and Blakeley (1995), Young (1995), Parrish (1996).

> inappropriate in the NHS and deeply resented by nurses. Managers in the NHS hospitals (unless they are among the senior nurses given a role in management) have not the ability to see what might be going wrong on the wards (p. 10).

In this sense Ackroyd (1997) suggests that hospital managers cannot and do not give nurses attention in this sort of way. Yet what is revealed in my examination of Jo-care is that MBWA, which relies on co-operative, high trust relations as an organising device, can be found in the hospital's day-to-day practice. The basic idea behind this approach was that everyone should be kept informed and the trust level kept so high that people feel free to talk about new ideas, including inevitable mistakes that occur, which in turn might make it easier for them to do their jobs. Taking this argument further, Campbell (1992) refers to Hewlett-Packard's (H-P) mission and explains that

> [t]alented people are not going to be happy with a command and control management process; they need supportive and caring managers. H-P managers also believe that MBWA is the right way to behave from a moral point of view. The H-P Way states the following: "Managers must get around to find out how their people feel about their jobs and what they feel will make their work more productive and more meaningful" (p. 12).

This explanation appears entirely in keeping with a staff nurse's account:

> Paula: (...) I get the feeling that an incredible amount of information gets passed on, to the CNE anyway. But I have to say that it's good for the nurses too (2.78) when the CNE comes in past. And if someone comes in past and that someone is important and looks around then they don't just look and see if everything's going all right or if it's dusty. But they really ask how we are and what's happening on the ward. (1.97) Uhm then it all has something to do with the fact that I'm important in their eyes. And I think it's very important that they really take me seriously. Otherwise they'd send for the ward sister every week and ask "What's new?" That would also be a way of getting information. But that's not how it's done here. They come in past the ward and it really doesn't matter which nurse is on duty. And they ask "How are you", "How are you doing" and "What's going on on the ward?" or "Is everyone OK?" I think a lot of information is passed on but apart from that it's more convenient. And because these [walkabouts] are on a regular basis things like tension, inhibitions and anxiety are reduced.
>
> Maggie: (...) Anything you want to add regarding this topic? Something you're dying to say?
>
> Paula: .hh .hh Ye::s (...) I did my education in [name of hospital] and there was a CNE there I never saw. OK it was a huge hospital, but (...). Here [in Jo-care] you just can say what's bothering you, or make suggestions and they listen. It's not at all difficult, approaching the CNE. I think that's great. You don't always have to

run to the CNE's [office], they come themselves. That's an advantage and it makes a huge difference - a positive one. For the most part positive. Sometimes you have to be patient. But some things only change if uhm another person higher up has the same idea, about changing the exact same thing. [laughter] These are very interesting experiences. So you need patience, but a lot more gets done here in comparison with other hospitals where the CNE is not present the same. I think it's good that she comes to the ward. I've got a funny story I'd like to tell. [laughter] One day the CNE came and wanted to work on our ward. So there was a patient the CNE came into contact with and the CNE said the patient was dressed much too lightly. And suddenly the CNE was here, working with us, for about 5 minutes. And it was obvious and someone said, "Gentlemen, you're really a bit out of practice." And in a way it was a good feeling because you were one up on the CNE, at least as regards nursing [laughter]. I thought that wasn't bad. It was good and you noticed they'd been away from nursing - practical nursing - for a while.

This interview excerpt can be summarised in terms of co-operative, high trust work relations in which hierarchical control and bureaucratic closure were challenged by Jo-care's CNE. Of course, there was a reliance upon the effectiveness of the old social bonds of loyalty, dedicated hard work and the belief in the hospital's goodness but there was also a new sense of caring and a rhetorical commitment to find 'pleasure *in* work' (Donzelot, 1991, p. 251). In the following interview excerpt the CNE reflects on his intentions in walking about the hospital's floors:

Maggie: Fi::ne. So what's your actual intention, when you go through the wards? Is there a wish to show yourself, or to be closer to the staff? Or to solve problems right there on the spot?

Mr. Fawkes: Why do I do it? (2.28) That's (4.25) Here you have - how can I put this - you're feeling the pulse. When you go through the hospital you see changes happening and crises beginning to develop. Yes. Uh you sense the atmosphere and develop a feeling for that. Yes. And I think - this is a very important point for me - uh because here the most important area is personnel management. And to really be on the spot here - to sense what's happening and to react to crises as quickly as possible, and to nip something in the bud right away. Things don't have to get that far, don't have to escalate. What you have to do is actually uh (2.81) realise quickly what's going on. And that's actually a reason too because (2.93) - how can I put it - (4.13) because I think there's nothing worse for a nursing director than for what's going on in a hospital to just go right by him. And only because he doesn't ever leave his office.

Maggie: You mean the CNE barricades himself in his office and has members of staff summoned to him.

Mr. Fawkes: Exactly, exactly. Uh, that would be for example the worst thing for me, barricading myself in the office and just letting hospital business drift on by me. If you know what's going on in the hospital each and every day then that can also be an advantage of the CNE over the other professions in the hospital.

Similarly, the head of the medical division, was in no doubt about the appropriateness of his personal appearance in Jo-care's departments and wards:

> Mr. Chatwin: Well, for the same reason I find them [the regular personal appearance] good [tentative laughter] - because it's the proper thing to do. And it's the right [thing] in an organisation like this for the management to be visible. And that this situation is given and that, if necessary, suitable or unsuitable questions can be put [to the managerial leader]. And that uh communication quite simply is there, taking place. The majority of the problems in our hospital occur because there's no communication. Because groups cut themselves off and because people refuse to have any understanding for what's going on in the other person's head. Uh of course it's nothing new but it does have to do with the fact that we all try to keep our distance from each other. And that we all build fences [walls] round ourselves. You know the saying, 'nice fence, nice neighbours'. But sometimes you've got to look over the fence.
>
> (...) I'd say there are regular rounds - the daily meeting in the intensive care unit. Or the daily round - to do with my case and special area - on the ward where I have my private patients. That's something regular and is part of a proper daily routine. But there's also an informal part, so to speak. You know, you don't go to a ward and say "Is there some matter you want to discuss?" That's the wrong way of going about things, I think. Because if I were a member of staff I'd think "Here he comes again." Or "Here comes the boss on his rounds again. God, I'll have to say something to him." No, it's different. I go to a ward and ph I create communication. Communication arises not through me talking about the weather but through me mentioning something I have in common with the other person. And then the things that worry or interest us come up in conversation by themselves, because most people end up not being so reserved after all. Talking about a certain topic or at least touching on it. And through (2.82) this kind of behaviour people are given the message uhm that the [boss] is there. Without wanting to hear about something in particular or carrying out some mission - just being there. Taking that for granted. Some say "No, we don't need that," but the justification for it is there. (3.25)
>
> (...) All I can say is that in my area of work rounds are not an obligation. Except for the medical round, if you want to include that. But I go through the hospital in a leading role. I'm coming from somewhere completely different. I'm coming from a place where it's necessary to see what's going on. To have a look round and see what the atmosphere's like. If necessary to influence or improve it. Maybe to do just the opposite - to calm things down a bit. But also to see what can be improved. I mean not during the round itself, but there are things you notice then which can be taken care of on another level. I get a lot of information like that from people or I notice if someone's angry about someone else. And that's all background information. I think in music (acoustics) they talk about the rustle or whisper - the white noise. That's what I mean and that's what it amounts to. You just see what's happening and if you hear the same complaint ten times about the same situation then there has to be some truth in it - so hurry up [and get something done about it]. Or if you hear something positive ten times - or, well even just four times - then you know too there'll be something in that.

Both accounts illustrate, and are used here to single out, the apparent cultivation of an open and responsive atmosphere which relies on shared values, norms and an

understanding of events and procedures. The sense of trust was supposed to be further heightened by the personal accessibility and approachability of Jo-care's senior managers and help create a form of management which could ease some of the difficulties that derive from hierarchical relations. As previously mentioned on page 190, the introduction of high trust work relations was embodied in the cultural rhetoric and this collegiate ethos aimed at appreciating people's ideas and contributions. That is, Jo-care's people were supposed to be seen not merely as an economic component of service provision but human beings whose social and moral welfare had to be promoted both in the workplace and in the community beyond (Rose, 1990).

In this new role, Jo-care's directors were required to bypass the chain of command in order to keep communications flowing and to encourage people's flexibility by showing attention to new ideas and organisational details. In this sense, they were asked to communicate within the formal limits of authority given to them by virtue of their rank as well as within the informal limits of authority granted to them by Jo-care's people as a result of their trust and respect for them as individuals. Through persistence, they intended to reinforce and/or instil soaring values and path-finding visions that generate enthusiasm, excitement and commitment among Jo-care's people. Thus, the senior managers should use these walkabouts to regularly demonstrate to people where they wanted them to take this hospital organisation, and to make people feel that they were working for something important and worthwhile. This finding supports Kondo's research (1990) on the disciplinary production of selves in the Japanese culture:

> Thus the ethics centre draws on deeply held values, asserted at a particular moment in history. It reinforces a particular kind of worker/management relation within a particular economic situation in order to recapture an idealised past of benevolent paternalism and worker loyalty (p. 114).

As in Kondo's research, the emphasis was placed on the activation of people's commitment; this was perceived to require the internalisation of values and beliefs generated by the new organisational culture. This process of keeping in touch was,

however, highly selective, given that the creation of high trust relations was strongly related with 'long-term attitudinal restructuring and cultural reconditioning' as outlined by Reed's discussion (1995) of managing total quality (p. 46). That is, Jo-care's rhetoric of co-operative, high trust relations was built on people's commitment to incorporate new values and aimed to change how people think and feel about their day-to-day work.

For example, people typically located at the front-line in Jo-care, such as nurses, medical doctors, physiotherapists and domestic staff must follow a certain dress code. Here, people stand out from other people in Jo-care based upon the 'geographical area they are situated in', as well as, their professional dress (Mueller, 1995, p. 84). Most of Jo-care's people who are placed in the administrative building and/or apartment house wear civilian dress but the ones who actually deliver the health care work which a patient values are dressed in white or coloured uniforms. Similar to other hospitals, these people wear name badges which are used as visible identity tags. In this regard Jo-care's people are following a particular dress discipline to consider hygienic rules and enable the patient clientele and managers to know who they are. The CNE and his deputy were particular concerned about the people's styles of personal interaction and outer appearances. Jo-care's CNE confirmed this policy and both of them specifically admonish the few people who do not measure up:

> Mr. Fawkes: .hhh hhh. What annoys me, quite personally, is what uh sometimes uh nursing staff look like. How are they dressed? Do they take care of their appearance - are they well-groomed? What's their hair like? I'm one for appropriate, clean dress and appearance. If I go into a bank today then I expect the teller to have clean shiny hair, not greasy hair. For instance Ms. Sterne and I have divided that up too. Ms. Sterne talks to the women and I speak to the men about that. That's what we worked out. And (2.62) what always amazes me is why they themselves don't have the feeling that being well-groomed is also part of being a nurse and why they don't have the appropriate appearance. Well, that this particular sensitivity is just not there.

This interview excerpt reveals that Jo-care's senior managers were able to observe a wide range of behaviours for evidence of any deviations and irregularities. To the extent that the sources of such conducts were discovered, the facts were used to

'coach' Jo-care's nurses in order 'to help them realign their behaviour within acceptable standards' as mentioned in Zuboff's study (1988) on the *Information Panopticon* (p. 317). In this respect, the idea of MBWA simultaneously carries a procedural element directed to effective managerial control over labour processes and health care performances and a shared rhetoric aimed at the instillation and clarification of values that directly impact upon work behaviour. The former argument tends to emphasise a logic of control by visual inspection and standardisation, the latter is a way of controlling employees through the 'pretence of family imagery', thus providing space for senior executives to act as 'caring' and 'protective' heads of the organisational household (Kerfoot and Knights, 1993, p. 665). A comment from the deputy CNE articulates the kind of control Jo-care's people face while attempting to reconcile competing demands:

> Ms. Sterne: Well the main reason for me [to go round the wards] is so problems - as far as they exist - can be dealt with as soon as possible. I mean that you pick up on [a problem] quickly and act or react quickly if it's a problem concerning something which has to be solved fast. And then it's important too to maintain contact [to the staff] and nurture our relationship. And that you're able to say something quickly. Mhm. (2.19) And it's also important for me to get a overall impression of things when I go round the wards. Of course I miss some things because I'm on the wards all the time. I see that with Mr. [name of deputy CEA], when he notices things. Although of course he notices different things, different from what I notice.
>
> Maggie: How can he notice these things? Does he go round the wards?
>
> Ms. Sterne: Well he often goes through [the hospital] in the afternoons. For instance he notices things like if a bed's in front of a fire alarm. That's the kind of thing he pays more attention to. After he mentioned that to me [intense laughter] I think now too that he's really right. And that I have to watch that. The beds should be kept away from the fire alarm because if there's a fire it has to be easily accessible. So that's an example. [laughter]
>
> Maggie: [laughter] That's really crazy.
>
> Ms. Sterne: Ye::s. He'll notice something like that. Or, for instance, when I was going through the urology ward, and (into the nursing office and treatment and store room) from the back. I was there just on Sunday and well it certainly gave me food for thought. All the doors were wide open. The medicine cupboards were open and the cupboards for the modular system too. Everything wide open. I began to wonder and had a quick look round. Then I said "What's wrong? Has chaos broken out or something? [laughter] All the cupboards are open, etc." I also said "You can't just disappear and leave all the cupboards open. That's dangerous" Well everyone rushed to shut all the cupboards. But I got an overall impression of the tidiness on that ward. Or I notice as well when the desks are uncluttered and the look on the staff's faces is more relaxed. Or, yes, if everyone's

running about and things are hectic. You see all that. Or if things are untidy, that kind of thing. You get an overall impression just from the way things look. That is the organisational aspect as well as the visual [appearance] of the ward and of the people working there. How are they behaving? What's the atmosphere like? Any problems anywhere? Just after we moved [into the new wards] it was all very obvious, close to the surface. People were tense, under pressure. You notice that. That comes across.

Maggie: So if you notice the medicine cupboards or the fire alarms then it occurs to me you're trying to get an impression of things. And if you pay particular attention to something then you're drawing other peoples' attention to that in a certain way too. Like for example the medicine cupboards are open]

Ms. Sterne: [Mhm. Yes. Mhm, mhm.

Maggie: Do the nurses feel like they've been caught red-handed? It's like that a little bit, isn't it? You say yourself that you go round the wards so you can regulate things, influence things a little]

Ms. Sterne: [Yes, yes. Yes. Yes, it's my aim - to regulate things. Of course. Well, as to whether people feel caught out or not [tentative laughter] that's their problem. Well I just think that it's my job to mention that. Although it is sometimes the case that I just observe. The incident with the medicine cupboards wasn't important. But I often notice things over a longer period of time.

This comment illustrates two parallel themes, the thrust of maintaining contact and the acknowledgement that Jo-care's people are under scrutiny. The former involves pretending to nurture close working relationships; i.e. it entails empowering the workforce and relinquishing control by integrating caring values, and can be regarded as central to the whole challenge of Jo-care's bureaucracy. The latter suggests that managerial initiatives such as MBWA are prescribing and controlling the labour process; i.e. it comprises 'staff behaviour, attitude and appearance' during interaction with managers and patient clientele as described in Taylor's study (1998) on emotional labour (p. 87). In this context, there is a contradiction between the cultural rhetoric that senior managers can be trusted or to whom people can just say what they want and Jo-care's reality of managerial control in which the reduction of tension renders people 'more compliant and predictable and, therefore, the lives of those exercising the power more comfortable' (Kerfoot and Knights, 1993, p. 665). As reflected in Sewell and Wilkinson's account (1992a), however, it is important to remember that the result of this kind of supervision is an incomplete closure of control which means that Jo-care's people can 'vary the pace of their work, 'cheat' on quality standards, and improve on [formalised] methods' in order to create idle

time and abuse hospital resources with little fear of the senior managers finding out or stepping in (p. 275). A staff nurse in Jo-care has put it like this:

> Paula: Mhm, well I said that there's not actually a hierarchy in the hospital. That's what I'd say. But there are still a lot of nurses, for them a hierarchical structure is really important and I think that's something personal and very individual that varies from person to person. So there's a lot of people who feel they can't talk to the CNE or tell him/her the truth about something.
>
> A simple example; you're sitting having a short break for a cigarette. That's not done any more on the ward, but it used to be. Before you could have a smoke or two on the ward. And I think why not, if you happened to have a spare couple of minutes. It was no problem for me justifying that, even to the CNE. But a lot of the others thought along the lines of "Oh God, what if the CNE comes along". And I think somehow it's a question of self-confidence, asserting yourself. If I know that I work hard, and that I'm there when I'm needed and slave away doing things sometimes even after my shift's over - well then, why should I grudge myself a fag if I've got time for a smoke? I can justify that to the CNE, and the CNE accepts and finds that OK. That's the way s/he is. S/he says that quite openly, right in front of the nurses. But even though, for a lot of nurses they are, well, the bosses (2.28) and so you don't say too much to them.
>
> Maggie: Mhm. Are they afraid of the consequences or is it more a feeling of unease in the presence of a stranger? Or because someone who's higher up in the hierarchy could see everything?
>
> Paula: I think it's just got to do with power. Ye:s. I think of course the CNEs are our bosses and superiors. They have the power (2.10) well I don't know, to criticise us or if the worst comes to the worst, to give us the sack. Or to write a bad report about us, whatever. So from that point of view you have to watch out - in inverted commas. I never really had the feeling I had to watch out because quite simply I can answer for what I do and how I work. And I think I do a good job, at least usually [tentative laughter] uhm. and I have enough confidence not to be afraid of the CNE. (...) Although there are certain things you have to be careful about, even with the CNE I suppose. The CNE's are only human too and there are things you notice you shouldn't mention. If the CNE says today we'll do things like this, then it doesn't mean s/he thinks the same way about it after two weeks.
>
> Maggie: Oh, mhm.
>
> Paula: Yes. So you've got to be careful with the CNE's too. (...)
>
> Maggie: Mhm, mhm. And what happens during the more general CNE rounds on the ward? What have you been able to observe then?
>
> Paula: Well first of all "O::h, the CNE's coming!" I think that's the main thing. Just like "Wo:w, the professor is coming". Just because of =
>
> Maggie: = Authority? =
>
> Paula: = authority's coming [nodding of head] and now hoopla - watch out. That just slipped out there, spontaneously. [laughter] Yes, I think you're just a bit

careful. I mean you're careful anyway about what your're doing. And you do a quick check of yourself to see if everything's OK for the CNE.

Maggie: If your uniform's straight or what?

Paula: Yes, if uniform's straight. Or if things the CNE saw the day before and criticised have been taken care of. Uhm, yes, well I think you do that because of the authority aspect we were talking about just now.

Only on the surface of Paula's account one can find a congruence between the new image of unity and togetherness on the one hand and the characteristics of people's empowerment, skills and growth on the other. As this staff nurse suggests such a perfect analogy cannot be generalised in Jo-care's day-to-day practice because it was the unpredictability of the human factor which revealed various problems, limitations and contradictions in these work relationships and therefore in the 'instrumentalisation of subjective potential' as described by Flecker and Hofbauer's critical observations (1998) on the new model worker (p. 113). That is, people cannot be forced to reshape their mental disposition as long as control devices are offered that lead to the visual inspection of them and/or to the accomplishment of purely managerial goals. In relation to this Reed (1995) refers to the cultural management of total quality (TQM) which can be viewed as one component of an overall discourse and strategy of control:

> [T]he actual implementation of TQM-type principles and methods is likely to be much more partial and contested than the ideal type would indicate. Indeed, judged as a practical control device, TQM has severe internal contradictions which will be reproduced in the form of highly selected and contested operationalisation within the work organisation (p. 47).

This extract illustrates the inherently contradictory character of managerial policies which are based on the logic of symbolic forms and technical methods; i.e. they diffuse procedural control mechanisms as well as shared values throughout all levels of the organisational hierarchy. Here, the cultural rhetoric can be translated into a sphere of reality through languages and practices, which want to 'shape, normalise, and instrumentalise the conduct of organisational members' (Reed, 1995, p. 46). Considered in this light, the underlying rationale of creating an atmosphere of mutual trust was to legitimise a programme of technical and cultural change which aimed at

transforming Jo-care's people's behaviour and belief systems. As an alternative to the professional-bureaucratic traditions, the extension of high trust work relations was meant to sweep away the collectivist constraints and sectional conflicts and give meaning and direction to the organisational culture of Jo-care.

Within Jo-care, a series of distinctive innovations has been carried out in the name of service-orientation towards people and peoples' needs. This conclusion sits rather uneasily with the ideology of high trust work relations because in Jo-care's day-to-day practice this reality falls far short of the ideals to which it aspires. Commenting on his premise, the CNE explains what he does to cultivate a very open and honest atmosphere:

> Mr. Fawkes: Yes, and that's actually my premise - cultivating a very open and honest atmosphere among staff. And that has been successful the last few years. Through that you become dependable for staff. Yes. You become dependable and another personal aim of mine is having a kind of closeness at a distance to staff. I mean I don't overdo the role of the boss but try to put a bit of my personality across, be a person. So I talk a little about my private life, something funny or a little anecdote about my wife and kids. Or make some kind of joke, I do that too. So that employees notice "aha, he's not just our superior, our boss - Mr. [Fawkes] is a human being too just like us. With normal everyday problems and worries." But I do take care not to get too close. I always call it closeness at a distance. But it's not faked or anything but (2.56) it's in me and so I act that way.

What becomes clear from this extract is Mr. Fawkes' premise in becoming dependable and having a kind of 'closeness at a distance' to staff. As the above suggests, 'closeness at a distance' represents face-to-face contacts between a nurse and his/her assigned senior nursing manager. Such occasions represent one way in which Mr. Fawkes claims he employs MBWA in order to create co-operative, high trust work relations. That is, this comment suggests that Mr. Fawkes values and stresses individual contacts with nursing staff on a day-to-day basis. Here, the social distance between senior management and staff seems to be lessened through the development of a more approachable style of management.

When treating language as a materiality which is not only representational, however, the phrase 'closeness at a distance' indicates, to some extent, that high trust work

relations are set aside. A different reading of this expression is that the word 'closeness' derives from the Latin word *claudere* which stands for 'shut' or 'stop an opening' (Onions, 1966, p. 183). In its wider sense, *claudere* also means 'to be close', 'to be proximate' or 'to be near together' (Collins English Dictionary and Thesaurus, 1993, p. 202-3). In contrast, the word 'distance' derives from the Old French or Latin word *distāre* which stems from *dis - stare* and stands for 'to stand apart' or 'to separate mentally from something' (Onions, 1966, p. 271 and p. 276; Collins English Dictionary and Thesaurus, 1993, p. 325).

As the term 'closeness at a distance' is used in Jo-care's day-to-day rhetoric, Mr. Fawkes infers that he does 'not overdo the role of the boss' and tries to put his 'personality across'. At the same time, however, he implies that he keeps himself at a distance and takes care 'not to get too close'. Thus, the word 'closeness' is dismissed when Mr. Fawkes refers to himself as 'distant' to Jo-care's people even though at other times he perceives himself as rather 'close'. Here, I am not suggesting that Mr. Fawkes does not have enough understanding for his employees, but merely that such understanding is not gained through having a kind of 'closeness at a distance' to staff. Therefore, the different connotations indicate that 'closeness at a distance' is an epigrammatic effect by which contradictory terms are used in conjunction; i.e. an *oxymoron* (Collins English Dictionary and Thesaurus, 1993, p. 815). In this piece of textual reading, however, I have not drawn attention to how Jo-care's people feel about this rhetoric-reality gap. For various examples see the following discussion.

A number of Jo-care's people expressed a sense of uncertainty with respect to 'a spirit of "oneness"' and referred to constraints and limitations which cannot be overcome or erased, even by further refinements of social interactions between senior executives and staff (Deal and Kennedy, 1982, p. 11). That is, the research data does not indicate a strong endorsement of co-operative, high trust relations by front-line staff. In the interviews, the majority of people neither spoke positively about the value of high trust work relations nor welcomed the reduction of social distance

between senior management and front-line staff. Commenting on her experiences, one staff nurse explains that an obvious ambiguity discourages her from believing in high trust work relations:

> Esther: (...) the funny thing is when I see how she [Ms. Sterne - the deputy CNE] interacts and acts. Sometimes very detached, and then sometimes very warm-hearted. So you never really know where you are with her, I notice that. And mostly she's in a hurry, it's just small talk. (...) Sometimes there's so much detachment there that nothing comes across. And, and it's as if there was a shield you can't penetrate. It's like "I'm here but I've got to go right away".
>
> Maggie: Does the white uniform she has on help? The fact she's dressed like the rest of the nursing staff.
>
> Esther: I didn't know she always wears nursing uniform. Really? I've mostly seen her in her own clothes [laughter] (3.34). pphh. (...) She doesn't always wear uniform. I've seen her just as often... I'm not always here when she comes but I've seen her as often in her own clothes as in uniform. And sometimes I find her more detached in uniform (2.00). So the uniform doesn't change anything in that respect. It really depends more on her expression. And how she speaks. I mean you notice if she comes to ask "how's everybody". (...) Somehow you just notice she's just carrying out a job and that she's really thinking about something totally different. That's how it seems to me anyway. Another difference is that with her it's not only the case that she seems to feel obliged to ask something. With Mr. Fawkes [CNE] it's more often the case. He comes less often because of how they divide up the work and when he does come it's sometimes ridiculous, I think, like he doesn't have a clue about what's going on the ward. As if there were a huge distance there and then sometimes he comes in a really good mood and is really nice and funny. He doesn't distance himself, but he hasn't changed a lot either [nearly silent laughter].

Another staff nurse remembers it similarly:

> Vivienne: (...) And uh Mr. Fawkes is always one for making great promises and coming to the ward like a real sunny boy. You know, like "Oh, everything's great, hurrah etc.". No-one says anything to him anyway, it's always her [Ms. Sterne - deputy CNE]. But she's always the baddie then, because she can't put all the things Mr. Fawkes promises into practice. (2.18) And I'd say she doesn't have the authority she actually should have, as a deputy CNE. Like you just said, that she comes and says "Right! This is how things have to be done!" I miss that in her and as far as I'm concerned she's not really someone I can respect.

Both interview excerpts explain by examples that nursing members keep themselves distant; i.e. they use an ironic tone and show a certain degree of distrust towards nursing executives within this hospital organisation. They devise their own individual ways of thinking about these hierarchical relationships which inherently involve personal experiences from Jo-care's day-to-day practice. Consequently, the

social implication was that their experience encourages them in keeping one's distance and this is what the everyday practice of this hospital organisation consists of. This finding supports Casey's cultural study (1995) on the disciplinary production of selves in which employees perceived 'a fine line between welcome and unwelcome speaking up' and most of the people 'chose not to risk crossing it' (p. 141). Such a cognitive and affective response illustrates a lack of confidence in high trust work relations and represents people's attempts to assert control over beliefs and feelings which are perceived as threatened with outside control. In this sense, Jo-care's situation does not appear to have stabilised and people have not endorsed the ideas and aims of the high trust rhetoric. As observed by Kunda's (1992) critical research of Tech - a computer corporation:

> Distancing then, is a declaration of autonomy, an emphasis on free choice and open exchange, a hint that the self behind the role is not coterminous with the role, despite the claims of others - and, perhaps, one's own suspicious - that it is (p. 188).

Another demonstration of contradictions and ambiguity in respect of high trust work relations was that nursing members expressed considerable doubts about 'the attainment of the value of 'honesty' within such a political organisation' (Hope and Hendry, 1995, p. 69). To illustrate this one staff nurse refers to the disparity between claims made and the evident facts of the circumstances to which they relate:

> Maggie: So communication should actually be good. They all attend the important meetings together =
>
> Sally: = Let's talk about honest communication. .hhh hhh. Cards on the table. (1.53) Somebody has an idea. Maybe someone else has the same idea in their head. Surely it's possible to meet somewhere in the middle and work together to build something up.
>
> Maggie: Who's to blame - the CNE or the head of Department of General, Further and Post-registration Education? Who is not prepared to communicate?
>
> Sally: It's to do with the people involved.
>
> Maggie: These people don't get on with each other?
>
> Sally: Exactly! (2.44) I really hope no-one's going to find out about what I say on this tape.

Maggie: No, no - really no-one is going to know about what you say.

Similarly, a pool nurse explains how the policy of honesty is not promoted in Jo-care's day-to-day practice:

> Vivienne: (...) when that LORE [name of organisational development programme] poster came out, "Getting on with each other" and "How to deal with patients" - that was the pits - "We say hello and so on". I mean like we were little kids or something. And I wrote an article then in the organisational journal. I don't know exactly what was in it now but I said things that were totally justified. And then for a while there was the problem about whether we could print the article or not. They weren't sure if it could stand as it was. But we printed it after all, etc. But just the very fact that we had to discuss whether we could write something or not - that's really... Well the organisational journal is really a typical example. They wanted an organisational journal, at all costs. And then all of a sudden they said we always had to show it to [names of CEOs] first. I've no idea who looks at it in the meantime but in any case this was more or less censorship. YES, terrible, I think it's terrible. I think in our hospital you can get away with quite a lot, yes. But despite that you do have to be careful about what you say and to whom. (...)

It was the suspicion of dishonesty which heightened people's awareness of the fabricated and synthetic quality of the managerial rhetoric. As a consequence, the biggest objects of scepticism and distrust were the senior managers and executives, particularly those who were in charge of cultural change projects. Even though they were always ready and prepared to reaffirm the advantages of Jo-care's managerial rhetoric, one of the CEOs admits that he too faces a similar pressure:

> Maggie: (...) Like the atmosphere, what is or isn't going on behind the scenes.
>
> Mr. Tate: .hhh. Although you do have to be careful about whether or not it's all true. You know everyone sees certain things subjectively. Me included, I don't want to exclude myself. So I do always investigate the information I'm given especially if it's (got to do with) communication. Any concern in the service sector is dependent to a degree of up to 80 per cent on communication - that's with the patient as well as within the organisation itself. And so you have to be careful that personal, subjective impressions don't get in the way of reality. There are different realities - put it like that.
>
> Maggie: There are different perspectives!
>
> Mr. Tate: Ye:s. (...)

It should be borne in the reader's mind that honesty is one of the key values of the cultural rhetoric which uses the language of openness, harmony and responsiveness

to convey how it wishes Jo-care's people to be. The majority of my interview respondents, however, commented negatively on the constraints and artificiality imposed by the rhetoric and/or were well aware of the boundaries and restrictions within which they had to operate. That is, an atmosphere of openness and mutual trust had not been created through the relaxation of hierarchical relations because the discrete associations between senior managers and staff are clearly defined and fairly limited. This suggests that the creation of high trust work relations has not restructured the modes of consciousness and actions of Jo-care's people at their work place, despite the presence of MBWA on the part of senior executives. This argument is in line with the results described in Rosenthal *et al.* (1997), who evaluate excellence, human resource and total quality management in retailing:

> The most frequent examples given concerned lapses by management into the 'old' authoritarian mode of issuing commands or behaving disrespectfully or condescendingly towards employees (p. 496).

A critical factor that further hampered the implementation of nurturing close working relationships was that Jo-care's CEOs have not been placed in the front-line management. As previously mentioned on page 185, Jo-care's everyday management has been provided by an in-bred tripartite directorate which means that a professionally educated nurse, medical doctor and administrator use their occupational and business knowledge to manage this hospital setting. Much of the basic communication of the ongoing flow of changes, however, was a mature combination of the CEOs visible style of leadership in the departments and wards, a conference and meeting structure across the hospital and the home-grown efforts of the divisions. In particular, Mr. Tate's identification of the need to extend the breadth of Jo-care's communication lines was an accurate judgement, but the results of his random visits were not what had been anticipated:

> Mr. Tate: (...) The contact to employees in the hospital has been greatly reduced, I did that quite intentionally.
>
> Maggie: The contact was more intensive before?
>
> Mr. Tate: To begin with in any case. We also went over [to the hospital], went through the wards and well... [expansive, illustrative gesture with hands]. The

problem then is that the superiors - the hierarchical level of the management board is on - lose out.

Maggie: Mhm. That's right. During the interviews I carried out with hospital employees I was often told that the interdisciplinary seminars had made a lasting impression. That's the main association that occurs to people when you mention CEOs.

Mr. Tate: Yes, we also talked about problems on the wards and in theatre. Had meetings, I mean by that problem-solving sessions. After all on some of the wards things were going haywire. When we started here - partly. This wasn't working out, that wasn't working out - various things.

Interview interrupted for a few minutes due to important phone call.

Maggie: Fi::ne so you used to go through the wards etc. And got very involved in the process. But then you with-drew, intentionally, because it was leading to a loss of authority for the others]

Mr. Tate: [because you can't run an organisation like that. We'd have had to banish the tripartite management board.

The above account is an excellent illustration of cultural artefacts and processes and extends the argument of this section to its logical conclusion. In every respect, Mr. Tate summarises his position well and notes that he is an excellent human resource manager who initiated a new cultural politic of communication. Some of his actions in the early 1990s, however, contained contradictions and generated an ambiguity in the managerial rhetoric as well as an highly uneven change process in Jo-care's day-to-day practice. It was in this sense that the development of high trust work relations was not always consistent with the experiences of the hospital based services which had been developing in Jo-care since 1950s. Of course, the management of Jo-care's culture set in place social forms which were qualitatively different from those of the traditional professional and paternalistic styles, but an enhanced form of people's commitment beyond their call of duty was not necessarily elicited by this hospital organisation.

The Programme of Participation and Staff Development

The development of Jo-care and the reorganisation of its internal character was not left to take care of itself. The major developments set in motion by Jo-care's CEOs raised the need to consult, convince and involve people internally in ways which had never been crucial up until then and in most cases had never before been attempted.

This entailed parallel shifts effected on Jo-care's people and centred on the refinement of their skills and attitudes towards improved quality service, a reworking of the notion of cost consciousness, and a movement in the balance between management and staff priorities. In the first instance, the remarkable vocabulary of Jo-care's CEOs served the purpose of disseminating crucial values and the extensive seminars created the potential for an enormous and receptive audience. From 1993 onwards Jo-care's CEOs assembled around them a mass of communication groups which made up LORE - the pronounceable name of Jo-care's organisational development programme.

Following the establishment of these groups within Jo-care, the emphasis strongly shifted towards providing more cohesion and enhancing people's abilities to achieve the hospital's objectives. As previously mentioned on page 197, the aim was to involve staff at all levels in the running of Jo-care and to enable them to actively participate in the success of this hospital organisation. That is, the intention was to bring quicker and more realistic responses to the everyday situations arising in Jo-care as well as better strategic planning. It was hoped that people's involvement and co-operation would ensure clarity about organisational goals and give them interpersonal skills they were thought to require. Thus, the wider objectives were not merely related to the search for greater service innovations and/or the continuous improvement of quality care received by the hospital's patient clientele but were associated with the creation of an environment that appreciates common understanding and creates high levels of commitment and satisfaction among Jo-care's people. In this sense, Jo-care's people were supposed to get more insights, discretion and responsibility to shape their services according to what they regard as people's needs and to learn that they were capable of delivering quality care within the resources available. As the head of the medical division remarks:

> Mr. Chatwin: (...) And uh it's really helpful to see - we've been practising that here in the hospital and you're familiar with all these different LORE groups. So it's wonderful seeing what comes up all of a sudden, things we had no idea of. What makes the other tick? What does he have to do? Or think he has to do based on his training, his goals. Or because of the political views he might have. I think it's a lot easier to harmonise if you can contribute your own ideas and if the

> others try to understand. I think that's the only way to run a hospital sensibly, by at least being informed about peoples' needs. They can't all be taken into consideration but I do at least have to know about them in order to make a decent decision. That is one [a decision] which doesn't hurt one [person] and leaves someone else with their back to the wall. And so as far as that's concerned the CNE's rounds through the wards are especially important.

From this interview excerpt, it can be seen that Mr. Chatwin accepts the responsibility for developing empowered people while he refers to impressive theories of intrinsic motivation. Central to his view is also the creation of an environment that values difference and within which Jo-care's people work together to maximise their strengths and encourage mutual support. As Mr. Chatwin suggests, it is the new ethos of unity and collegiality that enables Jo-care's people to work together, to multiply their efforts and to support each other through critique and affirmation. This explanation appears entirely in keeping with a pool nurse's account:

> Vivienne: (...) I have the feeling that at the beginning super things were done and planned. And a lot of money was spent on the personnel, for all these parties and celebrations which were meant to motivate us. (...)
>
> Maggie: Was there a kind of euphoric feeling among the staff, a desire to change things?
>
> Vivienne: More than that [nodding of head] I was still a student nurse then and was pretty involved. In our first and second year I was the class representative and worked on the organisational journal too. And we were the young, creative, dynamic team and the whole time it was "Everything is going to change and everything's going to get better". There was a real wind of change, I got quite carried away by it. Inspired. (...) But that's the way it really is. It is. You join in or you're out. That's how things are here, either you're young, dynamic and open-minded but not too critical - then everything is great. (...) Well, I can't really say I understand it all. I think they want young, dynamic and open-minded staff, who are able to accept criticism. But also very much in the position themselves of being able to express criticism. I was told that very clearly during my interview, their concept of the ideal personnel. And I do think that I'm <u>like</u> that. But I just have the feeling in our hospital (3.97) perhaps a certain external image is being aimed at. Uh that they [senior management] would like to see personnel like that and perhaps even see some like that.

Central to Vivienne's view is the creation of people who commit themselves to the values and beliefs of this hospital organisation. That is, people are supposed to give credence to the rhetoric and are inextricably connected with Jo-care. As Vivienne suggests, the ideal state is one of being a person which is 'young, dynamic and open-

minded' because when that is accomplished, the hospital's interests and self-interests are one. The extensive involvement of Jo-care's people is similar to Kunda's finding (1992) which are based on an ethnographic analysis of a computer corporation:

> [E]ncouraged by organisational forms and a variety of promised outcomes, members are expected to invest heavily not only their time and effort, but also their thoughts, feelings and conceptions of themselves. The consequent removal of a clear demarcation between self and organisation is presented as the basis for effective organisational action (p. 91).

In addition to sending the message of participation and collaboration, the education of Jo-care's people in the cultural rhetoric became an integral part of the overall programme. A first package of values was taught by Jo-care's CEOs at the organisational seminars, the members of the tripartite directorate and the head of the Department of General, Further and Post-registration Education were, however, encouraged to adapt them to departmental needs and ward conditions. Here, the message became one of confidence in and sensitivity towards Jo-care's nurses dealing with their patient clientele and their styles of interaction towards their co-workers and colleagues. Additionally, the new programme centred on greater transparency and raised skill levels as well as attempting to be more flexible and less antagonistic than Jo-care's traditional scheme.

Within this *Learning Organisation*, as the hospital calls itself, nursing members were expected to participate in delegated decision-making and to learn the ideological discourse in order to take appropriate action. As predicted and prescribed in popular management writing, the emphasis was placed on the creation of an environment that facilitates employee learning and develops co-operative links for competitive advantage. That is, the work-related purpose was to teach Jo-care's people in a series of new values and skills, and to find ways of translating those into individual behaviour.

What is also important to note is that people's education was based largely on how people think and not what they are. That is, the stress was on teaching as the imparting of neatly packaged answers to limited questions. Those initiatives were

possible because Jo-care's CEOs presented an optimisation report and strategy catalogue in which they determined the attributes necessary for people to be successful in their work and the degree to which those attributes can or cannot be encouraged through education. Among those who participated most actively in Jo-care's reorganisation were the 'progressive intellectuals' as they are called by Chomsky (1991, p. 8); i.e. senior staff of the various departments and consultants of the medical profession, who took great pride in being able to direct a resilient work force into reorganisation by involving and persuading them and eliciting their enthusiasm. In this respect, the discourse of participation and staff development fitted in with the change of Jo-care's organisational culture in which people learn about themselves and strive for a decentralisation of decision-making powers. That is, autonomous and better informed people were expected to take the future of this hospital organisation into their hands and to be capable of developing their own destiny. Commenting on the way Jo-care's people are educated, a ward sister explains:

> Ruby: (...) Uh for instance our LORE seminars a few weeks ago, "Learning from Success". There were people there from the central buying department, computer department, anaesthetist doctor, etc., and also a few nurses. (3.75) That was a success in the same kind of way. Well, I knew almost all of the people there, some a bit better than others through working together. And when we see each other we say HALLO to each other. And before you were never actually sure whether to say hello or not. So that's stayed, in my opinion, and is still kept up - a good combination.
>
> Maggie: And the results of these seminars? Have these results been put into practice?
>
> Ruby: In the LORE for instance there's more and more (2.90) checking up, supervising. At every meeting we try to ... well as far as I've seen. Whenever there's a new goal to be achieved someone is deemed responsible. And in the next meeting they have to give a report about progress, results, the general situation. Everyone is given a certain length of time but they have to present a result - whether positive or negative. (3.47) So there's a certain degree of effectivity there. (3.34) If you're in a LORE group then you're keen on seeing things get carried out. (...)

As this statement suggests, the emphasis was on a combination of values and the promotion of an 'amoebic-like structure' as found in Hope and Hendry's study of corporate culture change (1995, p. 68). That is, Jo-care's CEOs value investments in

human capital as much as investments in architectural re-developments and they use an organisation-wide, formalised structure of interlocking communication groups to support people's efforts on the front-line. As a result, Jo-care's people are more likely to be more satisfied at work and perhaps even talk more positively of their hospital organisation than they would otherwise do. Jo-care's programme of participation and staff development, however, offered largely uncritical descriptions of what had taken place in the day-to-day practice of this hospital organisation. Regarding Wilkinson (1998) and Warhust and Thompson's view (1998b) one has to question who is educating and/or empowering whom and why, as well as who reaps the benefits?

In Jo-care, shortly after commencing my fieldwork, it became obvious that the interrelated notions of employee participation and staff development were sold as natural occurrences because the hospital's CEOs presented them as if they were entirely products of the time and displayed them within a positive context. While there may well be some valid grounds for an educational and participative agenda, one critical aspect of this rhetorical product is that it did not challenge the managerial prerogative. The key point here is related to the fact that it is still Jo-care's executive management who may compromise the goals which entitle people to participate in decision-making and to learn the appropriate behaviour within their work environment. One staff nurse emphasises and elaborates this point of view as she refers to the primary source of Jo-care's rhetoric:

> Sally: You can write down a lot of things on a sheet of paper. (2.37) Recently I was down in the admission office and someone said to me "Look Sally, I found something about [name of consulting company in charge of the hospital's main chair]". They [CEOs] knew all about what was going to happen in Jo-care. Well at the beginning of the interdisciplinary seminars certain catchwords were presented. And they got written down on cut-out paper clouds. And suddenly there they were again although I can't remember exactly. And I saw it was true. Yes, my colleague was right. You know I'm not the kind of person who goes through the hospital =
>
> Maggie: = Wait a minute - let's go back. The cut-out paper clouds used in these seminars turned up again.

Sally: Well they wrote on paper and had lots of clouds. (...) And one of the phrases was about money. And my colleague said that's exactly what's happened. But I can't remember exactly what it was.

Maggie: So you think the CEO knew exactly before the interdisciplinary seminar the results they wanted. And which direction they wanted to point the staff in.

Sally: Ye::s. (...) Well I think that they knew exactly what they wanted to achieve. Even before they approached us they knew the goal they wanted to achieve. And before they did the interdisciplinary seminars with us they knew in which direction they wanted to guide our thoughts. They definitely knew that, because otherwise that would have been bad management. They had already prepared certain things for us. During the first seminar they got on our nerves, saying "Tell me, how are you all? You really feel that bad?" In the second seminar all they said was "Well, how are you?" - "We all feel so goo::d". At the first seminar there were six people from our ward, a strong team. At the second seminar there were only three or four of us and we got divided up for various workshops. The first time we were divided up into groups according to wards. The second time it was more mixed. There was more of an exchange of ideas, on a bigger scale. But then we were told there weren't going to be any more seminars. There's only one day in Jo-care when we can all meet up and discuss our opinions, our experiences. (...)

As this interview extract suggests, the appreciation of people's participation did not facilitate a particular framework for organisational action and their learning has not led to new patterns of authority, responsibility and incentives. Actually, this staff nurse's response demonstrates that she has been eager for organisational and personal development but more than confused about the process of its achievement. For Sally, the discovery that Jo-care's organisational development programme served just to bring people in line with managerial objectives led to a betrayal of her expectations. Her own considered verdict is that the rhetoric was glibly conceived and that at the end of the day Jo-care's people were used to prepare new strategies and policies which were defined and determined long before.

The critical comment of this staff nurse provides some useful insights into how Jo-care's people perceive and understand their involvement and/or the development of their knowledge and skills levels which presented contradictions to the cultural rhetoric. That is, the degree of participation and education offered by the rhetorical programme was strictly within the business-oriented agenda set by Jo-care's CEOs and has not extended people's real insights and/or participation in higher level strategic decision making. Here, the rhetoric of participation and staff development

is delusive because the existence of it and the managerial motives do not imply that Jo-care's people are autonomous or more educated. This argument is in line with Wilkinson's critical account (1998), who draws on empowerment as a form of employee involvement initiative:

> While there a wide range of programmes and initiatives which are titled empowerment and they vary as to the extent of power which employees actually exercise, most are purposefully designed not to give workers a very significant role in decision-making but rather to secure an enhanced employee contribution to the organisation. Empowerment takes place within the context of a strict management agenda (p. 40).

Because control by Jo-care's executives can never be absolute, they not only require the compliance of people within the hospital's labour process but also their consent and co-operation (Cressey and MacInnes, 1980). Another critical point in the rhetoric is the claim of the rise in more educated people because, as described by Thompson and O'Connell Davidson (1995) 'the key issue is knowledge, not education' (p. 20). With reference to Jo-care's past, clerical founders and ecclesiastical administrators were already keenly aware of the complex knowledge base possessed by the Sisters of Mercy and medical professionals, and how important these existing forms of knowledge were to the development of this hospital organisation. Whatever the levels of education, Jo-care's people use and apply their cognitive and technical knowledge to exert a powerful influence over the organisation of the hospital's day-to-day practice. According to Warhust and Thompson (1998a) "[i]t is important not to lose sight of the elements of continuity. All workers are, of course, knowledgeable about their work - and always have been" (p. 7). In this respect, there has not been a real challenge to the knowledge associated with the nursing and/or medical profession because the hospital as such continues to remain completely dependent upon the bodies of knowledge provided by its professional staff.

Of course, there are some formal arrangements by which to acquire more professional skills and knowledge in this hospital organisation (i.e. training and education workshops) but Jo-care's people are expected to find the means for

achieving their career plans by themselves. That is, those who want to become more knowledgeable are expected to inspire themselves, to co-operate with others and to take the opportunities that Jo-care offers for training and staff development. Thompson and O'Connell Davidson (1995) hit this particular nail at the head when they describe how the initiative of personal development helped *Albion's people* 'to manage themselves and their relationships with peers and the company' (p. 31). Developing a similar point Warhust and Thompson (1998b) refer to Purcell and Earl [1977] and explain that senior managers

> engage in what might be termed 'peace work', allowing informal, adaptive behaviour and practices of workers within the labour process as long as it contributes to, or at least does not undermine management's needs to get the job done (p. 12)

By its very nature, however, people's knowledge and skill base is most likely to be more Jo-care-specific due to their organisational workshops, performances and social relations in the hospital's day-to-day practice. That is, Jo-care's people are unable to realise the degree of in-determination, monopoly and control of their knowledge and skill base enjoyed by liberal occupations; e.g. *freiberufliche/r Krankenpfleger/in* [i.e. free practising community nurse] or *frei praktizierende/r Ärzt/in* [i.e. free practising medical doctor]. In other words, Jo-care's people cannot decide independently how their knowledge and skills are transferred to the organisational context even though their education and accreditation system would allow their independence from any organisation. In each respect, as described in Reed's empirical review and theoretical syntheses on expert power and control (1996), the knowledge and skill base of Jo-care's people is likely to be more 'organisation-specific or localised' and lacks 'the degree of abstract codification and generic application typical of established professions' (p. 584). At the time of collecting my research data in Jo-care, it was the regulation and intensification of people's occupational work which were the most typical observed sensations.

Looking at the managerial motives in the hospital's day-to-day practice it becomes clear that participation on the part of Jo-care's people and their detailed knowledge

was used to identify and solve problems at hand. That is, the use of Jo-care's people to make plans and carry out problem solving is an accepted technique in the hospital's day-to-day practice as they can make more accurate judgements than other individuals since they bring a greater sum of knowledge and information as well as greater number of approaches, to the organisational problem. According to Warhust and Thompson (1998b), it was the 'growth of *knowledgeability* in work' which drove Jo-care's CEOs to use educational and participative mechanisms as normative arrangements in order to capture people's knowledge through off-line problem-solving groups (p. 13). That is, the knowledge and ingenuity of Jo-care's people was utilised by the CEOs, and the removal of barriers between functions was oriented towards continuous improvement, cost effectiveness and speeding up innovation processes. Indeed, Jo-care's people were knowledgeable and experienced enough to contribute collectively towards greater service innovations and to assist in the context-specific evaluation of their day-to-day practice. As a result, they became subject to increased monitoring of performance and were increasingly drawn into what Milkman (1998) refers to as the 'intensification of their own exploitation' (p. 31). That is, people mainly participate in groups to study themselves because they are closest to the work situation on the hospital's floors, and suggest improvements which senior managers are unable to think of by virtue of their detached position in the hierarchy.

Explicit and implicit in this argument is the evidence that conceptual knowledge derives from Jo-care's people and their shared understanding, and this knowledge was exploited by senior managers to facilitate greater creativity and learning at work. Another argument is that the move towards employee participation and the use of their knowledge and skill base, facilitated by the availability of information technology, provided accurate and up-to-date information about people's performances and organisational processes, which enabled Jo-care's CEOs to make rapid responses and faster decisions. As mentioned previously on page 219, this process involves control mechanisms for appropriate participant behaviour which were rigidly described and applied by Jo-care's CEO. Seen in this light, it was this

multi-faceted and complex knowledge base which enabled senior managers to reorganise people's work and according to Braverman (1974) this provides a form of power that makes their superior position as an occupational group justifiable. Thus, as Warhust and Thompson (1998b) argue, the new programme of participation and staff development has not replaced but rather 'complemented the traditional vertical division of labour and command structures' (p. 13).

Once again, the inconsistencies are evident, as I have demonstrated regarding the gap between Jo-care's rhetoric and its day-to-day reality. However, moving beyond general critique, it is necessary to add interview accounts of how Jo-care's CEOs and their staff live and operate within that gap. To illustrate both processes, I focus on one excerpt in which Mr. Tate speaks about one important product of Jo-care's rhetoric, while he is referring to the hospital's reality:

> Maggie: Could things function at all without an organisational philosophy?
>
> Mr. Tate: Well, basically they can. But then the leading chairman - the values laid down in the organisational philosophy - uh. he would has to be more or less always in the hospital. Then you could demonstrate these values. Well, that's my experience anyway; the less the superiors are there and the more responsibility you delegate the more important it is to have an organisational philosophy. So that the people practically - I always use the word crash barrier. They can drive along the road freely, as long as they're within the limits of the prescribed values. It's nothing other than values which are laid down.
>
> Maggie: So on the one hand there's tremendous freedom of action, speeding about within these crash barriers. They can skid and everything as long as they keep within the limits, the barriers, and don't overstep them. On the other hand the organisational philosophy provides a certain framework where you have to say this far and no further.]
>
> Mr. Tate: [Yes, yes. That's right. That's the way we do it in almost every hospital now. Maybe you have to give it a different name though. To begin with and when the people rave about [name of town where the interdisciplinary seminars took place] then it was all nothing other than working out the organisational philosophy. (...)

As this interview extract suggests, the rhetoric-reality gap is evident when Mr. Tate talks about the use of Jo-care's organisational philosophy and states that it is a different form of management. The rhetoric is about more 'responsibility' and 'delegation' due to which Jo-care's people 'can drive along the road freely'. In

contrast, the reality is more a question of driving within these 'crash barriers' which are 'the limits of the prescribed values'. Here, as reported by Thompson and O'Connell Davidson (1995), Mr. Tate insists that the organisational philosophy underpins people's autonomy even though 'the system of supervising is exactly the same' as the one which existed to direct and control them traditionally (p. 25). In reality, people's work is closely prescribed by the organisational philosophy of this hospital organisation and they must conform to criteria set out by Jo-care's CEOs.

Another value of the organisational philosophy to Jo-care's CEOs is that they are able to keep themselves distant from the hospital's day-to-day practice. This could be one explanation as to why this small consultancy company manages to be highly successful even though they are in charge of more than 13 different hospital chairs at the same time. Thus, the promising picture of Jo-care's rhetoric is hard to reconcile with much of what was reported to have been happening in the real world of this hospital organisation. In demonstrating a critical view on contemporary rhetorical products Warhust and Thompson (1998b) express:

> The prime mistake of those promoting the post-bureaucratic organisation is to believe that new horizontal forms of co-ordination have replaced rather than complemented more traditional vertical divisions of labour and command structures. (...) What *is* happening in many workplaces is the emergence of a dual structure which combines the search for innovation with enhanced financial and operational accountability. Methods of co-ordination and accountability therefore become more complex, but vertical structures remain the backbone of organisations (pp. 13-4)

There are a number of parallels between this quote and the arguments presented above because it also illustrates the inherent gap between Jo-care's rhetoric (i.e. the programme of participation and staff development as a new horizontal form of co-ordination) and the reality of its day-to-day practice (i.e. the managerial responsibility to direct and control the service and labour process). Considered in this light, such an evaluation allows a more realistic response to Jo-care's rhetoric and it was in this domain that changes in the productivity of people's work were attempted.

The majority of Jo-care's people made significant contributions to improve the service and labour process but in their day-to-day practice numerous problems emerged. That is, a lot of them followed the lines of action within the hospital's dialogue because they felt they were involved and providing important information to executive or divisional managers. However, the new programme created frustration among Jo-care's people and tension between management and staff. Commenting on the ways people experience and respond to the participative and educational project of Jo-care's management, one of the pool nurses reflects upon her feelings:

> Vivienne: Well these are my feelings and they are personal. And since my interview I've been carrying that around with me. That you either fit in or... Well, I can't even say exactly how (4.66) how they - I don't really know who, the LORE or the chief executive management? I don't even want to say the CNE - how they want their staff to be. I can't make it out. You're meant... it seems to me (2.59) a uniform person who can be put [to work] anywhere, anywhere - it doesn't matter whether in business or wherever. Somebody who is madly motivated, madly open-minded and who's CRAZY about work but - well, maybe s/he's scared about losing his/her job or something - who's prepared to do anything to measure up and do his/her job properly. (...)
>
> And the rest of what goes on in the hospital - well it was really great that we got a new cafeteria and that the building's all new, but you begin to wonder why they don't give us money for nursing equipment or why there are cuts. Or why we can't get extra staff. So you think more about things like that. I do anyway and, most of my colleagues as well I think. Take the LORE project for instance - that's a real stumbling block. Why do the ward sisters have to attend these meetings all the time and why does so much money get spend on making up new rules for us? The money's needed more on the wards. (...) I don't feel at ease about the whole thing. Our hospital is getting more and more beautiful on the outside and by that I mean the whole service offered to private patients and all the other stuff and carry on. But somehow I have the feeling - like with Scientology - that it's all nice friendly people who always smile and everything's great. But it's all so smooth and slippery, nothing to get hold of, to put your finger on. (3.12) That's how it all seems to me.
>
> Maggie: This kind of organisational policy has been familiar in industry and other service sectors for much longer than it has in hospitals.
>
> Vivienne: Yes, I know about it through McDonald's. Yes.

This pool nurse's account typifies a sense of distrust and hesitation that became most apparent among the less powerful people in Jo-care. That is, the above interview excerpt illustrates Vivienne's critical awareness of the hospital's rhetoric, her precarious view of its practicality and the limitation of manufacturing people's commitment. It was pretty much the same with other people in Jo-care because some

of them reported various attempts to participate in managing their own affairs which just caused problems. To illustrate this one staff nurse remarks:

Sally: Oh, I had a conflict situation with Ms. Sterne [deputy CNE] a:nd (3.03). Yes I think I spoke my mind too much to someone. I spoke openly about something and she got wind of it.

Maggie: You didn't keep to the line of command? =

Sally: = Probably not, but more by accident. I didn't use to be so timid. But at the end of 1995, 1996 I always said I was once bitten, twice shy - bitten by Jo-care. If I hadn't known [female name] and hadn't had her to talk to about where to do my [post-registration] courses. I was so disappointed about the whole Jo-care system. It was really awful.

Maggie: Who was it you told something to that you shouldn't? Was it the CEO? About your personal impression of Jo-care maybe and he passed that on to the CNE in the form of criticism?

Sally: Yes, it must have happened in [name of town] at a [interdisciplinary] seminar. (...) In the second seminar, when the CEO approached me and Esther. He said to Ms. Sterne "Yes Ms. Sterne, these are our uh committed employees. We've got to do something for them" or something like that. Well we didn't keep quiet after he said that but said that's what we'd been waiting for all the time. [clears her throat]

Maggie: And did you talk a little about how things were on the ward?

Sally: Well, you know we go to a lot of courses. And whatever we learn there we want to pass on. We prepared notes and offered courses on the ward. For instance we introduced curds compresses. A:nd other wards heard about it and so naturally we showed them too. Then we went to Ms. Robinson [head of Department for General, Further and Post registration Education] and told her we'd be interested in giving courses at the school of nursing. She wrote it down on a piece of paper (2.06) Ye:s and (2.50) we said the same to the CEO and told him about what we'd done and so on. And we probably shouldn't have done that. Because we left her [Ms. Sterne] out. I really don't know. Anyway she didn't speak to me for six months after that. She avoided me and it was very obvious. Well I hadn't done anything wrong but =

Maggie: = So you think that the CEO went to her and said she didn't give her nurses a free rein to develop their creativity?

Sally: Yes, I think so, because we spoke so openly. It was simply the last straw. You know you can't live from commitment alone, you want to achieve something too. You get older and for that reason too you go to the courses. And everybody just made promises. And =

Maggie: = And has anything changed? I can see a change in the last four years the CEO has been here - and I've been familiar with Jo-care since 1989]

Sally: [Everything's going back to how it was.

Maggie: Going back?

Sally: Ye:s.

Altogether, people's critical view of Jo-care's rhetoric can be related to their experiences at work and that their function, is in part, to be '"spectators", not participants in action' as described in Chomsky's (1991) critical review of mediating control (p. 12). Of course, Jo-care's people have more of a function than that; i.e. apart from their physical participation in managing their day-to-day workloads, they are occasionally educated and/or authorised to become real participants. In other words, Jo-care's people are allowed to take part in project teams and to have a say in communication groups. The significance of these cultural formations is, however, that their participation within these decision-groups does not imply rights and does not transfer organisational responsibilities. Instead, the focus is on making use of Jo-care's people and the people working in the hospital's services were faced with the realisation of this managerial intended consequence.

One thing for sure is that the rhetoric Jo-care's CEOs have used - for instance, the programme of participation and staff development - simply did not succeed and actually undermined the credibility of top management. That is, the hospital's day-to-day practice was full of contradictions that limited innovation, motivation and drive because Jo-care's people felt more trapped and were less able to talk openly about what was really going on. This finding is in line with the arguments expressed by Argyris (1998) who evaluates the potential of employee involvement, reengineering and total quality programmes:

> [W]hen change programs are imposed without recognising the limitations of empowerment and when managers and employees are not helped to deal effectively and openly with them, the organisation ends up worse off than it was to begin with (p. 104).

Thus, despite all the best efforts that have gone into fostering participation and staff development, people's values and attitudes remained very much like they had been before Jo-care's reorganisation. Of course, Jo-care's people do what is expected of them in their day-to-day practice but most of them have not transformed their thoughts which could have resulted in high levels of commitment and satisfaction

among them. To be fair, however, it is important to remember that in Jo-care more than 700 people are employed who care and treat patients or carry out other forms of labour in the hospital's day-to-day practice. Nonetheless, the rhetorical framework is an illusory goal that Jo-care's CEOs cherish but never quite reach.

Conclusion

An emphasis of understanding has been placed in this and the previous chapter upon the design of distinctive interventions rather than their effects, and upon the diversity and unevenness of people's responses. Such an intention made it possible to discuss managerial strategies and to talk plausibly about the programmes of change which have been applied to achieve specific organisational goals. The importance here was to note the difference between traditional structures of bureaucratic and professional control, such as hierarchical and/or functional differentiation, and the idea of normative control which seeks to create people who commit themselves to the values and beliefs of the hospital organisation. While people's performances within the traditional bureaucratic structure are defined largely in terms of formal roles and required behaviours, within the system of normative control they are determined by informal processes and a particular set of attitudes and values. In Jo-care there was evidence of both types of control which enabled the hospital's CEOs to enhance their corporate power not only through the provision of the normative rhetoric but also through the managerial prerogative. Under these circumstances there were clear contradictions between the claims of the managerial rhetoric and the reality of its day-to-day practice with which Jo-care's people have to live and work. The consequence of these contradictions was that Jo-care's people were identifiable by their different stances and behaviours towards the managerial rhetoric. There were people who followed the lines of actions within the hospital's rhetoric and coped with the organisational demands through the application of organisational misbehaviour. However, there were others in Jo-care who did not change their way of thinking and had to make every attempt to survive within such a working environment. This meant that it was not easy for them to sustain an equilibrium between their personal and/or occupational selves and their official role under these

inconsistent conditions. Thus, Jo-care's people experienced the managerial rhetoric not only as a set of programmes by which to work, but also as an imposition which they had a struggle to cope with.

Chapter Ten

Concluding Discussion and Reflection

Introduction

This ethnographic investigation set out to explore and describe the reality behind the rhetoric of one hospital culture. The idea of changing the culture of an organisation is a popular concept within the world of academe and within the contemporary workplace. This intellectual product is concerned with the management of values, beliefs and meanings within organisations and this present concern involves the claim that cultural renewal induces employees to identify with the objectives of their employing organisation. To examine the practical and ideological implications of such a claim I undertook an in-depth study of the nursing division in one leading hospital institution: Jo-care. The questions I wanted to address were whether and how the cultural rhetoric is implemented in Jo-care and what it has done to the organisation's people. As the service attitude remains the ideological base of the health care professions and as people are able to organise themselves and pursue a certain degree of autonomy, a different account of the management of meaning is provided. In this concluding chapter I reflect on and critically discuss the main findings concerning Jo-care's re-created culture and its meaning for those subjected to it.

The Background of Jo-care's Case

Initially, there was a dominant hospital culture associated with a homogenous, largely professional workforce. The official reasons for creating a new culture derived from the hospital's perception of its need to respond to Jo-care's general lack of organisational and financial cohesion and the 2nd Health Care Reform Act of the early 1990s. As illustrated in Chapter Six, the hospital was encumbered with a configuration of management and organisation of work that was no longer appropriate, and its hierarchical structure did not facilitate the forms of employment relations essential for realising people's potential. During that period, managerial officials had concerns about the problems in communication and co-operation

between the different disciplines and the loyalty of Jo-care's employees towards their hospital organisation. By 1992, the hospital authority had introduced a managerial control system in the form of advanced information technology, but more importantly, it appointed new people from the outside who set in place economic, political and social forms that were qualitatively different from those of the old Jo-care.

As chief executives, these new people were able to propose a series of general reforms and designed a managerial strategy to convert Jo-care from a charitable hospital institution into a modern health care enterprise. As shown in Chapter Six, the hospital's CEOs launched their tactical ideas from a platform based on the mobilisation of Jo-care's corporate culture, and the subsequent events arising from their managerial rhetoric provided a sound base for a series of organisational reforms in the 1992-1996 period. The aim here was to preserve and refine what Jo-care's people valued at work, to improve economic perspectives by cutting out inadequate structures and processes, to develop service opportunities where they were feasible and manageable within current resources, and to step up the development of managers and staff. The enhanced service-orientation towards people, the generation and utilisation of knowledge, the increased cost-consciousness and the interest in its external public profile became core corporate concerns as discussed in Chapter Seven. These diverse themes became home for various corporate operations which Jo-care's long-term rhetoric required.

The official Story: On the Surface

Optimistic descriptions, predictions and prescriptions of the development of services and workplaces within the health care sector are nothing new, and claims of institutional excellence, empowerment, total quality and human resource management belong to the tradition of proclamations of pop management writers, uncritical academics and famous consultants. In retrospect it can be argued that the best-selling books of Peters and Waterman (1982), Deal and Kennedy (1982), Pascale and Athos (1982) and Ouchi (1982) were influential in helping to lay the

foundation for the modern managerial rhetoric within health care. That is, in the public utterances of CEOs and in both the popular, exultant management literature and more analytical offerings, the pressing need to be a successful health care organisation has been an on-going refrain. While Jo-care's CEOs may not have read the four key books of this period, the received wisdom and buzzwords of the modern managerial rhetoric within health care were fully dispersed within hospital circles. They used the language and practices of the fluid excellence pattern to reach deeper into people's personal selves in order to achieve an economic and moral revival through a programme of culture change. Described by the CEOs as organisational development, the overall programme of culture change included an emphasis on service orientation within a particular workflow, planned exercises in normative re-education, increased discretion on the part of Jo-care's people and a shift to a more participative and supportive style of management.

On the surface, all the evidence suggests that Jo-care's rhetoric was considered an important element because management and staff alike took the implications of it very seriously and spent a considerable amount of time in attempting to introduce codes, schemes and formulae into their everyday practice. The rhetoric required almost excessive dedication from Jo-care's people to the organisation and, for its part, the new structure and processes of the hospital were designed around these people, with clear lines of communication and responsible autonomy right down to the front-line. Here, Jo-care's CEOs were seeking alternative devices to the traditional bureaucratic-professional arrangements and attempted to carve out a niche within the wider hospital environment. Within this niche, Jo-care's rhetoric was used to implement technical and symbolic actions and to transform Jo-care's people into internally committed people obliged to improve the performance and strength of their health care services.

Above all, it was the emphasis upon people's morale that lead Jo-care's CEOs to claim that organisational reforms would not only be more effective and efficient, but also have beneficial effects on patient care and employee satisfaction. Here, the

managerial rhetoric can be seen as a normative educational approach to change, offering Jo-care's people a new way of looking at their organisational world. A vital aspect was to develop people's self-confidence and to integrate organisational and professional goals with their personal sense of self. As quoted on page 188, within Jo-care the CEOs acted as 'moderators' and adopted an informal and flexible approach towards people which facilitated a number of initiatives in the form of creativity and learning. The managerial motivation was supplemented by a range of participatory and developmental schemes which, over time, were expected to convince Jo-care's people that there were no alternatives to the reforms which the CEOs had instigated. Certainly, impressive changes were and have been taking place in Jo-care with particular emphases on people's utilisation and productivity, the provision of excellent health care service to its patient clientele and continuous cost improvements. Within this trend, the creation of the patient-oriented day-to-day programme (POT) and the initiative of resource allocation and management systems is particularly notable. Also notable is the creation of high trust work relations and the programme of employee participation and staff development.

At first sight, the hospital's image appears economically balanced, politically correct and socially sound; i.e. it has strengthened its political existence in the larger city area, the economic situation is stable and Jo-care's people continue to improve their co-operation and develop new services. It is also particularly significant that the hospital's people appear to be strongly in congruence with institutional excellence and engage in the sort of behaviours that Jo-care's rhetoric was seeking to elicit. This suggests that the rhetoric appears to have had an effect on how Jo-care's people saw specific aspects of their organisational world. Given these results, it is worth acknowledging that Jo-care seems to function somewhat better than the norm, since it has been classified with 350 other German hospitals in terms of excellent health care performances, managerial personnel practices, and good public relations (Focus, 1998). In short, Jo-care is an organisation that aims to serve its patient clientele and local community by competing with the best, in offering accessible health care at the leading edge and in bringing a handsome reputation to the ecclesiastical authority

which invests in it. Thus, a plausible justification of Jo-care's rhetoric can easily be found because a particular emphasis was placed on excellent health care services, staff development, economies of scale and its external public profile.

The unofficial Story: Below the Surface

Whereas the official story of Jo-care focused on the new approach with which the hospital organisation is managed, what is discussed in this section are the ways in which the cultural projects of management affected Jo-care's people and how they responded to it. That is, in the following discussion people's experiences of Jo-care's rhetoric and related managerial initiatives are examined. The section is organised in the following way: Firstly, the theoretical stance is shown to be important and two dominant perspectives are outlined which may reflect most recent attempts to manage corporate culture change. The labour process perspective, in particular the structuralist approach within the health care sector, is then further explored.

Again, the content of the rhetoric is briefly outlined and reviewed. Here it is shown that its impact is likely to be shaped by pre-existing management concepts. The consequences of such initiatives in terms of management control are then reviewed. In the second part of this section I examine the practical and ideological implications of Jo-care's rhetoric and the employee experience of the managerial initiative. That is, I draw together my previous discussions and show that, in this context, an optimistic view has little substance with regard to service-orientation towards Jo-care's people, high trust work relations, staff development and participation. However, there are good grounds for supporting the claim that the organisation of nursing care has its own imperatives and depends on paid professionals with shared values and a service attitude. Thus, a different account of the management of meaning is provided, but one which takes the different mode of rationality within health care into consideration.

Jo-care's Rhetoric in Context

A number of the principles displayed in Jo-care's rhetoric underpin most recent attempts to manage corporate culture change. Rosenthal *et al.* (1997) summed it up quite neatly:

> At the centre is the individualising philosophy of the contemporary enterprise culture, in particular the values of self-actualisation, freedom and 'respect for the individual'. This philosophy informs the 'excellence' approach to organisations, which in turn influences human resource and quality management. A second principle is that of full utilisation of human resources as a basis for obtaining competitive advantage, through high employee satisfaction, commitment and productivity. A third is the notion of assigning more discretion and responsibility ('empowerment') which is central to all approaches. Fourth, there is a weight given to customer satisfaction achieved through continuous improvement and service excellence. Finally, there is an emphasis placed on the need to integrate individual and organisational goals through the creation of 'strong' performance-oriented corporate cultures (p. 483).

The main body of case study and survey evidence is polarised into a post-structural position and a labour process stance. These matters were discussed in detail in Chapters One and Two. As a reminder, however, there are those who report a greater subjection of employees which arises out of the manipulation of meaning, and there are those who report enhanced bureaucratic and normative control within the labour process which arises out of the refinement of managerial techniques. The post-structural position is that the fundamental rules underlying the approaches of excellence, empowerment, total quality and human resource management are effective by means of cultural ideologies or discursive practices. The claim here is that the value-driven approaches do indeed work in the ways they allege because the systems of discourse and practice, in alliance with disciplinary power, mean that organisations greatly influence what employees internalise as personal identity. However, the neglect of the potential power of the knowledgeable human subject obviates any use this post-structural perspective may have for the analysis of organisations.

Alternatively, the labour process stance holds the view that total quality and human resource management, and the broader ideas of excellence cannot be used to build commitment and shared understanding among employees because they are

hypocritical and not trustworthy. The labour process view presented in this research perspective suggests that, while executive managers seek commitment and greater employee discretion, in effect by means of propaganda and structure, it is the increase of new forms for controlling employees, that establish hegemonic power over their thoughts and so substitute consent for coercion. Labour process researchers analyse the implementation of specific cultural programmes in terms of attempts at managerial control and employees' ability to resist within the confines of the capitalist workplace. Against the post-structural view of the inseparability of discourse and practice and the discursively constituted nature of reality, their ideological view assumes a critical reality that acknowledges the possibility of people being active human subjects, who through negotiation are able to break the chain of power and make their own histories within social structures.

The various research accounts of the labour process perspective are long on the content of conflict and accommodation that characterise private sector workplace relations. They are short, however, on the substantiation that the ideologies and strategies of excellence, empowerment, total quality and human resource management do work differently in state sector organisations such as hospitals where the traditions of professional autonomy and an ethic of service are shared by the employed occupational groups. As discussed in the second chapter of this study, the occupational group of nursing does not rely solely on their technical knowledge and skills to provide physical labour but also on shared values, in the form of an ethic of service and welfare, to provide health care labour to their patient clientele. Little evidence has been presented to support the view that the conditions of work of these people within health care are more 'conducive to commitment' and it might be expected that a greater internalisation of values and associated behaviours is effected among them (Thompson and Findlay, 1999, p. 181). In the following paragraphs I will draw together my previous discussions and reconsider what the implications might be for Jo-care's people.

The labour process perspective presented in this research suggests that, while Jo-care's CEOs seek commitment and greater employee discretion, it is the exercise of increased centralised control which has been reinforced; a form of control which does not challenge the managerial prerogative. Even though the intuitive style of management, the re-education and the participation of Jo-care's people were very much the order of the day in the 1990s, the key point about these cultural schemes is that a different form of control was required to create norms and meanings congruent with professional and corporate interests among Jo-care's people. In this set of circumstances, the implementation of specific initiatives, although presented in a positive light by the CEOs, have not only led to normative and behavioural control devices, and therefore to a greater subjection, but also to an enhanced utilisation of Jo-care's people. In sum, therefore, if the aims of Jo-care's rhetoric are achieved in practice, they are realised through enhanced managerial control, physical and mental work intensification and the gaining of employees' creativity and active consent. In the following paragraphs I will draw together my previous discussions and reconsider what the implications might be for Jo-care's people.

The Roots of Jo-care's Rhetoric

It is easy to assume Jo-care's rhetoric is simply a new natural phenomenon in that management and staff make scant reference to its ideas and practices. In fact, the majority of Jo-care's people presented the rhetoric as if it were entirely a product of the time and did not see it within a historical context. Even though Jo-care's rhetoric is heralded as a new and radical philosophy of hospital management, it is in many respects a case of *The Emperor's New Clothes* (Argyris, 1998). Influenced by the work of consultants, the rhetoric embodies many of the ambiguities and contradictions evident in earlier workplace strategies such as the concepts of 'industrial betterment', 'welfare capitalism', neo-/human relations and 'quality of working life'[1] (Barely and Kunda, 1992, p. 363). Whereas the proponents associated

[1] Where industrial betterment and welfare capitalism sought to address the problems of organisations by socialising employees through the communities in which they lived, the neo-/human relations and quality of working life movement sought to transform the organisation itself and, more importantly, management, into a cohesive collective. See Jacques (1996) or Barely and Kunda (1992) for examples.

with the previous management concepts speak of organisational climates and occasionally note that organisations have cultures, the authors of the managerial culture literature explicitly link 'strong' organisational cultures and employee commitment to corporate competitiveness and success. For example, Deal and Kennedy (1982) write in no uncertain terms:

> The impact of a strong culture on productivity is amazing. In the extreme, we estimate that a company can gain as much as one or two hours of productive work per employee per day (p. 15).

All these workplace concepts share a common assumption that employees prefer to exercise self-control and contribute to an organisation so as to meet their needs for self-actualisation. It is also assumed that planned exercises in normative re-education and a participative and supportive style of management are likely to lead to job satisfaction and/or better quality decisions. As Wilkinson (1998) has put it with regard to the theoretical implications of empowerment:

> It is assumed that first workers have the opportunity to contribute to organisational success and as they are closer to the work situation they may be able to suggest improvements which management would be unable to by virtue of their position in the hierarchy. Empowerment would also increase job satisfaction and reduce turnover as workers feel more committed to organisational goals. In addition, as workers are empowered this reduces the need for complex and indeed dysfunctional systems of control, hence increasing efficiency (pp. 44-5).

Even though all the concepts are based on the individual employee and emphasise normative control there is also an economic case for the concepts which is primarily rational. In practice, however, they are usually seen as a type of staff development and participation scheme, designed by executive management and intended to enhance people's contribution to the organisation and to generate commitment among them. While some forms of such schemes provide employees with new information and prospects through which their knowledge and influence could be enhanced, they do not replace people's beliefs and emotions and/or challenge the managerial prerogative. Whatever the practical limitations, the onus is on executive and senior managers to involve and educate people and/or to give people the

opportunity to be involved and to become educated (Wilkinson, 1998). That is, managers, particularly at executive and senior level, carry 'the culture burden' of becoming directly involved in determining and introducing normative regulations (Thompson and Findlay, 1999, p. 179). Thus, a distinction can be drawn between participative and educational initiatives and managerial initiatives which may involve and develop people (the former including the growth of democracy and the body of professional knowledge).

Certainly, the results of my research suggest that Jo-care's rhetoric in the context of its usage in recent years can be seen as reflecting this organisational approach. It clearly fits within the above mentioned tradition which emphasises human resource issues such as service-orientation towards people, a continuing organisational learning process, a climate of high trust and increased discretion on the part of Jo-care's people. Indeed, Jo-care's rhetoric also emphasises more direct business considerations such as the provision of quality care and the increased flexibility and creativity of its people. Thus, business considerations and labour issues are united within Jo-care's rhetoric by sharing a common assumption that the interests of employees and their executive managers are inextricably connected.

Despite the promotion of a new unity and loyalty, which are the primary attributes of the corporate rhetoric, there is evidence that Jo-care's rhetoric is based on earlier workplace strategies that try to match the social and psychological needs of employees with those of the organisation. That is, the necessity for change has long been a feature of popular management discourse and one can read much the same in the articles of the 1950s and 1960s. An alleged renewal of particular ideas can therefore not easily be claimed because even the most superficial historical glance at Jo-care's rhetoric demonstrates a recurring interest in 'workplace social engineering' (Thompson and Findlay, 1999, p. 170). The early 1990s saw the old managerial strategies emerge in their modern forms. While many managerial initiatives may have affected the day-to-day practice of Jo-care, they need to be seen in a particular socio-political and historical context.

The 2nd Health Care Reform Act was introduced as a specific solution to a government problem faced by the Helmut Kohl administration. That is, the health minister Horst Seehofer along with the German parliament and the upper house [i.e. *Bundesrat*] warned that a breakdown of the health care system was imminent unless action was taken. The problem was how to contain health care costs without overtly rationing or limiting the availability and/or quality of health care to the German population. Amid public and political concerns, the legislation and methods offered by the government were concerned with non-discriminatory and culturally acceptable concepts, such as the improvement of quality service and interdisciplinary co-operation, the promotion of efficiency and effectiveness, and - in particular - the elimination of mismanagement.

At some point in the early 1990s, business thinking within hospitals had become familiar with governmental concerns and attracted by the notion of new modes of managing. It was argued that the environment was now more competitive, partly due to the liberalisation of the health care sector, and that patients were becoming more demanding in terms of choice, quality, and service. Many of the non-profit hospitals were restructured into independent hospital trusts, and on these occasions certain higher officials could not entirely resist the temptation to indulge in pop management ideas to impress their employees, patient clientele and local community. The most popular ideas were related to the fact that hospitals too often deliver health care service in inconvenient practice locales, in ways that are inconsistent if they are subject to individual preferences of different occupational groups, and in ways that demonstrate too little regard for its patient clientele. Such ideas were also advocated by the influential management consultants of this period, including those who became Jo-care's CEOs, whose ideas also popularised the recent approaches within health care. Whether it was a matter of the establishment of a 'flexible' bureaucracy, a 'strong' professional culture and/or a responsive health care organisation, a flood of claims as to the institutional excellence, rationality and effectiveness of hospitals began to appear and were, too often, believed.

In Jo-care, the new value-driven approach brought about implications for the management of its human resources. Within a short period of time the newly appointed CEOs moved away from an approach based on compliance, hierarchical-professional authority and limited employee discretion to one involving greater emphasis on health care quality, high trust work relations, responsible participation and staff development, and where there was a call for the utilisation of people's expertise and for their commitment. This was, as the head of the Department of General, Further and Post-registration Education has put it, Jo-care's "only way to survive and compete in the business and political world of the 1990s". This statement illustrates an important point of view; i.e. that the cultural projects of management may be seen as a business necessity since Jo-care could no longer function as before. Under these circumstances, it appears that people's loyalty was especially significant at this time and the call for commitment became crucial. Furthermore, the development of the rhetoric was inevitable as the main chair of the hospital had been allocated to Jo-care's CEOs. That is, the new CEOs had to respond to reduced revenues and increased organisational problems through the diverse programmes of organisational change. As the rhetoric spread in Jo-care's day-to-day practice, the most common development was the attempt by the CEOs to undertake a programme of generalised change, wrapped up in new language and practices. Thus, all the talk about people's self-actualisation and job satisfaction was very much secondary to simply introducing complex executive control, higher levels of quality care, advanced efficiency and labour productivity.

Empowerment and Staff Development

One of the stated objectives of the managerial rhetoric was to empower and develop Jo-care's people. That is, people were allowed greater discretion in regard to decisions and actions that could be taken on behalf of the hospital organisation without reference to Jo-care's CEOs. As previously noted, the analysis of documentary materials and my interviews with Jo-care's people indicate that this was a contradictory approach because even though people did get involved, they did not acquire the ability to display more discretion. The importance that people place on

these initiatives indicates that there is not much flexibility within the day-to-day practice of Jo-care. Examples include the introduction of resource allocation and the creation of the organisational philosophy to control the behaviour of Jo-care's people. This form of normative control was accompanied by an increase in technological and bureaucratic control. As I have noted earlier, the use of advanced information technology and the managerial prerogative enables Jo-care's CEOs to maintain centralised control. Support can be found in the investigation of Harley (1999) who recognises that "hierarchical structures remain central to the majority of contemporary organisations, and the impact of other changes to work organisations must be understood in this context" (p. 41). As observed by Kunda's (1992) critical research of *Tech's* normative exchange:

> The essence of bureaucratic control - the formalisation, codification, and enforcement of rules and regulations - does not change in principle under a system of normative control; it merely shifts its focus, at management's discretion, from the organisational structure to the organisational culture, from the members' behaviour to their experience (p. 220).

With this in mind, the enlargement of people's participation in managerial decisions, the rise in the amount of accessible information and an increase in autonomous decision-making, previously exercised by their executives or senior managers, can be considered as insignificant. Therefore, there has been not an advance in people's discretion because Jo-care's CEOs established the participatory agenda in a restricted frame and it can be suggested it was firmly within their managerial agenda. As I have noted in the first part of this section, 'normative control' is not new, but in Jo-care the theoretical concept has been transformed into its day-to-day practice. The evidence suggests that this process was made easier by the interest of Jo-care's CEOs in the implementation of such ideas, the availability of information technology to support the new principles and practices, the climate within the wider health care sector that legitimised such managerial efforts, and, not least, the need for Jo-care's continuing long-term economic viability.

On the positive side, the introduction of an organisational development programme has lead to the involvement of Jo-care's people in self-managing project groups.

That is, the CEOs have redesigned the role of Jo-care's people by the introduction of their direct involvement in the hospital's operational groups. In the early 1990s, however, the CEOs were keenly aware of the experience of people and how important this knowledge was to the development of Jo-care. As Jacques (1996) reveals in his historical account, it has long been the key concern of managers to 'make capital'[2] out of the originality of what people know and do (p. 143). In this respect people's involvement has had a critical aim because the agenda of staff development emphasises more direct business considerations; e.g. quality, efficiency, flexibility, effectiveness. The logic here is that Jo-care's people stabilise everyday practice by organising particular activities for the benefit of this hospital organisation. Contrary to the claim of the emergence of the *Learning Organisation*, the interview and observational data suggest an increased use of Jo-care's people and there have been considerable benefits arising from their involvement, both in monetary and innovative terms. However, neither the ecclesiastical authority nor Jo-care's CEOs offer sufficient reward, such as financial participation and/or representative participation[3]. Despite the emphasis on service-orientation towards Jo-care's people, the analysis shows no association between organisational benefits and employee reward. Below all the rhetoric of participation and staff development the most important trend was that the benefits tended to be for the hospital organisation rather than for Jo-care's people. This argument is in line with the observations expressed by Warhust and Thompson (1998a):

> [T]he hollow laugh received when mentioning the word 'empowerment' in most organisations is the true test that employees at many levels experience this 'great innovation' less as the opportunity to exercise extra discretion and more as the necessity to undertake more tasks (p. 9).

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[2] This aphorism is from Thomas A. Edison [1917] who was the founder and business executive of General Electric; but it is reflected in A. W. Co. Shaw [1917] (ed.) *Handling Men*, Chicago, IL, A. W. Shaw Co. p. 81.

[3] Once again, it is important to note that the research data are taken from a Roman Catholic hospital that has to operate as a non-union environment. Industrial action and secular work are in contradiction to the theological laws of the ecclesiastical authorities. That is, ecclesiastical employers and employees are considered to be in the service of Christ, so that no conflicts of interest between church leadership and employees should arise. However, in order to meet their mandate of care, these authorities must employ secular staff whose primary motivation is to earn a living. Nonetheless, the Christian service ideology is applicable to all staff relations.

It is noteworthy that the participative programme has become firmly established in the day-to-day practice of Jo-care. According to interview respondents, however, as the programme entered its fourth year, there were attempts by the more experienced people to reduce and/or withdraw their involvement in Jo-care. The observational data complement the interview data which means that people experienced change fatigue and felt 'worn down' by the increased expectations in Jo-care's day-to-day practice. However, there were others who recognised their particular work role and who displayed the appropriate and expected behaviour as outlined in Jo-care's rhetoric. Despite their conformity with the required role, they used defence mechanisms where the appropriate performance could be abandoned.

Physical and Mental Work Intensification

In addition, the introduction of the POT was intended to increase the emphasis on service orientation towards people within a particular organisational workflow. Both my observational and interview data indicate a strong endorsement of service orientation by the front-line people in Jo-care. In the hospital's day-to-day practice and in the interviews, no one spoke negatively about the value of the POT and/or questioned the aim of high quality health care services. In other words, the majority of Jo-care's people were enthusiastic about the POT and reported an understanding of the initiative. As outlined earlier, the interactions between Jo-care's people and patient clientele are likely to be highly individualised, but the former are used to provide health care labour at work in exchange for a wage. Under these circumstances, even within a highly scripted hospital system, the skilled and knowledgeable people in Jo-care share vocational interests and have some power in organising details of day-to-day patient care. It is interesting that Thompson and Findlay (1999) argue that professionals, with their superior qualifications, creative work content and operational autonomy, are "working well beyond what any reasonable interpretation of the employment contract might suggest" (p. 181). In this context Anthony (1990) suggests that

> there is no doubt that the allegiance of the inhabitants to a common culture is reinforced by a tradition of moral concern (...) the internal values of health or

> education are shared by the inhabitants, who influence the culture of their organisation because they regard its institutions as instrumental to their practices and to their concern with internal values (p. 6).

As this statement suggests, the provision of personalised, flexible and innovative services is already shared by the occupational groups within health care and is dependent on their professional education. That is, the patient-oriented behaviour of Jo-care's people is based upon something active and it is precisely this form of commitment that enables them to make use of their knowledge and skills and operate within operational autonomy. My informal and formal interview data have enabled me to provide an overall picture of the situation in Jo-care prior to the implementation of the POT. In following the approach of Rosenthal *et al.* (1997) people were asked whether the POT had changed the way they did their health care work in Jo-care. This was helpful because I can argue that Jo-care's people already showed a strong commitment towards patient-orientation, health care quality and accountability prior to the implementation of the POT. Thus, the POT did not significantly change the way people do their health care work because prior to the implementation of the rhetoric they already engaged in the kind of patient-orientated behaviour Jo-care's CEOs were seeking to achieve through their rhetoric.

People's pre-commitment does, however, not exclude them from managerial interventions to manage and mobilise them in pursuit of higher health care quality and increased productivity. I prefer to identify what the CEOs refer to as 'service-orientation towards people and people's needs', as the reorganisation of professional labour in Jo-care. In this respect, the POT, as implemented in the day-to-day practice, is closely related to the control revolution brought about by Weber (1946, 1947, 1982). That is, the desired and popular flow-line work operation involves control patterns which are based upon a rational objectivity to minimise any irregularity and assure continuous employment of labour in different parts of the hospital. In the current context, Jo-care's CEOs appear to want a standardised 'best practice', but also a 'strong' professional culture which embraces the new values of flexibility, quality and creativity. Here, as Ackroyd and Bolton (1999) argue, there is evidence of 'the manipulation of the context of nursing work combined with the

continuation of traditional autonomy' in Jo-care (p. 383). As previously noted on page 239, one consequence of the POT is tension between management and professional labour: the former must accept or limit the autonomy of the occupational groups while the latter must live with the restriction or seek to enlarge it.

Yet according to Thompson and Findlay (1999), many occupational groups have found themselves increasingly under pressure, not only in terms of 'time and effort' but also in terms of their work 'autonomy' (p. 181). As I have noted in Chapter Eight, the resource allocation initiative caused additional controls to be added to the contradictory pressures discussed above. Here, people are not only controlled by the hierarchical line of authority that manages Jo-care but also by those procedures which were put in place in order to meet external regulations and/or accreditation guidelines. This institutional condition created additional tension and consequently Jo-care's people have been increasingly constrained by regulatory mechanisms concerning the quality and cost of their health care work. As articulated in Dent's review (1998) of hospitals and new ways of organising medical work:

> It is important to note (...) that the distinction between organisational and institutional control is, in reality, far from clear-cut. Both types of control can and do co-exist uneasily together. The autonomy of doctors is something that is constantly being renegotiated (p. 208).

The friction and tension created by these co-existing types of control raises an uncertainty and stress among people which they have to struggle to cope with in their day-to-day working lives. However, Jo-care's people still retain their professional control over their health care tasks even if they perceive a loss of practical autonomy and an increase of managerial and/or governmental demands. What protects Jo-care's people from real subordination to the labour process is the 'technical complexity' of health care labour and the uncertain nature of the everyday hospital practice (Dent, 1998, p. 218).

While the POT advances service quality and labour productivity, the result is a very high level of physical and mental activity in caring for patients at a higher level of

acuity. That is, there are indeed enhanced service improvements in terms of quality and efficiency operating in Jo-care, but the POT is based upon planning and executing mechanisms which give people less latitude and increase patient throughput. Even though the POT has cut the stress of the nurse's job, for example by reducing the occasions when a nurse has to call a medical doctor and/or suffers from the irritation of a patient's delayed return to the ward floor, the critical factor is that despite its patient focus, the POT has lead to an increase in effort and work. In actual fact, the nature and effects of such work intensification are not consistent with the increased competitive pressure to ensure Jo-care's survival. Rather they are consistent with the competitive productivity of Jo-care's workforce in comparison to the overall budget.

Moreover, continuing staff development in the form of further and post-registration education was seen as an integral part of Jo-care's rhetoric. This corresponds with the view of the provision of service-orientation towards people and the appearance of the quality agenda in Jo-care. Some of the interview respondents reported that a flexible deployment of nurses had been introduced and this brought about an intensification of stress and intellectual effort. That is, staff nurses are now required to work on a variety of ward floors within different medical disciplines, such as general medicine, surgery, urology, nephrology, plastic surgery, gynaecology and obstetrics. Similar to the events documented in Melia's study (1987) on the occupational socialisation of nurses, whenever the work on one ward decreases temporarily, the nurses' wide ranging abilities enables the CNE to re-deploy them easily in other areas where the need for human resources is greater. Here, people's flexibility remains within the occupational group and the result of this staff development initiative is a significant increase of pressure on the individual nurse. Thus, the outcome of this analysis suggests that Jo-care's people are working harder, which contrasts with the prescriptive findings of the excellence advocates who enthusiastically promise the phenomenon of 'working smarter not harder'.

Trust, Commitment and Control

In another managerial intervention, changes in people's attitudes and behaviour towards others were presented as vital aspects of Jo-care's rhetoric. As I have indicated previously, a key theme of Jo-care's rhetoric is the creation of high trust work relations in order to reinforce and/or instil soaring values and path-finding visions which in turn generate enthusiasm, excitement and commitment among Jo-care's people. Through persistence, the social and physical proximity between senior managers and Jo-care's people has now improved through Management by Walking About (MBWA). However, the symbolic de-emphasis of traditional bureaucratic control is superseded by the presence of MBWA because this managerial initiative encourages and enforces adherence to people's formal role (Kunda, 1992). That is, these frequently occurring interactions between senior managers and staff are a very clear form of face-to-face control and are pervasive in Jo-care. Another element at the heart of these walkabouts is a form of normative control where people's extensively articulated beliefs are influenced and supervised by senior managers in Jo-care. In other words, there is some managerial attempt to prescribe the thoughts and feelings of Jo-care's people within a particular economic and political situation. Thus, my research data suggest that Jo-care's people are managed at more of a closeness and less of a 'distance' (Foucault, 1979a; Miller and Rose, 1990).

The majority of interview respondents were well aware of the boundaries and restrictions within which they operated and an atmosphere of mutual trust, even given the presence of MBWA, has not appeared to be any more widespread than in previous times when loyalty was largely dependent on the 'mobilisation of emotions' and the ability to blend organisational and sub-cultural identities (Thompson and Findlay, 1999, p. 172). This is confirmed by Whitston and Edwards' study (1990):

> One person put it this way; she would trust her manager to deal with her decently as an individual, to respect confidences and so on, but she would have little trust in management at any level to look after her interests, or to put them very high in considerations (p. 295).

While there was a general feeling that senior managers were approachable and friendly as people, employees were very conscious of external pressures, and felt that not only had the work got harder, but that senior managers were more demanding, and more inclined to pressurise Jo-care's people. It was particularly obvious during the ward rounds when Jo-care's people were asked to give account of what they had done and what they would be doing. Even though Jo-care's people expressed a degree of confidence in their own handling of ward and/or departmental matters, they reported a feeling of intense pressure and, in many cases, considerable personal suffering, manifested in uncertainty and associated forms of despair. Thus, the social construction of an atmosphere of mutual trust has produced a contradictory amalgam of employment relations and 'managerialism' (Pollitt, 1993).

The Structuring of Meaning

The structuring of people's subjectivity through Jo-care's rhetoric is another central theme within this study. As has been shown throughout the study, one of the core questions of this doctoral thesis is whether the managerial rhetoric has influenced people's perception of their organisational world and whether this indicates their personal acceptance of an enhanced service-orientation, a continuing organisational learning process, an increased cost-consciousness and an on-going interest in the hospital's external public profile. At the level of service-orientation towards people, there is considerable doubt that the programme had any impact. Of course, the language of service-orientation towards people was pervasive among Jo-care's people and they appeared to structure their representations of work activity in its terms. However, this is not surprising, given that people embodied the professional values and attitudes of health care before the start of Jo-care's reorganisation. As I have illustrated in Chapter Two, this service attitude is dependent upon a powerful health care ethos still prevalent amongst Jo-care's staff and as such, management has been able to depend implicitly on these traditional forms of people's loyalty. Whitston and Edwards (1990), for example, give an account of the development of people's commitment in a large general hospital:

> In effect workers' commitment to their own estimation of the importance of their work provided the basis for a degree of self-discipline, and of cooperation with management, which has largely enabled management to implement its own programme despite the deepseated worries amongst many of the staff (p. 296).

Clearly, the pre-commitment of Jo-care's people helps them to associate their health care work with the rhetorical project of service-orientation towards people. For the same reason, they were highly receptive to the quality and accountability rhetoric, which means that people accepted collective and personal responsibility as well as being willing to initiate and communicate in Jo-care. However, Jo-care's CEOs were looking for something more than people's passive contribution to service-oriented loyalty. The ultimate objective was the provision of a more efficient, flexible and innovative health care service achieved through people's commitment to Jo-care. Indeed, Jo-care's people were exposed to the ideas, aims and vocabulary of the rhetoric in a variety of ways, as I have indicated in Chapter Six. The most important of which were the intuitive style of management, the participation in the interdisciplinary seminars and the information and communication network of Jo-care. If the cultural rhetoric had indeed shaped people's consciousness, I would have expected those people who participated in Jo-care, and who were exposed to the cultural rhetoric, to be more likely to have embraced the rhetoric and for what it stands. As I have outlined in Chapter Three, this important feature was observed while I was participating on the ward as an active nurse, during my participation in various meetings and through the application of the management by wandering around approach used by the CNE and his deputy. This enabled me to see the impact that people's participation and their normative re-education in Jo-care had on their internalisation and endorsement of the values.

Altogether, Jo-care's people demonstrated only moderate levels of understanding of the core corporate concerns at the time of data collection, and this suggests they had not taken on board the values and assumptions espoused by the managerial rhetoric. The result of my data analysis therefore does not support the idea that their regular involvement and the systematic exposure to the hospital's rhetoric had any significant impact on attitudes and perceptions on the ward floors. In the interviews,

people gave a variety of responses, but the main themes were nevertheless almost always related to 'distancing behaviour, cynicism, deep acting and resigned behavioural compliance' rather than to the acceptance and endorsement of the required values (Thompson and Findlay, 1999, p. 177). While such responses may be seen as limited by some readers, the important point is that they do not show compliance of Jo-care's people with new management directions. Thus, the Jo-care case is entirely consistent with the main body of case study and survey evidence into organisational and labour process research which reveals considerable scepticism and demonstrates that no transformation of values and attitudes has been achieved.

Notwithstanding, there was evidence that Jo-care's people have been responsive in terms of the behaviour displayed at work. That is, there were several ways in which Jo-care's people responded to the rhetoric-reality gap between managerial words and deeds. The most obvious may be people's talk, because it was noticeable how much spoken evidence indicates a personal awareness of managerial motives and the mismatch between Jo-care's rhetoric and the reality of its day-to-day practice. For example, the majority of people expressed their views and grievances openly and questioned the way in which they were treated in the day-to-day practice of Jo-care. The observational data are complementary to the interview data in this respect because the perceived level of '*upward communication*' was seen as relatively high (Wilkinson, 1998, p. 47). Here, as reported in the study of Rosenthal *et al.* (1997), people themselves saw Jo-care's rhetoric as an instrumental resource in their day-to-day struggles with management 'to bring managers into line with *their* expectations' (p. 496). In this context Warhust and Thompson (1998a) remark:

> And there is ample evidence that management failure to implement their own rhetoric of better human resource policy, training or service quality is often used by staff as part of their armoury of tactics to improve workplace life (p. 21).

Certainly, the managerial rhetoric appears to have presented a challenge to the educated and qualified people in Jo-care, because it does not provide clear and consistent grounds by which to assimilate new values and/or implement co-ordinated actions. Once again, the operational autonomy of skilled people from direct

managerial control, the internal cohesion and their commitment to the health care service help to explain some aspects of the behaviour found in Jo-care's day-to-day practice. Everyday management was therefore 'a matter of persistent informal negotiations and compromise' because Jo-care's people were able to use elements of the rhetoric to their own and the patient's advantage (Whitston and Edwards, 1990, p. 292).

Taking this evidence into account, it appears entirely justified to argue that the success of this hospital organisation was not driven by corporate culture change. The most persuasive evidence came from Mr. Tate, i.e. the CEO, himself, who found out that "some of the staff on the wards do not understand why [you need an organisational philosophy in Jo-care]. But others do understand, it varies a lot". That may have been no great calamity for Jo-care's CEOs, but there was a more immediate danger awaiting them. Cynicism and scepticism was exactly what many people expressed openly about Jo-care's rhetoric because it made promises and created expectations which resulted in a contradictory reality. Under such circumstances, as reported in Kunda's study (1992), many people found that their work lives were captured in an ever-accelerating vicious circle:

> The race to meet corporate standards of accomplishment, get corporate approval, and procure the pecuniary and personal rewards the culture promises becomes the only way to find stable meanings and compensate for a sense of confusion, lost authenticity, and inner emptiness; but it is a self-defeating exercise, one that recreates and reinforces the very circumstances it seeks to correct (p. 222).

Consequently, the management of culture change was not an effective mechanism because in its contemporary form the rhetoric produced high levels of uncertainty, mistrust and involuntary economic activity. Evaluating the broader evidence, it appears that the managerial initiatives were strategically related to the policy objectives of the 1990s and people's behaviour was merely adjusted for organisational purposes. For example, the streamlined and labour-intensive behaviour which was defined and promoted through the POT had little to do with the new ideological factors of Jo-care's rhetoric. Like other contemporary initiatives, the POT worked because it was dependent upon the consent and the concession of

individuals and upon work processes which promote and reward 'appropriate' behaviour (Thompson and Findlay, 1999, p. 179). In their critical study of corporate culture change, Hope and Hendry (1995) observe that

> [i]t was clear from the research conducted within Healthco that the change initiatives that have concentrated on behaviour have been far more successful than the initiatives concerned the inculcating shared values (p. 70).

As this extract suggests, a certain degree of comfort can be found in the behavioural compliance observed and reported in Jo-care. For the most part, change in people's behaviour was sufficient for Jo-care because it not only made people work smarter and harder for operational purposes but it was also relatively easy to achieve. It could therefore be argued that the contemporary initiatives were geared towards the creativity and perseverance of people without which Jo-care's CEOs would have been not able to successfully transform 'labour power into profitable labour' (Smith and Thompson, 1998, p. 560). But all this had nothing to do with cultural control.

There was, however, another reason why corporate culture change in Jo-care may be seen as limited. This included the collusion and contradictions that interfered with the hospital's direct achievement of its corporate goals. As observed by Thompson and Findlay (1999):

> Employees may not have bought into the message, but they have learned to live in and with it, to become culturally literate in a way that management cannot always control (p. 183).

The research data discussed in Chapters Seven, Eight and Nine suggest there was a wide range of misbehaviour to be observed in Jo-care. As illustrated in Chapter Three, I used the participative method of investigation drawn from ethnographic research and because of this methodology I was able to account for a good deal of my observations in terms of overt misbehaviour and adaptation towards Jo-care's rhetoric. Through numerous detailed examples I showed how Jo-care's people actively managed their working lives. For example, there were not only various attempts to appropriate time and space, but there was also widespread evidence of

hospital food and goods being taken for personal ends by nursing staff with the knowledge of their superiors. Here, as in Collinson's research (1992), I can challenge the preconception about what happens in organisations by suggesting that Jo-care's people are by no means 'passive recipients of things' that are done to them, nor are they simply controlled by senior management (Ackroyd and Thompson, 1999, p. 54). While Jo-care's people displayed a reluctance to overtly express their displeasure about effort intensification and complex managerial control, they were able to maintain a sense of freedom because they had the potential to exert some control over their working lives.

Having made these points it is still necessary to remind the reader of the distinct setting of the hospital, and the continuing influence of a health care ethic amongst Jo-care's staff. As reported in Collinson's account (1992), much of the behaviour I discovered in Jo-care was related to people's ideas about their occupational interests and personal identity, which were formed distinctly from the interests and identity of the new managerial group within this hospital organisation. Likewise, the interview data suggest that people's misbehaviour did not manifest itself in their autonomous dealings with the patient clientele but rather that their pre-existing attitudes, value orientations and past experiences have led them to choose a response which was not always dutiful or did not conform to other aspects of Jo-care's day-to-day practice. For example, those who consumed unused cooked hospital food had been influenced by a wider social construction of ecology and Christianity. Thus, the behaviour Jo-care's people displayed was something which they had learned since their early nursing training and human socialisation. Considered in this light, the view of executive managers - that the people will be willing to identify with Jo-care - appears too simplistic because according to Ackroyd and Thompson's framework (1999), "[a]ll misbehaviour is associated with processes of identity formation and self-organisation" (p. 27).

There was, however, more to it, because some of the misbehaviour I observed and experienced in the day-to-day practice could be seen as people adapting their

behaviour to work pressures and particular modes of managerial control (e.g. the active subversion of managerial control through the manipulation of statistical figures). As the evidence suggests, hostile misbehaviour did take place, not as a response to the traditional conflicts of employment relations, but at times when the reorganisation of this hospital was undertaken without 'concern for its social implications' (Ackroyd and Thompson, 1999, p. 18). It is highly likely that people's feelings of hostility will increase in Jo-care, thereby increasing the likelihood of continued and developing forms of resistance such as sabotage, pilferage or time wasting. However, as Jo-care's people strive to retain their professional status, combined with the ethos of health care workers, it is more likely that any rebellious behaviour will take on more subtle forms than work to rule or outright aggressive action.

Most of the misbehaviour developed and produced by Jo-care's people has been clearly identified as such; however, there were managers who made many concessions towards accepting it. As quoted on page 224, the consumption of unused cooked hospital food was certainly, informally, encouraged. Allowing people to consume unused cooked hospital food was common practice in Jo-care; however, it needs to underlined at this point that managers were 'complicit conspirators' (Ackroyd and Thompson, 1999, p. 78). But, when Jo-care's people had become used to consuming unused cooked hospital food, senior managers occasionally confirmed that the consumption of it was actually illegal. Here, it is important to note that the consumption of unused cooked food could, at any time, have been interpreted by managers as inappropriate behaviour and not only subject to 'official sanctions' but also to 'criminal proceedings' (Ackroyd and Thompson, 1999, p. 79). This allowed an effective and complex system of control to arise around the tolerance of the consumption of unused cooked food in Jo-care. Although this is an obvious example, managers were able to move between the affirmation of their complicity and the withdrawal from co-operation.

Given this, it is not too difficult to answer the question of who was carrying the social consequences of these inconsistent conditions. There was little doubt that Jo-care's people were paying the price because there appeared to be less chance for them to build up a reliable degree of trust and to gain job satisfaction from their everyday experience at work. The evidence suggests that although people maintained a sense of autonomy and showed a service-oriented loyalty towards the patient clientele, they were far from reaching the level of commitment to Jo-care which the CEOs seemed to regard as the ultimate success of cultural control. In this sense, it can be argued that the managerial rhetoric had not had the effect of re-structuring people's occupational and personal concerns with a singular attention to Jo-care. Perhaps the best proof was people's cynicism and scepticism concerning the business rhetoric and general intentions of executive and senior managers. Indeed, this widespread cynicism and scepticism was more than merely apparent within Jo-care, it seemed to be deeply ingrained within people's mindsets.

Managers and the Culture Burden

The only people that were enthralled by Jo-care's rhetoric were its own creators and its credulous promoters. Apart from Jo-care's CEOs, these were the members of the tripartite directorate, the head of the Department of General, Further and Post-registration Education and a smaller group of managers from various departments and wards. With my initially untrained eye, it appeared that their commitment to work and to the objectives of Jo-care's rhetoric was more developed and effective than that of their employees. According to Mulholland (1998) this is most likely to be the case because managers are explicitly under greater pressure as regards providing successful organisational change and changing the people in this way. Similar arguments are documented by Hope and Hendry's study (1995) on corporate culture change:

> [T]he new managerial behaviour requires an investment of 'self' rather than the dogged mimicry of behaviour or values set down in a corporate handbook. If the self is not engaged then the power is reduced, for the required behaviour is distanced from the person itself (p. 63).

Certainly, most of the people in management were able to accept and/or tolerate this demanding role in Jo-care's day-to-day practice. As I grew to become more of an organisational member rather than an outsider, however, there were a number of ironic evaluations and cynical interpretations of the contradictory policies of Jo-care's rhetoric from the above managerial people. As quoted on page 236, the CNE felt that 'a better atmosphere and more co-operation' was created during the last few years. At the same time, however, he and his deputy were very aware of the contradictions and pressures faced by the implementers of the rhetoric, and both of them had a deal of sympathy for people on the ward floors which they felt was not always the case with Jo-care's CEOs. For example, it remained the case that the continuous supply of skilled nursing personnel and the sufficient funding of advanced equipment was of particular importance to them. While this stance cannot be seen as purposeful resistance as such, it was nevertheless a notable impediment on the process of corporate culture change.

However sceptical in some respects, their 'conditions of work' may have enabled managers to accept and endorse the required values (Ackroyd and Thompson, 1999, p. 76). In other words, their extended responsibility and increased discretion may have made them more susceptible to a more persistent form of commitment in the light of new work experiences under changed circumstances. Further, they may have more readily accepted the culture change initiative in Jo-care since they are the people who have gained and benefited from it. As Thompson and Findlay (1999) have put it: "Ownership of successful change initiatives brings not only material rewards, but also the power to direct the initiative" (p. 180). Lastly, the rhetoric may have been used as an important resource through which managers were able to control Jo-care's people and establish their own right to exist. For example, the rhetoric may not only have been used by managers to justify 'cost cutting exercises, changes in work practices and demands for increased productivity' but also to promote their personal interests such as their individual performance, job security and career prospects (Thompson and O'Connell Davidson, 1995, p. 31).

Despite the reality of increased corporate and financial control, their status as human subjects suggests that they experience similar control conditions more characteristic of the 'wage-worker for life' (Jacques, 1996, p. 91). Evidence of this is the resource allocation initiative in Jo-care which, when subject to analysis and evaluation, examines managerial conformity and compliance. This argument supports Mulholland's critical view (1998) on management and careers:

> If review and appraisal is introduced with the intention of reducing the managerial scope for misbehaviour, then trust and loyalty in return for career and secure employment no longer forms the basis of the relationship between subordinate managerial layers and corporate management in the privatised utilities (p. 201).

Here, it is important to differentiate between the experiences of those managers directly responsible for culture change, such as Jo-care's CEOs and others. That is, managers have to be seen as a heterogeneous group because some of them have to be managed or manipulated by others. This is a view that has been echoed by others, such as Anthony (1977) who observes how a majority of managers

> receive generous salaries but (...) [t]hey are not often consulted about the design of their organisation and the structure of their jobs. They are more likely to be the unwitting victims of reorganisation (more and more frequently); transferred, retrained or dismissed at the behest of organisational plans drawn up by distant consultants; regarded as human resources, shuffled and distributed by specialists in management development and planning (p. 311).

Indeed, the exercise of the power of office is a matter of executive management. Even though external forces in the health care sector do exist, Jo-care's CEOs have made much of the notions of institutional excellence and competition, and continually emphasised the pressing need to increase service quality and improve efficiency in order to function somewhat better than the norm. As quoted on page 249, individual people in management, whether it was the upper or the middle management level, were exhorted to join in and to give their support to the continuing existence of Jo-care. It was therefore a way of heightening pressure for changes to working and employment practices in Jo-care. Pretending there were negative driving forces within the hospital and referring to an almost entirely

fictional health care market, the rhetoric served as an important source to make change appear to be an inescapable consequence rather than an example of what the CNE of Jo-care called 'angst management'. This view is sharply articulated in Thompson and Findlay's (1999) critical review:

> Not only are senior personnel figures often centrally involved in cultural initiatives, they are in prime position both to recruit and to promote 'culturally appropriate' managers to key positions in the organisation, thus further disseminating the message (p. 181).

From this standpoint, it is plausible to claim that only a small minority of managers - in effect the elite that 'personifies capital' - occupy positions of comparative privilege (Braverman, 1974, p. 405) and have a 'direct managerial identity of interest and outlook' with the authority of this hospital organisation (Eldridge, Cressey and MacInnes, 1991, p. 64). However, according to Anthony (1990) the people involved in the subordination and control of others are most likely to be captured by culture change and to be isolated in the process because they are driven not only by 'economic motives' but also by their personal aspiration to 'superimpose the values and purposes of "their" organisation' upon their subordinates (p. 3). This takes us back to the claim that Jo-care's CEOs are the masters of their own destiny in so far as they are providing an expert managerial service, the quality of which the ecclesiastical authority is in no position to be able to judge. Is this characteristic of Jo-care? Of the health care sector? Of all hospital organisations? Possibly[4]. However, the systems of bureaucratic and normative control and their consequences as outlined here seem to disguise this reality in an environment that claims a major role in supporting not only the patient clientele, but also the people who care for and nurse them.

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[4] See Pollock (1999) for a short review of the managerial rhetoric in the Primary Care Trust in Lothian, Scotland: "The development of clinical governance systems should directly affect nurses as a major professional grouping within Trusts. Obviously developing clinical governance systems cannot be done overnight. They say it takes between eight to twelve years to *change a culture* and I am sure it will take us almost an equally long time to *change the culture within nursing* from being reactive to proactive" (p. 10, emphasis added).

Conclusion

This thesis is an organisational study and my central concern was to explore and describe the ideologically and practically organised work conditions of one hospital locale. A predominant theme running through this doctoral thesis is that *what an organisation is* cannot be described *a priori*, but has to be formulated through critical realist research with regard to economic, political and social considerations. Consistent with this point of view, this research sees one hospital organisation as existing in a largely determinant relationship with its public environment, as a social instrument that not only provides health care services but also, as a side effect, produces distinctive cultural artefacts. While the environmental aspects present imperatives for behaviour that chief executives may enact in the hospital through technical and symbolic means, the latter emphasis offers the prospect that the socio-cultural qualities, which develop within a health care sector organisation, may be managed in order to contribute to the overall systemic balance and effectiveness of an organisation. With the topic of culture as a substantive focus, I have sought indirectly to provide empirical evidence for the symbolic anthropological proposition that a corporate culture derives its sense, first and foremost, from the organisation's history and the social relationships in which people engage when dealing with their working environment. What has been developed is a labour process analysis of one hospital culture, an analysis based upon the expressive forms and manifestations of human consciousness of which the organisation can be said to consist. While in some respects this is a study of culture, it might be better described as a study of human resource strategies and of activities of producing corporate culture change as a meaningful event for the hospital's people. My attention has exclusively been given to the analysis of the managerial strategy, its ideological and practical implications as well as to people's responses; an analysis of which evolved during the course of critical realist research on corporate work. It was in the course of this ethnographic investigation, mainly of the nursing division, that the cultural schemes came to be recognised as normative projects of control which were working less through formal mechanisms than through informal processes and value-systems. The rhetorical principles, organised to achieve specific organisational goals, were mainly related to

aspects of people's sense of self and attempted to bind their hearts and minds to the corporate interests. Whatever else culture change might mean in other organisational contexts, in the hospital I describe here contradictions were invariably generated by the prevalent rhetoric and the reality of its day-to-day practice. For an employee working in this hospital organisation, it meant not only the reinforcing of hierarchical and normative control and the enhancing of physical and mental effort, but also the intensification of material and symbolic uncertainty in the workplace. The ultimate consequence in a social respect can be regarded as critical because most employees were struggling to survive in Jo-care's reality and make sense of their personal and collective role at work.

Times change, and so do buildings.
Changing people is harder, or so I have found.
(Lomax, 1996, p. 38)

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Appendix One

Glossary

Jo-care: For reasons of confidentiality the name of this hospital will not be disclosed. Throughout this thesis it is referred to as *Jo-care* as a guarantee of anonymity.

CEO: The Chief Executive Officer (CEO) is in charge of the hospital's main chair and has the direct responsibility for all the services in Jo-care so that key decision can be made.

CNE: The Chief Nursing Executive (CNE) acts as head of the whole nursing service in Jo-care which involves membership of the tripartite hospital management board.

CME: The Chief Medical Executive (CME) is the representative of all medical disciplines in Jo-care which involves membership of the tripartite hospital management board.

CEA: The Chief Executive Administrator (CEA) is the general administrator of the hospital; this involves bookkeeping functions and membership of the tripartite hospital management board.

Rhetoric: The cultural rhetoric is a crucial element of the managerial strategy and the CEOs direct a behavioural process in which people's general attitudes and values are determined by persuasion and education.

POT: The POT is the acronym of the *patienten-orientierten Tagesablaufrahmenprogramm* [i.e. patient-oriented day-to-day programme] which co-ordinates the work of various different occupational groups.

LORE: The LORE is the acronym of the *Leitbildorientierte Organisationsentwicklung* [i.e. philosophy-oriented organisational development programme] which aims to put the organisational philosophy into Jo-care's day-to-day practice.

Appendix Two

Transcription Notations

The form of notations used throughout this thesis was developed by:

> Jefferson, G (1985) An Exercise in the Transcription and Analysis of Laughter in T. A. van Dijk (ed) **Handbook of Discourse Analysis**, Vol 3, pp 25-34, London, Academic Press.

Extended square brackets mark overlap between utterances; e.g.:

and then I did]
[did you

An equal sign at the end of an interviewee's utterance and at the start of the next utterance indicates the absence of a discernible gap; e.g.:

anyway, Jasper =
= Okay, okay

Numbers in brackets indicate pauses timed to the hundredth of a second; e.g.:

I was walking (8.39) about the ward corridor when s/he came around

One or more colons indicate an extension of the preceding vowel sound; e.g.:

Yea::s, I see::

Underlining indicates that words or phrases are uttered with added emphasis; words in capital letters are uttered louder than the surrounding talk; e.g.:

This was <u>not right</u>, not right AT ALL

A full stop before or after a word or sound indicates an audible intake or exhale of breath; e.g.:

I think .hh this is hhh. manipulation

Round brackets indicate that material in brackets is either inaudible or there is a certain doubt about its accuracy; e.g.:

I saw that these activities (happened) within this (...)

Material in square brackets is clarificatory information; e.g.:

Arthur [the interviewee's colleague] said this would be okay

Appendix Three

Teilnahmeerklärung [i.e. Informed Consent]

Name [i.e. name] :

Alter [i.e. age] :

Geschlecht [i.e. sex] :

Ausbildung [i.e. qualification] :

Jahr des Examen [i.e. general education completed in (year)] :

Weiterbildungen [i.e. post-registration qualification] :

praktische Erfahrung [i.e. practical experience] :

eingesetzt als [i.e. position held] :

Ich nehme an einem Interview teil, das im Rahmen des Forschungsprojektes [Instilling and Distilling a Reputation for Institutional Excellence: a critical Reflection on Organising Practice] im Krankenhaus [Jo-care] in [name of city] von November 1996 bis Mai 1997 durchgeführt wird. Das Interview Gespräch wird mit einem Kassettenrecorder aufgezeichnet. Es wird mir eine volle Anonymität zugesichert sowie Vertraulichkeit im Umgang mit den Daten. Durch meine Mitwirkung entstehen mir keine weiteren Rechte oder Verpflichtungen an dem Forschungsprojekt[1].

_____

Unterschrift [i.e. signature]

[1] I (agree to) take part in an interview carried out in connection with the research subject [Instilling and Distilling a Reputation for Institutional Excellence: a critical Reflection on Organising Practice] in the [Jo-care] hospital in [city] from November 1996 to May 1997. The interview will be recorded (on cassette). Anonymity and confidentiality with regard to the data has been guaranteed. My participation does not involve further rights or obligations in connection with the research project.

Appendix Four

Rethinking Nursing Management Education

During the late 1980s the state of nursing management education and training became a matter for concern, debate and action in Germany. In the early 1990s a first step was taken towards academia with the implementation of a four year degree course in nursing management[1]. A managerial programme was established at undergraduate level in universities and universities of applied sciences which awards graduates with a diploma in nursing management. This academic initiative aims at producing a more coherent, extensive and integrated system of nursing management education and development.

Apart from this accomplishment there is still a three year hospital-based nursing education in the dualistic form which relies on a one third theoretical and a two third practical agenda. In other words, nursing education as such has not been established in the world of academe and this involves a huge amount of contradiction concerning the academic education of nursing managers. However, there is political interest from various nursing associations to replace this traditional vocational system with a four, three and a half year or three year generalist nursing education similar to that of other academic professions (Deutscher Bildungsrat für Pflegeberufe, 1994; Deutscher Berufsverband für Pflegeberufe, 1995; Bundesausschuss der Ländergemeinschaften der Lehrerinnen und Lehrer für Pflegeberufe, 1996, 1997; Deutscher Pflegerat, 2000, Zopfy, 2000). But these educational programmes will still be hospital-based in an apprenticeship system and aim to enable qualified nurses to enter the four year nursing management degree courses at the universities or universities of applied sciences. Another option to provide access to higher education in nursing

[1] Here, I refer exclusively to the provision of 'nursing management education' at the level of universities and universities of applied sciences in the western part of Germany. In the academic year 1991-1992, the initiative was taken by the Fachhochschule Osnabrueck - Fachbereich Wirtschaft which established the first nursing management education in the world of academe (Müller, 1997; Robert Bosch Stiftung, 1992). It is enough perhaps to say that a nursing management education programme was already introduced under specific and limited conditions within the communist regime of the German Democratic Republic at the Humboldt University in East-Berlin in 1982 (Beier and Jahn, 1997; Robert Bosch Stiftung, 1992).

management is the *Abitur* [i.e. school-leaving certificate, qualifying university entrance] and a 12 month practical in nursing.

The establishment of an academic education in nursing management highlights the strategic role and significance of CNEs within health care organisations and encourages a variety of discourses by several political influences in order to create an academically defined conception of nursing management. The key argument maintains that CNEs lack the developmental, educational and training opportunities of their academic competitors such as chief medical executives and chief executive administrator (Robert Bosch Stiftung, 1992, 1996; Deutscher Bildungsrat für Pflegeberufe, 1994; Küpper, 1996). Thus, one of the main arguments for CNEs needing a background in academia is to increase their techniques, skills and functional strength on the tripartite management board. Holding one of the top management posts, running the hospital's largest service and building the image of a modern, progressive and competitive occupation is likely to offer such an opportunity. It seems that these are the main problems which CNEs face, both in their work as senior managers and in the management of their own careers.

Another argument quite common in this literature is concerned with the increase of the body of knowledge in nursing; i.e. achieving a knowledge base and substantiating itself as a modern discipline. It is assumed that an academic background in nursing management (alongside the academically educated nursing teachers and nursing scientists) will professionalise the nursing profession by developing and transferring theories into an evidence-based practice of nursing care. As outlined in the accounts of Freidson (1970, 1994) and Etzioni (1969), such a self-interest is related to a professional independence which should protect the profession's ability to serve their clientele. This faith in academia and its people leads to the assumption that other disciplines will appreciate the independence of the nursing profession from the medical profession and which in turn will improve its nursing care and health care services in general. This argument is in line with Brykczynska's observations (1993):

> Modern nursing wishes to be more academically sound, for it claims that an increased knowledge base will put nursing practice in a better position to be intelligently implemented. This more in-depth knowledge of man's health [sic], environment, nursing theory and understanding of man's bio-psycho-social and spiritual being, is to take place in an atmosphere of freedom, choice and learning (p. 145).

However, creating knowledge in the field of nursing is more than just empirical inquiries or a bank of studies in particular areas. Such an idea of nursing management education, as functional to the nursing profession, is built upon the model of professional training in which the existence of a body of knowledge is central to effective practice. It appears to be expected that knowledge is generated and dispatched by the academically educated nursing managers. With reference to French and Grey's critical writings (1996), one could claim that "the archetype of this model might be that of medical training, where licence to practise is contingent on the acquisition of a defined set of knowledges and skills" (p. 3). For various reasons, however, management within nursing cannot strictly be compared with medicine or law as there is no social or occupational closure around practising as a nursing manager. According to the *Krankenpflegegesetz* [i.e. Nursing Act] (1997) there is a legal acceptance in becoming a nurse but there is no legislation involved in becoming a nursing manager.

Since the set up of the academic initiatives in nursing management the contemporary situation has advanced so far that most of the research and lecturing is done by representatives of other disciplines such as sociology, psychology, social-gerontology, divinity, economy, business, etc. and it is by no means clear that an academically educated nursing manager is more effective than one who does not come from the world of academe. In addition, nursing management education is characterised by a predominately 'how to' approach (Wilson, 1992, p. 103). For example, change management produces symptoms of stress in some individuals, so nursing management education involves a programme of 'how to cope' strategies which range from physiological recipes to psychological approaches and so on. Specifically for nursing managers, instruction for change involves similar recipes -

'how to cope with; how to keep up with; how to manage and how to manage others in the process of change' (Wilson, 1992, p. 104).

The discussion in which I am engaging here is extremely long-winded because it goes back to the values and societal relations of education and, according to Thomas and Anthony (1996) such an argument would be better placed within its own epistemology. In this context French and Grey (1996) refer to Marcus Tullius Cicero who has seen 'knowledge as an end in itself' or others such as John Locke, who wanted to judge 'knowledge in terms of utility' (p. 4). Both claims are complex and are crucial in the development of nursing and nursing management and would set the tone within a more critical discussion. In terms of nursing management education I want to refer to a more critical debate which does not focus on the extent to which education contributes to the development of effective nursing managers but regards nursing management education and nursing management practice as problematically linked. For French and Grey (1996), the 'rethinking of management education entails more than the elaboration of new pedagogic techniques' (p. 1). Such a critical view emphasises that nursing managers do not only learn specific techniques and skills to deal with the problems that they face, both in the management of their work and their own careers, but that nursing managers do have to change the way in which they think about managing. This particular view is absent among the nursing management education discourse in Germany and can merely be associated with the various positions collectively identified as practitioner-oriented. In line with French and Grey (1997) I suggest that the emphasis on managerial techniques has to be reduced, since these become rapidly dated, whereas greater emphasis has to be given to social and analytical skills, learning to learn and flexibility. Such a response has been subjected to critical scrutiny by Roberts (1996) who suggests that managers need to be taught the limits of their influence through an appreciation of the limits of rationality and the 'immature' human sciences[2]. Here, management itself does not

[2] With few exceptions, as Paleys (1996) reviews in a similar analytical context, "the debate seems to be stuck in a mid-century time-warp, innocent not only of post-Popperian, post-Kuhnian writers in the Anglo-American tradition, such as Hesse (1963), Feyerabend (1975), Lakatos (1978), Hacking (1983) and Bhaskar (1986), to name but a few; and not only of the feminist contribution to scientific thought, illustrated by the work of Keller (1985), Harding (1986), or Longino (1990); but also of structuralism

become an 'illusory activity' because the content and methods of management education change and because management education abandons its pretensions to be able to provides managers with techniques and skills in a traditional sense (French and Grey, 1996, p. 3). Thus, in rethinking nursing management education, a continuing process is implied rather than an archetype to which nursing academics should work. However, the development of such a perspective must also be attentive to the contextual constraints and takes it impetus from a variety of positions such as labour process analysis.

Be that as it may, in this thesis I am not concerned with exploring 'how to' professionalise nursing in Germany but refer back to Jo-care, the site of my study, in which the day-to-day practice takes place.

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and post-structuralism, including Lévi-Strauss (1966), Barthes (1973), Foucault (1970, 1980), Latour (1987) and Derrida (1973, 1981)" (p.670).

Appendix Five

The Organisation of Nursing Work

Interviews are one source of data which illustrate what people do in their day-to-day practice. The starting point for me was to ask the participants of this study to 'describe a typical day at work' and with this question most of the natural conversations with the interviewees began. The nurses I questioned gave account of slightly different styles of management directed towards the organisation of a ward. That is to say, one nurse does not necessarily describe exactly the everyday practice of others when s/he is talking about the day-to-day practice as s/he sees it. The following account however, gives one staff nurse's description and provides a useful introduction to the social setting and its institutional discourses because both create conditions of possibility for the construction of the everyday practice.

> Ester: A typical work day. Well for the early shift [clears her throat] work begins at 6 a.m. with the report in the patient allocation system u:hhm. The night nurse hands over to the day shift and the signals [of the Kardex] are pulled until everyone's finished (listening). And [gives a little cough] usually we plan in our heads how to start. Or, if there's a student nurse there, you explain what's to be done or talk about the patients. Depending on how good s/he [the student nurse] is or if s/he knows the patients.
>
> And then after 6.30 a.m. - the nursing trolley has been set up by the night shift - you can get going. And you begin to wake people and wash them, give Heparin ® [anticoagulant medication] injections, check vital signs [blood pressure, pulse, temperature] till about 7.45 a.m. (2.07). What you haven't been able to manage by then or, if patients in a bad way just aren't able to wash themselves or don't want to..., then you postpone that till later. You just do what you can in that time. Then, from 7.45 a.m. onwards breakfast arrives. 7.45 till 8 o'clock (...) don't forget the insulin injections [clears her throat].
>
> At 8 a.m. the first shift goes for breakfast. The others hand out breakfast in the meantime, feed patients and give medication the patients can't take themselves. At 8 a.m. the antibiotic drips are started (2.66). At half past, at 8.30 a.m., the second shift goes for breakfast. The others collect [the food trays] and fill out the diet cards and may be already arranging the time for the medical round if the doctor's there. (...)

The above interview excerpt gives a detailed image of the organisational scene and how the morning on this ward begins. Esther's view of a typical day stands for the daily practice and is an account of certain performances at her place of work. This means she differentiates between various types of work activities such as listening to

the report in the patient allocation system, planning the daily activities in her head or the Kardex, and going ahead with the daily programme to wake people, wash, and check them until breakfast arrives, etc. In this way she identifies different nursing tasks, which are done on a regular basis, and gives a visual impression of the outer forms of the everyday work activities. In describing nursing on the ward, Esther reveals something which is taken for granted and establishes a pattern of the way nurses do their work on a day-to-day basis.

Another example shows how the early shift continues and how nurses do their work on a day-to-day basis. Here, the same view becomes apparent as in Esther's version of the day-to-day practice, which means that the account entails a focus on actions within the context of a hospital organisation. Additionally, the reader is able to discover a certain kind of order which nurses follow in order to get their work done:

> Paula: A typical day at work. It's best if I start with the early shift. The nicest thing about it is meeting up with everybody first. (Listening) to the report, drinking a cup of coffee (...). Well, that's when patients in the different parts of the ward get allocated. You look up [the Kardex file] and see what's to be done that day and what's happening. Well I mean by that you have a look at the patient files so you can plan the day's work. Like which patients are being operated on, etc.
>
> After that we go into the patients' rooms and carry out direct care activities. I always try and see I get allocated to the same patients over a longer period of time. As long as it's not an area of the ward with a difficult patient, because then it's good to swap at some point. But otherwise I find it's really good to know your patients well. Because for instance then I can take things into consideration like one patient liking to sleep in a bit while another is already awake when I go into the room in the morning. So of course I start with the patient who's already awake and keep the sleepyheads for later.
>
> Maggie: Mhm. Why not.
>
> Paula: [tentative laughter] Yes, I think that's right too. After all you don't have to start doing things at 7.14 a.m. and be finished with everything by 7.20 a.m. Yes, then there's breakfast - first for the patients and then for us. [laughter] Yes, then there's some time for further nursing care for your allocated patients. But mostly there's always something else to be done. For instance all that to and fro with the medical rounds. I think that's been changed now, the rounds are more regular, more punctual. That was always a problem before.

The above interview extract illustrates an interesting point of view which could be rather insignificant for the reader as s/he gets introduced to the day-to-day practice of

a hospital ward. Like Esther, Paula is talking about on-going activities which are scheduled for different times each day but, apart from identifying and distinguishing between different types of work activities, she describes something very special. Even though Paula considers various activities in the day-to-day practice she also indicates that the daily labour process is achieved within a certain degree of order. That is, a central feature of this account of nursing practice exposes how the day-to-day practice is organised on this ward and the underlying pattern of organising nurses' work is one in which the patient is in the focus. Melia (1987) summarises this clearly defined and discrete type of ward management in the following terms:

> [P]atient allocation is a way of organising the delivery of nursing care in which each nurse is allocated [to] one or more patients and is responsible for their care. The use of detailed care plans, in which written individualised instructions for the patient's care could be found, was the hallmark of a patient oriented style of management (p. 34).

In the research work produced by Glaser and Büssing (1997) such an explanation is referred to as a holistic model of nursing care:

> [H]olistic forms of nursing care involve more than just being patient-oriented; there is an obligation for the organisation to make it possible for nursing staff to carry out a daily routine in its entirety. This is not only of advantage to the patient, improving the quality of his/her nursing care, but also benefits the health and well-being of the nurse[1] (pp. 301-2).

In contrast to this type of ward management there is a traditional view which puts a focus on routines in terms of specific tasks being taken by nurses in a chronological and scheduled order. Known as 'task allocation' and/or the old way[2] of organising nursing work there is an emphasis on rationality and economic endeavour which

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[1] [G]anzheitliche Formen der Pflege umfassen mehr als die Patientenorientierung, sie sind auch daran gebunden, dass die Organisation der Pflege Möglichkeiten bietet, vollständige Tätigkeitsabläufe zu realisieren, die sowohl zum Nutzen des Patienten und der Qualität seiner Pflege sein sollen als auch der Gesundheit und dem Wohlbefinden der Pflegenden zugute kommen (Glaser und Büssing, 1997, pp. 301-2).

[2] Task allocation obtained widespread notoriety in nursing practice until religious nursing became less popular in Germany. This was due to the fact that these nurses were working along the lines of religious life. Under this situation the organisation of nursing care was securely under the control of its own membership which meant that the religious nurse was in charge of a ward. They followed a strict division of tasks according to the ideology of their organisation and the qualification of the employed nurses.

results in 'routinised care' when several care plans are combined and translated into a certain programme in terms of the whole ward (Melia, 1987, p. 38). Here, routines are defined by the nature of work and a tight regime draws on technical premises which place nurses in jobs appropriate to their caring abilities. That is, work is fragmented into a series of 'senior and junior tasks' and organised around an administrative convenience as described by Moult, Hockey and Melia (1978, p. 10). For example, direct care activities are allocated to junior nursing staff whilst senior nursing staff or religious nurses guard their exclusive monopoly of the administrative and/or medical work. Under this sort of arrangement, different tasks are scheduled for different times of the day and this could mean that a particular amount of work had to be accomplished before the next shift arrived on duty.

Work which is organised along these lines of thought contrasts with Jo-care's contemporary nursing practice and such a mode of organising does not favour any degree of complexity and flexibility because it provides a more dependent and fragmented approach. Paula's account reflects an example of Jo-care's day-to-day practice and covers a range of issues associated with patient allocation (Melia, 1987) or a holistic nursing system (Glaser and Büssing, 1997). This involves placing an emphasis on the individual person and tailoring care to the patient's particular needs. For patient allocation to work, nurses must be prepared to be creative, to solve problems, to use their knowledge and skills in continuous improvement. Here, it is envisaged that a staff nurse, supported by a nursing student or others, is responsible for assessing care needs and planning, organising, monitoring and evaluating care in partnership with patients and their relatives. This evidence is given in Paula's account as she refers to the hand-over report from night to early shift and says: 'well, that's when patients in the different parts of the ward get allocated'. Moreover, she refers to a particular degree of continuity as she claims: 'I always try and see I get allocated the same patients over a longer period of time. As long as it's not an area of the ward with a difficult patient, because then it's good to swap at some point. But otherwise I find it's really good to know your patients well'. This development brings about that nurses are ultimately managers of their own affairs and they view

the patient as the central focus of their attention. This means nurses require a lot of personal judgement as there is no longer any reliance on task-centred routines and such a patient-centred view implies a different dynamic to the day-to-day practice. What is of concern here, according to Pembrey's study (1980) of the organisation of individualised nursing, is that a considerable amount of de-centralised planning and co-ordination takes place in the everyday affairs and it looks like this composite work design is 'determined by an individual patients needs' (p. 16).

Wards are sub-divided into three or four sections and at each hand-over report[3] each nurse is told who to work with and not what tasks s/he has to do. This means nursing staff on duty are divided into different teams and there are distinctive ways in which nurses get allocated to one geographical part of the ward. Either, the ward sister[4] allocates staff nurses, student nurses and her/himself to a different section of the ward, or the organisation of allocation becomes a matter of 'negotiated order' among the staff nurses (Pembrey, 1980, p. 85). Several work spaces appear which play an important part in ordering the day-to-day work on the ward. This means there is a division of labour into particular spaces because caring activities are provided for a small amount of patients and the physical movement of nursing members in a location means that they are the body that the allocated patient comes across. Each team consists of one or two experienced nurses and/or one nursing student, and Paula's account makes clear that the way in which nursing care is actually organised does not always equate to the same patients. According to her account, nurses are able to pick and choose for which patients they want to care for and as the organisational philosophy of Jo-care suggests, a patient-centred care is made apparent:

> Our activities focus on the patients and his/her well-being. All fe-/male hospital employees in their capacity as healers and helpers endeavour to accommodate the needs of the patient by means of medical efficiency and competence, a personal caring attitude and the co-ordination of patient care. Preventive health care is encouraged through regular information and advisory sessions. (...) Appropriate

[3] Apart from early and late shift there is only one qualified nurse on duty during night shift which means that I refer to the report from night to early shift and the hand-over from early to late shift.
[4] The way in which nursing care is organised in Jo-care's day-to-day practice leads to the fact that the ward sister or charge nurses are sometimes off duty.

> nursing care is decided according to the needs of the fe-/male patient; it is planned with specific aims in mind and of consistently high quality. Upon request we involve members of the patient's family in nursing care. We take the patient's way of life and his/her habits into consideration as far as possible and beneficial.

In treating patient allocation as something which is created through language and discourse extends existing views on patient allocation. The word 'to allocate' derives from the medieval Latin word *al-locare* which stands for 'to locate' or 'to allot to a place' (Onions, 1966, p. 26). In this sense, the word 'patient allocation' does not correspond to the original explanation because it is actually not the individual patient who gets allocated to a particular place. Of course, nurses' actions are around the individual patients but the nurses are not assigned to particular patients. To reiterate, nurses are designated to a location for a particular purpose and this argument signifies that the practice-in-use does not reflect the phrase 'patient allocation'. Such a work pattern would include nurses' actions being provided for a specific group of patients which are served independently of physical dividing patterns.

Clearly, this patient-centred concept of nursing practice contrasts with the two examples drawn from Jo-care's day-to-day practice. In particular, it is not actually the individual patient who gets allocated to one nurse or group of nurses, but rather the opposite. This means the ward gets split up into different areas of work and one section of the ward gets allocated to one nurse or two nursing members acting as pair. Explicit here is that it is not the patient who gets allocated in keeping with the activities which nurses carry out in their day-to-day conduct, but rather that the activities of a nurse or group of nurses are restricted to a range of beds in a particular area of the ward. In this sense, nurses do have a particular degree of choice as to which patients are assigned to them, and such a nurse-centred view does not tally with a very patient-centred mode of organising work. This pattern of work was already found by Moult *et al.* (1978) and they refer to 'group based care' in which nurses' actions are wholly or mainly restricted to one part of the ward, although it does not preclude any interaction with patients in the rest of the ward (p. 40). In other words, the patient-centred programme of Jo-care's nursing practice does not

involve a mobilisation and organisation of actions around its patient clientele. Therefore the inter-occupational division of labour within which nurses conduct their activities in Jo-care's day-to-day practice are distinguishable from the prescribed patient-orientation within the organisational philosophy and the ways in which patients should be cared for.

I now refer back to Jo-care's managerial rhetoric of which the POT is part.