Organization, Cultures and the Management of Change in the National Health Service:

Case Studies in One District Health Authority

Terence H McNulty

August 1990

Nottingham Polytechnic

Thesis submitted in partial fulfillment of the requirements for the award of the degree Doctor of Philosophy, C.N.A.A.

PhD SLC-

90/MCN Rep -

ABSTRACT

Organization, Cultures and the Management of Change in the National Health Service:

Case Studies in One District Health Authority

by

Terence H McNulty

This thesis is concerned with the issues of managerial effectiveness, organizational change and cultures in the National Health Service. Using the micropolitical and cultural perspectives it is concerned to offer an approach which builds on existing organization, management and change theory in order to further an understanding of these issues in relation to National Health Service organizations as well as other contexts.

The focus of attention is on the relationship between structure and culture at both the official and unofficial levels of the organization. The three case studies of organizations undergoing organizational change have allowed the opportunity to understand the complexity of the relationship between the official and unofficial arrangements in the organization and the impact of this on managerial effectiveness and organizational change.

The main finding of the thesis is that within organizations, structure and culture are inextricably bound and their consonance at both official and unofficial levels of the organization is a necessary condition for managerial effectiveness. The types of organizational culture developed during the investigation indicate how the plurality of interests, beliefs and cultures within an organization make it difficult to achieve this condition.

Concerning National Health Service organizations, the researcher argues that the recommendations contained within the Griffiths Report (1983) have offered a model of management which is based on cultural assumptions which are different to those which have traditionally underpinned the managerial process in the NHS. Following this, the researcher demonstrates via the cases, that the introduction of these recommendations has served to offer greater scope for a diversity of managerial style and philosophy at Unit level. They have also served to raise conflict between cultures, in particular the medical and managerial, to the point that the conditions needed for achieving managerial effectiveness do not exist.

Acknowledgements

Thanks are due to many people whom I have known whilst doing this research project and who have provided me with support, encouragement and guidance. Unfortunately, I cannot mention them all here but I particularly wish to thank Richard Wakefield and Sarah Mason for their friendship and help in making this task a bearable one. Special thanks go to the many members of my family. In particular, to my parents James and Josephine McNulty, you have been a constant source of love, frienship and sound advice, as well as to Kim, Debbie and Alex. Without your help and belief in me I could not have completed this project.

My gratitude also goes to Professor Tony Watson for providing the opportunity to undertake this project and for his immense amount of help with my career to date. Dr Colin Fisher for his patience, imagination and helpful comments along the way and to those people in the Health Service who have given me their time and the benefit of their insight and experience. I hope that I have done them and their organization justice.

Finally, I wish to dedicate this work to those who suffered as a result of the Hillsbororough Stadium disaster 15th April 1989. Let us hope that a modicum of commonsense and genuine concern for the game of football and the decent majority who watch it can find its way into the thinking of those who claim to the have its interests at heart.

CONTENTS

FIGURES

NOTE: ALL NAMES USED IN THIS INVESTIGATION FOR INDIVIDUALS AND ORGANIZATIONS ARE FICTITIOUS.

CHAPTER ONE

INTRODUCTION

This study is concerned with some key issues of managerial effectiveness, organizational change and cultures in the National Health Service (NHS). These are analysed within the context of NHS organizations by using a comparative case study method. Work on the project began in late 1985 and the bulk of the empirical data was collected in Autumn 1986 and during 1987.

The intention of the researcher is to take steps towards an improved understanding of managerial effectiveness and organizational change, particularly in relation to the NHS. Crucial to satisfying this intention is an understanding of the relationship between organizational structure and culture.

This relationship is discussed in chapter four, after it has been argued in chapter three, that the cultural and micropolitical perspectives afford a better understanding of organizational change and managerial effectiveness because they make it possible to consider, more fully than previously, the role of human subjectivity within organizational functioning.

To this end, a conceptual framework is developed and explained in chapters three and four which takes account of organizational politics and culture. Through the framework, interests, beliefs and cultural

assumptions which inform the choices and behaviour of individuals and groups within the organization are accommodated. The development of this framework is important because the review of organization, management and change literature in chapter three indicates that it is increasingly recognised, that whilst attempting to understand managerial effectiveness and organizational change, we must not treat these phenomena in a vacuum which excludes human activity. Rather, attention to the context is important and any investigation concerned with these issues must take account of the contextual features such as the historical, cultural and political factors of the organization.

The conceptual framework used in this investigation is an extension of a model developed by Watson (1986) into the nature and tasks of management. In the model, the criterion of organizational effectiveness which is used is long-term survival. In order to achieve this, it is necessary that managers pull the organization together and along in a general direction. Following on from this, the central argument which steers the investigation is, that to achieve managerial effectiveness, managers need to ensure that the culture and structure of the organization are mutually supportive and re-inforce one another in both the official and unofficial dimensions of the organization.

Arising out of the conceptual framework and also described in chapter four are a range of ideal types of organizational culture. These types are based on the relationship between the official and

unofficial arrangements in the organization. The value of these types is that they offer a way to examine the central argument of the investigation by providing an indication of some of the complexities associated with achieving these necessary conditions for managerial effectiveness.

Having laid down the theoretical and methodological basis of the investigation in chapters three and four, the remainder of the thesis is given to presenting the empirical data and discussing the main issues in the light of this data.

In chapter five, the recommendations contained within the Griffiths Report are described and analysed through a cultural lens. The argument offered by the researcher in this chapter is that, the structural and cultural content of the change recommendations are such that Griffiths has attempted to develop a new model of management based on cultural assumptions which are different to those which have traditionally underpinned the managerial process in the NHS. Through the reactions of representatives of professional groups within the Health Service, the researcher shows that the recommendations have been perceived by some as challenging the interests of particular groups of staff within the Service.

Therefore, the concluding argument of this chapter is that the recommendations have a conflict dimension. This cannot be ignored, because as a result of drawing on perspectives and knowledge from the literature on management and organization change, it is the

researcher's contention that the achievement of managerial effectiveness, whilst the Griffiths recommendations are being introduced, rests largely on the support and approval of individuals and groups within the Service. Changes in only the structural features of organizations will not achieve managerial effectiveness. Rather structural changes must be accompanied, supported and reinforced by cultural change. For this to occur, the assumptions and values which underpin the Griffiths recommendations need to be shared by individuals and groups within the Service. If this does not happen the necessary conditions for managerial effectiveness, as conceptualised in this investigation, will not be present in the organization.

To examine this argument chapters six, seven and eight comprise of one case study, each detailing the implementation of Griffiths recommendations within the Units of management of a District Health Authority (DHA). Two particular issues are addressed by the researcher in each case. First, the official culture and structure of each Unit is analysed in order to gain an indication of the extent to which the cultural assumptions of the Griffiths are espoused and acted upon by senior management in the Units. Second, through the observation of cultural and micropolitical processes operating in the Units, the relationship between the official and unofficial dimensions of the Units is discussed. Through this relationship, the Unit is described in relation to the types of organizational culture identified in chapter four. In turn, this provides an indication of whether the conditions for achieving managerial effectiveness, as

conceptualised throughout this investigation, are present in the organization.

Arising out of these chapters are the conclusions of the investigation. These are presented in chapter nine. With regard to the issue of organizational change, the cases support the argument expressed in chapter three, that when attempting to conceptualise and analyse organization change, attention must be paid to the context within which change is occurring. The cases discussed in this investigation show that organizational change is bound up within the subjective capabilities of individuals, who acting alone and in groups, interpret change and formulate their response to change in accordance with their own interests, beliefs and cultural assumptions. The evidence, of both opposition to and support for the Griffiths recommendations, in all the Units of management studied by the researcher, supports this argument. Further, this subjectivity is part of the cultural make-up of the organization and ensures that the culture of the organization can be both a facilitator or a barrier to change.

With regard to managerial effectiveness, the cases demonstrate that organizations are cultural milieux (Louis 1983) made up of individuals and groups whose different interests, beliefs and cultural assumptions infuse their lives with meaning. These meanings provide the basis for co-operation and conflict between individuals and groups within the organization. More specifically, in terms of managerial effectiveness, the official culture and structure of each Unit confirm

that management as an organizational function is informed by particular assumptions and beliefs. As an activity it is not removed from the political interplay. At the same time as promoting particular interests and espousing assumptions, managers are relegating other interests, beliefs and cultural assumptions to an unofficial status because they do not fit in with their attempts to pull the organization together and along in a general direction. In turn, this breeds and perpetuates opposition to official interests and arrangements. This opposition cannot be ignored because it is the basis of unofficial structural and cultural arrangements in the organization and as the cases demonstrate, to achieve managerial effectiveness, the official power holders, for example senior management, need to manage the unofficial arrangements in the organization in order to ensure that the structure and culture of the organization in both the official and unofficial dimensions are mutually supportive.

In terms of our understanding of management in the NHS, the investigation demonstrates that senior managers at Unit management level have taken the opportunity provided by Griffiths, to shape organizational form and behaviour according to local circumstances. General management has been introduced in such a way, that the official culture and structure of each Unit show variations in managerial style, philosophy and ideology. These differences indicate that the official culture recommended by Griffiths has been accepted to varying degrees by senior management in the Units. In itself, this local variability is a significant observation and is a major sign of

change within the Service.

With regard to achieving managerial effectiveness in the NHS, the researcher concludes that the necessary conditions for achieving managerial effectiveness as conceptualised in this investigation, will not be achieved whilst cultural assumptions held by clinical professionals such as Doctors and Nurses, are in conflict with those which are held by managers and being widely espoused as official. Chapter four offers the 'consensus' type of organization as the one best suited to achieving managerial effectiveness as understood throughout this investigation. None of the Units observed by the researcher can be described as 'consensus'. Conflict between the managerial culture and medical culture is present in all of the Units. This conflict means that the other types of organizational culture described in chapter four, are more useful for discussing managerial effectiveness in the NHS.

In particular the type of organization culture described as 'dualism' is the most useful for describing contexts such as the large acute hospital in which two cultures - the managerial and the medical are present. This is because the dual existence of these cultures is facilitated by official arrangements which allow both cultures to draw their strength from different symbolic and material resources and to exercise that strength in different spheres of the organization. For example, the medical culture is dominant at the care delivery levels of the organization, whilst the managerial culture is drawing some of its strength from its strategic position in the organization and

demonstrating this strength through the cultural assumptions which infuse strategic decision-making in the organization.

The researcher goes on to show that the relationship between these two cultures is a mix of both co-operation and conflict. Furthermore, the conflictual aspect of the relationship is likely to continue for two reasons. First, the official arrangements offer sufficient symbolic and material strength for both cultures to exist and exercise their strength in different spheres of the organization but insufficient strength for one to dominate the other at both the strategic levels and the care delivery levels of the organization. Second, resource pressures on managers and doctors are likely to continue to bring them into conflict with each other.

Therefore, the researcher suggests that 'dualism' is likely to continue to be an appropriate model for understanding the complexities of achieving managerial effectiveness in contexts where the official arrangements facilitate this relationship between cultures. An important issue for the future is whether it continues to be an uneasy relationship with the organization experiencing conditions associated with the 'dualism', 'informal empire', 'balkans' or 'imperialism' types of organizational culture or whether the relationship is good and the organization develops a 'consensus' type of organization culture.

CHAPTER TWO

RESEARCH DESIGN and RESEARCH METHODS

In chapters three and four, the researcher will explain the methodological approach and conceptual framework which has steered the progress of this investigation. In keeping with the grounded theory approach encouraged by Glaser and Strauss (1967), the conceptual framework has been developed as data has been collected and analysed. This chapter is given to a discussion of how that data has been collected and analysed.

This discussion is the researcher's contribution to addressing a weakness in research reports identified by Burgess (1982c). In an article entitled 'Styles of data analysis: approaches and implications', Burgess argued that accounts of the methodological operations involved in data analysis are "all to rare" (Burgess 1982c:235). Noting this criticism, the forthcoming discussion is the researcher's attempt to provide an account of the methods used and some of the key issues dealt with during the preparation, collection and analysis of empirical data. It is an attempt to describe and consider one's activities as a researcher, one's impact on respondents, the techniques, practices and approach of doing research and the methods of data collection and analysis. Simply stated, it is an attempt to address the fundamental question which faces all researchers - "how have I done my research?"

Qualitative Research Design

Bryman distinguished between research design and research method in the following way:

> The former should be thought of as the overall structure and orientation of an investigation. This structure provides a framework within which data are collected and analysed (Bryman 1989:28).

The methodological assumption, explained in chapter three, concerning human activity within the organization and the central proposition, explained in chapter four, are such that the style of the investigation is phenomological. That is, it is concerned with human subjectivity within everyday social life. As such, the research design can be described as qualitative. This description distinguishes it from research which can be described as quantitative. In 'Research methods and organization studies' Bryman offers a useful discussion of both qualitative and quantitative research design. The following explanation of the distinction between the two approaches to research is particularly helpful.

> The most central characteristic of qualitative, in contrast to quantitative, research is its emphasis on the perspective of the individual being studied. Whereas quantitative research is

> propelled by a prior set of concerns, whether deriving from theoretical issues or from a reading of the literature in a particular domain, qualitative research tends to eschew the notion that the investigator should be the source of what is relevant and important in relation to that domain. Rather, the qualitative researcher seeks to elicit what is important to individuals as well as their interpretations of the environments in which they work through in-depth investigations of individuals and their milieux (Bryman 1989:24).

A similar view was expressed by Van Maanen, in a discussion of the distinguishing factors between qualitative and quantitative research.

> ...qualitative researchers in contrast to their quantitative colleagues claim forcefully to know relatively little about what a given piece of observed behaviour means until they have developed a description of the context in which the behaviour takes place and attempted to see that behaviour from the position of its originator...data are symbolic, contextually embedded, cryptic, and reflexive... (Van Maanen 1983:2).

From the above extracts it is apparent that qualitative research has particular emphases. Citing the work of Burgelman (1985), Bryman elaborated on these emphases.

> ..the emphasis in qualitative research tends to be on individuals' interpretations of their environments and on their own and others' behaviour. The presentation of data tends to be sensitive to the nuances of what people say and to the contexts in which their actions take place. The emphasis tends to be on understanding what is going on in organizations in the participants own terms rather than those of the researcher (Bryman 1989:29).

The contextual and interpretive commitments of qualitative research require that specific methods of data collection are used. These commitments and associated methods are discussed later in the analysis. Prior to this, it is necessary to note the origins of this investigation because these origins have greatly shaped the qualitative focus, the decisions about the site of the investigation and the overall perspective which the researcher has brought to the investigation.

Background to the Investigation

A phenomological investigation requires that the preliminary stages of an investigation and any idiosyncratic factors associated with the research design are taken account of in the data collection and analysis phases as well as in the research report. Indeed, data collection starts with these stages and if not accounted for in the research design may irretrievably bias the investigation from the outset and damage the validity of observations.

The origins of this investigation are the researcher's theoretical interests and involvement in the National Health Service as an employee. The researcher's first involvement in the Service was from October 1983 to September 1984, when employed in a clerical capacity in an administrative department at the District Health Authority level of management. During this time, the researcher made a "layperson's" observation which has informed the focus of this investigation.

Although employed at a clerical level, contact at the dinner-table and the bar permitted sufficient informal observation of and conversation with senior managerial personnel from medical, administrative and nursing disciplines. It was as a result of this contact that the researcher became aware of the publication of the Griffiths Report. As a result of being a party to informal conversations amongst some managers at senior and middle management levels, the researcher became

aware of the ridiculing given to the Sainsbury's grocery chain. At that time, the researcher observed the ridicule without having any desire either professionally or out of general interest to delve into why Sainsbury's had become a source of shared derision. It was not until the researcher had left the organization and returned to an academic environment that the significance of the ridicule was fully appreciated. As a student interested in the Public Sector as well as organization and management theory, an interest in the recommendations of the Griffiths Report and their implications for the management process in the Health Service developed.

Having completed the final stages of undergraduate study, the researcher returned to the same organization in the same working capacity. Although this spell was brief (two months), it was critical to the development of this investigation. On returning to the organization, the researcher observed some significant feelings and opinions of individuals about the introduction of general management. Within the employing department, there was much uncertainty amongst individuals about their managerial futures in the Health Service and in fact many senior staff had left their posts since the researcher first worked in the organization. The amount of covert dissent towards the recently appointed District General Manager was also a significant feature of social life in the organization. Dissenting references to Sainsbury's, the private sector and the military background of the District General Manager (although expressed informally) appeared widespread.

Some of the structural changes being introduced at District level of management appeared to be a factor in the basis of dissent. As a student of management and organization, the researcher felt that these feelings could impact upon the effectiveness of the changes seemingly being introduced. With this thought as a starting point, the researcher's interest and desire to apply a scientific investigation to a Health Service organization, geared to looking at the introduction of organizational change had developed. Coincidentally, the opportunity to undertake an investigation designed to concentrate on the Health Service arose at Trent Polytechnic.

Major factors in the decision to accept the three year full-time research position included an interest in understanding this dissent as well as building on the practical insights already gained into some of the major managerial issues of the Health Service. In addition a basic appreciation of the theory associated with organization, management and organizational change was also an important factor. For example, the notion of culture within the organization and its implications in terms of organizational effectiveness was popular amongst practitioners and organization theorists at that time and seemed to offer a useful basis as a conceptual tool to understand social activity within organizations. The arguments for this are presented in chapters three and four.

Hence, the field of study has been greatly identified by the theoretical background of the researcher and an identified potential

problem, which can be loosely described as a resistance on the part of some individuals to organizational change.

In developing the research design, this theoretical perspective and perceived problem has been influential alongside factors of time, access and resource constraints. At the outset of any description of the research process it is necessary to note that the research strategy is a result of the interplay of one's interests and the constraints operating at a given time. Indeed the thoughts of Burgess are comforting to any researcher faced with these practical realities. He noted that:

> ..the researcher becomes a methodological strategist who engages in problem orientated methodology (Burgess 1982b:2).

A literature review (between October 1985 and Autumn 1986) of organization and management theory as well as Health Service publications further strengthened the belief in the potential value of the concept of culture to an investigation concerned with managerial effectiveness and organizational change. It also drew attention to a range of diverse and often conflicting reactions to the Griffiths Report (discussed in chapter five). These, allied to views expressed by colleagues whilst the researcher was employed within the organization, strengthened the researcher's resolve to scientifically investigate the recommendations of the Report. With these concerns in

mind, the progress of the investigation relied on making further decisions concerning the research design and research method.

These decisions have been greatly informed by the researcher's awareness of some of the constraints and circumstances which surround the research process. These were a regular topic of discussion during weekly research methods seminars held within the Trent Business School. Attended by senior academic staff and current researchers, it is important to note these seminars in this account. For this particular investigation, some of the constraints and circumstances impacting upon the research design have been:

the three year research contract and the recommended model of research management. First year, focusing the project, literature review and preparation for data collection; second year, data collection and third year, presentation of findings;

those associated with being the sole researcher on a project;

gaining 'access' to organizations in order to investigate one's subject matter.

As a consequence, the decision-making process associated with research design and research method has necessarily involved an opportunity cost (trade-off) process, in terms of what is practical and achievable in view of one's resources and constraints. The importance of this

pragmatic process needs to be emphasised and not underplayed in consideration of the methods used and view of the findings.

Case Study Method

Along with the decision to adopt a qualitative research design, the use of a case study method is a significant feature of this investigation. Mitchell offered the following working definition of a case study:

> ..a detailed examination of an event (or series of related events) which the analyst believes exhibits (or exhibit) the operation of some identified general theoretical principle....a narrative account of some event or series of related events does not in itself constitute a case study in the sense that I am using the notion here. A case study is essentially heuristic; it reflects in the events portrayed features which maybe construed as a manifestation of some general abstract theoretical principle (Mitchell 1983:192).

Much confusion surrounds the aims of the case study method. So much so that the validity of observations has been questioned and the reliability of the case study as a method of social analysis

questioned. The scepticism towards the case study largely rests in a view that generalizing from the results of one study is not possible. Mitchell addressed this issue in an excellent discussion of the case study method. It was noted that for some:

> The basic problem in the use of case material in theoretical analysis, however, is that of the extent to which the analyst is justified in generalising from a single instance of an event which may be - and probably is - unique. The problem is that of the typicality of the case which is used to support some theoretical analysis. A typical case implies that the particular set of events selected for report is similar in relevant characteristics to their cases of the same type (Mitchell 1983:189).

This 'weakness' has recently been considered by several theorists and a view has emerged which defends the reliability of the case study. Drawing on the work of Mitchell (1983) and Yin (1984), Bryman has argued that:

> ..there is a growing recognition that some of the accusations about the limited generalizability of case studies may be based on an erroneous application of statistical notions which treats

the case as a sample of one (Bryman 1989:172).

Indeed, much of the force of this defence for the case study method comes from the work of Mitchell who distinguishes between statistical inference and scientific or causal inference. Mitchell describes the distinction in the following way:

> Statistical inference is the process by which the analyst draws conclusions about the existence of two or more characteristics in some wide population from some sample of that population to which the observer has access. Scientific or causal - or perhaps more appropriately logical inference, is the process by which the analyst draws conclusions about the essential linkage between two or more characteristics in terms of some systematic explanatory schema - some set of theoretical propositions...the process of inference from case studies is only logical or causal and cannot be statistical and that extrapolability from any one case study to like situations in general is based only on logical inference. We infer that the features present in the case study will be related in the a wider population not because the case is representative but because our analysis is unassailable (Mitchell

1983:199).

Mitchell concludes the argument by claiming that:

> A good deal of confusion has arisen because of a failure to appreciate that the rationale of extrapolation from a statistical sample to a parent universe involves two very different and even unconnected inferential processes - that of statistical inference which makes a statement about the confidence we may have that the surface relationships observed in our sample will in fact occur in the parent population, and that of logical or scientific inference which makes a statement about the confidence we may have that the theoretically necessary or logical connection among the features observed in the sample pertain also to the parent population. In case studies statistical inference is not invoked at all. Instead the inferential process turns exclusively on the theoretically necessary linkages among the features in the case study. The validity of the extrapolation depends not on the typicality or representativeness of the case but upon the cogency of the theoretical reasoning. (Mitchell 1983:207)

The significant thing to note is that the aim and justification for the case method rests in its:

> .. explanatory power rather than its typicality (Bryman 1989:203).

Taking the argument of Mitchell and Yin, Bryman concludes:

> ..case studies should be evaluated in terms of the adequacy of the theoretical inferences that are generated. The aim is not to infer the findings from a sample to a population, but to engender patterns and linkages of theoretical importance (Bryman 1989:172).

Though such an argument resolved for the researcher the concern with the case study method per se, a further difficult decision was that of deciding whether the site of study should be the District level of management or the Unit level of management.

Sites of Investigation

The Griffiths Report offered a multitude of potential research foci both by way of its recommendations spanning four separate tiers of management and by the range of issues covered in the Report. For example, consumerism, decision-making and budgetary processes are all

areas of concern contained in the Report that justifiably warrant attention on their own.

Ultimately, the decision to adopt the Unit level of management as the site of the investigation was taken largely because of two factors in particular. First, the attention given to the 'Units of management' in the Report could not be ignored. As Griffiths remarked:

> Units of management (particularly the major hospitals) provide the bedrock for the whole NHS management process.. (Griffiths Report, 1983:18).

This comment along with others discovered during the literature search led the researcher to the conclusion that the Unit level of management is the level of management where the challenge to bring about organizational change in line with the Griffiths recommendations is at its greatest.

Second, after consideration, it was decided that an obvious advantage of focusing on the Units of management of a single District Health Authority was that there was in fact the opportunity to obtain comparative data by contrasting the different Units of management within the District.

The choice of Kingstown District Health Authority was made because the Authority satisfied criteria which Schatzman and Strauss (1973)

indicated are essential to satisfy in 'casing' a site. Because it contains two large general hospitals with similar contingent factors such as size and technology, as well as very old and very new Units of management with diverse historical backgrounds, it offered the scope to investigate the issues and problems of interest to the researcher. In addition the number of Units of management ensured that the workforce were of sufficient number, organization and variety of functional and professional background to suit the political and cultural interests of the researcher. Finally, and very significantly, it had practical advantages in terms of the minimal amount of travel to the 'field' required of the researcher.

The one major doubt about the selection of this particular District Health Authority stemmed from the researcher's previous involvement as an employee. This was a major concern because of former colleagues and contacts still working within the District. In an investigation committed to the understanding and interpretation of actors social worlds, the researcher must attempt to adopt the outsider's perspective and distance oneself from factors which may prevent the world being 'anthropologically strange'. If one is not able to do this, bias and unreliability of the research data may result. Threats to the development of the outsider's perspective can arise from knowing the organization to well. If this threat materialises a researcher can perceive actions as 'normal' and align oneself with particular groups or individuals. In this investigation the threat has been very real and great attention has needed to be paid to not

letting one's former administrative background adversely affects one's contacts with clinical professionals such as Doctors and Nurses and one's interpretation of their social worlds.

Ultimately two particular factors convinced the researcher to use this particular District Health Authority. First, the cost-benefit approach to research decision-making applied and it was felt that the benefits of using this District as opposed to another would outweigh the disadvantages. For example, the established networks of individuals who could be useful informal contacts and sources of data was regarded as a benefit. Additionally and very importantly, knowledge of the field and a working knowledge of the Authority offered a possibility to avoid time-consuming preliminary tasks.
Second and perhaps more important, because the researcher was an employee at the District level of management with no experience and (few contacts) at Unit level, the investigation would indeed be carried out in settings which were anthropologically strange to the researcher and in which there were no existing allegiances to factions or groups. With this decision made, the next major step in the development of the investigation was taken by gaining entry into the organization to conduct the study.

Access

The approach to the Health Authority for access into the organization is worth discussion because it raises another key issue which has had

to be dealt with: the 'role' of the researcher. In terms of this researcher's strategy for gaining entry into the organization, there are two key features of the initial approach for access which are important to note. First, it was decided to contact the 'official' most powerful person in the organization. Second, it was decided to be 'open' about the key issues and problems of the investigation and the role which the researcher perceived for oneself and for respondents. It is worth discussing both these features in some detail.

The idea of approaching the District General Manager who was 'officially' the most powerful person in the Authority was based on the assumption that this person was the gatekeeper of the organization. Gatekeepers are those individuals who can either grant or withhold formal permission to enter and participate in the life of the organization. The initial approach was made in the form of a letter to the District General Manager. He in turn delegated the gatekeeping responsibility to a manager in the Personnel function . The fact that the researcher had previously had contact with the manager and this person worked with ex-colleagues of the researcher was something which the researcher decided to use as an advantage. Hoffman (1980), Buchanan, Boddy and McCalman (1988) have all noted the use of friends in negotiating access. Eventually, a meeting took place between the Researcher, the Research Director of Studies and the gatekeeper.

The content of these discussions raises the second feature. In the role of gatekeeper, the manager required indications of the researcher's intentions, and this request was met through a discussion of the key issues and problems of interest to the researcher and the perceived amount of access required to pursue these. As such, an 'open' as opposed to 'secret' role for the researcher was proposed. Oral assurances were given to the manager that the organization and respondents were not to be subject to evaluation or criticism. Additionally, assurances were also made concerning trust and confidentiality of the Authority and respondents, as well as assurances that the research would not prove to be unduly disruptive.

Appendix A indicates the willingness on the part of the researcher throughout the investigation to consider the worries and concerns of the organization under study. Bryman has noted theorists such as Buchanan, Boddy and McCalman (1988), Crompton and Jones (1988) have noted the importance of being prepared to explain research intentions and deal with the organization's worries about the research.

Significantly, at no point in the access negotiations was it mentioned that the researcher should be required to submit a report(s) to the organization. That this has not been required was a relief to the researcher because such a requirement may alter the role of the researcher in the eyes of respondents. For example, producing reports may render the researcher open to the charge of being a consultant or agent of a group of people such as senior management.

At this stage, access negotiation was effective not only in obtaining the permission of the gatekeeper to enter the organization, but in the fact that no pressure had been applied by the gatekeeper to channel the investigation towards a focus which the official power holders desired. Other than speculating that it was hoped that the research would have practical consequences, 'impression management' by the gatekeeper was not a major problem. The only sign of a defensive attitude on the part of the gatekeeper was shown by the comment:

> isn't it too early to investigate the introduction of general management?

In fact the gatekeeper was not alone in expressing this view. (In further access negotiations at a later stage of the investigation other gatekeepers made similar remarks). Indeed the remark took on a major significance for the researcher because after analysis of this remark within the context of the total access discussions, it appeared to arise out of a genuine concern of the gatekeeper about how useful the Authority could be to the investigation, rather than an attempt to alter the direction and focus of the investigation.

Ironically, rather than putting doubts into the mind of the researcher about the time of entry into the organization, the remark further fuelled the researcher's desire to enter into the data collection stage as quickly as possible. As Atkinson (1976) remarked, the time of entry to an organization is vital to an investigation. Bearing in

mind the researcher's interest in looking at the introduction of organizational change, the gaining of entry into the Units of management in the first few months the general management process being introduced was regarded as a major benefit to the theoretical interests of the researcher. As Atkinson has argued, the first days are crucial times to enter a setting. The researcher viewed that these were the 'first days' of general management and to observe these early formative stages of general management was vital. This was so because at such times one anticipates that the culture shock being experienced by people may be at its height. For example, routines are likely to have been disturbed, traditional attitudes challenged in favour of new attitudes and key assumptions of the old culture made explicit in order to provide protection and barriers to change. As these issues are central to the focus of the investigation, obtaining access to the organization at this time as opposed to some later time was regarded as a major opportunity which could only benefit the investigation.

The only doubt in the mind of the researcher about this time of entry was to do with investigating an organization allegedly undergoing major organizational change. One associates great anxiety and sensitivity amongst individuals at such times. Significant in overcoming any access problems involving this potential sensitivity was the 'tactic' used by the researcher in the negotiation of access, of an open approach supported by guarantees not to evaluate individuals' or Units' performance. Also, the regular reminders to

the gatekeeper that the researcher was formerly a member of the organization and appreciated the sensitivities of the situation helped to build up trust in the researcher and the motives for conducting the investigation.

Hence, the initial access was seemingly effectively negotiated. However, as the data collection stage neared, it became clear that the individual Units of management had their own gatekeepers. This was a significant observation in itself because it indicated that the Units of management were perceived by their senior managers as separate organizations from the District tier of management and, as such, would make their own judgements about who conducted research in the organization.

As a result further access negotiations were needed. The Unit General Managers were now the gatekeepers and it was their permission upon which the progress to the data collection stage of the investigation rested. In meeting with these to discuss access, it must again be acknowledged that in the researcher's favour were favorable reports from members of senior management at Unit level who had worked with the researcher at the DHA. Thus, by the time the researcher met these other gatekeepers, much of the ground had been prepared through these contacts. Indeed, the meetings with the Unit General Managers turned out to be a personal rubber stamping of the investigation on their part.

Additionally, by the time the researcher met these individuals, the ideas had developed further and a clearer picture of the researcher's role and that of respondents had been developed. Hence much of the knowledge regarding the research role, scope of access, expected benefits to the organizations and assurances about trust were indicted in a document which was sent to the gatekeepers and subsequently to respondents prior to interview. This is shown as Appendix A. It is important to note that rather than perceiving this extra access negotiation as a nuisance, the researcher felt that it was a bonus in terms of the collection of data. In a phenomonological study it is essential to regard the access negotiation process and the role of the gatekeeper as an integral part of data collection. This has proven to be the case in this investigation as the different approaches of the gatekeepers in each Unit to the researcher and the aims of the study has been interesting and informative.

Clearly, at this stage of the analysis it is important to note that the researcher was also involved in 'impression management'. At the access negotiation stage, it must be noted that credibility and trustworthiness of the researcher had been checked by the gatekeepers with the researcher's former colleagues and superiors. Accompanying what must have been favorable references, it was necessary to take a great deal of care with self-presentation. In order not to look out of place, it was necessary that the researcher's appearance blended in with the setting. With this in mind the researcher's dress was a 'sober' looking suit, tie and shirt. This was a conscious policy on

the researcher's part to constantly blend in to the way of life of the organization.

With access negotiations effective, the data collection process could begin. The next major decision rested upon deciding the point of entry in each Unit. At the outset it was decided to cover all five Units in the district. In the end, the decision about the point of entry was informed by the issues which were of interest to the researcher.

The reality of the implementation was that at the time data collection process began in Autumn 1986, general managers had only recently been placed in the Units and management teams were only just being formed. Therefore, in the time limits of the investigation, it was anticipated that only a small number of people, in particular senior management personnel and those middle managers appointed to managerial positions would be useful to talk to in the first six months. Hence, in terms of the issues under investigation, it was anticipated that there would be a limited number of useful informants initially. This was checked out by arranging meetings with the Personnel Officers in each Unit. These individuals acted as key informants, giving much evidence on the historical background of the Units, the time scale for the introduction of structural changes and details of the organizational chart. In the terms of Schatzman and Strauss (1973), these contacts were useful in that they provided the researcher with a "Cook's tour" of the location, its layout and likely significant areas

and foci for data. Added to documentary data such as the newly drawn organizational charts (Appendices B, C and D), and the researcher's personal experience, this allowed the researcher to map the sites of investigation and further develop a strategy in terms of useful respondents and issues to pursue in observation and interview.

Having stated this, two things must be noted. Due to the researcher's previous experience of working alongside the Personnel officers in the Units, these contacts were very useful and went on for many hours and often occurred more than once. They were very extensive and it is vital to note that the researcher was not intimidated about appearing naive in terms of asking about aspects of the site or individual's roles in the social structure. This is important because ignorance of the field can often be a problem to the researcher in terms of credibility. Second, these contacts were not interviews as such. Although these managers were involved in the introduction of general management and would be requested to be respondents at some stage, at this stage of contact particular issues of interest were not pursued. The objective of the contact was similar to that of the key informant technique. That is, to obtain descriptive qualitative data which is difficult and time consuming to obtain through the more structured data gathering techniques such as questionnaire surveys (Tremblay 1982). In this respect, the researcher's thinking followed that of McKinnon who distinguished between informants and respondents. Mckinnon argued that using informants is a tactic which can be used to safeguard the validity and

reliability of data.

> Informants provide general background data on the organization and the people in it. As such they are an important means of overcoming the data access limitations which stem from the researcher's restricted time and mobility in the setting. Informants can provide an oral history of the organization's development, as well as details on its present structure and designated functions of participants (McKinnon 1988:50).

Research Methods

Having negotiated access into the Units of management and taken major decisions about adopting a qualitative research design and case study method, it became imperative to decide on the data collection methods to be used. Recently, Bryman (1989) has provided a very interesting classification of types of qualitative study. It is useful to use this to discuss the methods used by the researcher in this investigation.

According to the degree of participation by the researcher in the organizational setting, Bryman has classified qualitative studies into types, ranging from total participant studies to multi-site interview based studies. This investigation fits most closely to the 'interview

based' type of study identified by Bryman. It does so because unstructured interviews and documents have been the main methods of data collection. Some observation has occurred but it fits the author's description of being:

> ..largely non-participant, with the researcher being very much on the periphery of interaction, ... undertaken in a somewhat unstrategic manner.. supplementary and something that is carried out in the spaces between interview or at meal times (Bryman 1989:155).

The references in chapters six, seven and eight to observations made journeying to and from interviews and during conversation with managers at the lunch table fit this description.

An acknowledgement that the investigation fits this 'type' is a recognition that participant observation has not been a method of data collection used by the researcher. As participant observation is one of the major methods of qualitative research, it is worth briefly mentioning why the researcher has rejected this approach.

Useful discussion of participant observation have been provided by Becker and Geer (1982), and Bryman (1989). Participant observation involves participating in the worlds which one is trying to observe. Burgess noted that Becker said that:

> The participant observer gathers data by participating in the daily life of the group or organization he studies. He watches the people he is studying to see what situations they ordinarily meet and how they behave in them. He enters into conversation with some or all of the participants in these situations and discovers their interpretations of the events he has observed (Becker 1958:652, reported in Burgess 1982g:45).

The researcher considers that the key point made in all of these articles is that as well as a research method, participant observation is a particular activity or role adopted by the researcher. It is a role which whether performed openly within the organization, or secretly, involves a lengthy period of time in the organization. It is an attempt to totally immerse oneself within the way of life of the organization in order to uncover, at first hand, an understanding of that particular context.

Its rejection as a method to be used by the researcher in this investigation has ensured that whilst this study is part of the phenomonological/interpretive style of research, it cannot be classified as an ethnographic study per se. It is a qualitative study with the researcher attempting to satisfy, to some degree, the commitments and emphases which characterise ethnographies (Atkinson

1979) and qualitative research generally (Bryman 1989).

The necessity of engaging in trade-offs about the cost and benefits associated with some research design and research method vis-vis other design and methods, ensures that some emphases of qualitative research are followed more than others. As Bryman remarked:

> ..the four types delineated thus far allow the concerns of qualitative research to be realised in different ways and different degrees (Bryman 1989:159)

The decision to reject participant observation as a method was taken because the benefits of using an interview based approach out-weighed those offered by the use of participant observation.

The most significant of benefits was that interviews offered the scope of research which cannot be achieved by this deeper participation. Bearing in mind the time and resources available to the researcher, it was decided that the theoretical interests and issues at the heart of the investigation required at least some degree of structuring and control as well as an extensiveness of site and respondent which participant (direct) observation would not have enabled. Hence, the research methods used have been unstructured interviews, use of secondary data, documents and some unstructured non direct observation.

Having decided that interviews would be the principal method of data collection, the next crucial decisions were concerned with who should be interviewed and what style of interview to use. It is worth discussing these two issues in greater detail, beginning with the style of interview used by the researcher to collect data.

By using interviews, the researcher has relied principally upon conversation as the medium for data collection. However, in the use of conversation as a research method there are important differences in the style of conversation used. These differences are reflected in there being three styles of interview: the structured, semi-structured and unstructured.

The issue which differentiates these styles of interview is that of control by the researcher over the respondent. The structured interview uses a pre-arranged order of questions, issues and prompts. As such the interviewer largely controls the interaction with the respondent. At the opposite end of the spectrum of interviewing styles is the unstructured interview. This is aimed at delving deeply into the personal issues and experiences of the respondent. Bailey has argued that:

> The chief feature ...is its almost total reliance upon neutral probes that are designed to be as neutral as possible. They are generally very short such as "why ?" or "Uh, huh" or "That's

> interesting"....it is intended to probe the respondent's deepest and most subjective feelings. At its extreme it may elicit repressed feelings that even the respondent did not know he or she had or was not willing to admit even to himself or herself (Bailey 1982:201).

The main method of data collection in this investigation has been the unstructured interview. Through this method the researcher has been able to probe the meanings and assumptions of key actors within the Units. As Becker and Geer noted, this style of interview is geared to investigations which are more concerned with understanding an organization as opposed to studying causal relationships between pre-given variables.

> Research aimed at discovering problems and hypotheses requires a data gathering technique that maximises the possibility of such discovery....the more structured a technique, the less likely the researcher is to find facts whose existence he had not previously considered or to develop hypotheses he has not formulated when he began his study. A respondent in an unstructured interview is more likely to provoke a discovery by saying something unexpected than is the respondent who can check one of six pre-coded

> replies to a questionnaire item (Becker and Geer 1982:239).

Therefore, provided care is taken in the interview process, it allows one to pursue (albeit to a lesser degree than participant observation) the 'naturalism' and interpretive commitments of qualitative research.

In view of the importance of context, naturalism and interpretation, it is useful to note the comment of Palmer as reported by Burgess (1982i) in a very useful article entitled 'The unstructured interview as a conversation'. Burgess quotes Palmer as saying that the unstructured interview:

> assumes the appearance of a natural interesting conversation. But to the proficient interviewer it is always a controlled conversation which he bends to the service of his research interest (Palmer 1928:171).

Having stressed the qualitative emphases and the pragmatic issues considered by the researcher, the reference to control is very significant. Some control is viewed as desirable but the researcher has rejected the artificial nature of the structured interview in favour of the apparently unstructured style.

Appendix E indicates that a structure for interviews has been used by

the researcher but it is has been one which can be reasonably be described as loose and flexible in terms of style and issue. As a result of this, the researcher has been able to follow up particular themes which have emerged during the literature search whilst also offering the opportunity for the respondents to raise their own themes and constructs. To afford respondents this opportunity is essential in an interpretive study, especially one which has the concept of culture as central to it.

The issue framework (appendix E) has been used for all the interviews and what has made it an effective tool in terms of 'naturalism' has been that it has quickly been memorised by the researcher. This memorising, supported by the non note-taking approach are two tactics which have enabled the natural conversation to occur. The only in-road into this natural discourse has been the use of an audio-tape recorder to record the conversation. Indeed, initially, the researcher was sceptical about using a tape recorder, instead of taking notes, but after some pilot interviews it was found to have two benefits. These benefits have been borne out during the data collection process.

First, the tape recorder can be skillfully located so as to make it unobtrusive. In every interview, the permission to use a tape recorder has been sought. Once agreed, it has been removed from the vision of the respondent. As a result of this the researcher believes that reactivity has been minimal. Indeed, support for this rests in

the comments of several respondents at the end of the interview that 'you forget it is there'. Second, by not taking notes a normal speed conversation without obvious pauses and artificial barriers could occur.

Only one respondent rejected the use of a tape recorder, citing past experience with an unethical researcher as the reason for the rejection. All of the other respondents were asked by the researcher if it could be used and all accepted it. More importantly, through their comments after the interview and the quality of data produced, it is evident that the use of the recorder did not inhibit their responsiveness. Other factors helped the unobtrusiveness of the tape recorder. These included choosing a recorder with a quiet mechanism; using a suitably strong pick-up to ensure that the recorder could be placed well away from the respondent and using C90 Or C120 tapes to avoid the constant changing of cassette.

The actual conducting of interviews and the concern to meet qualitative commitments will be discussed shortly. However, it is necessary to move onto the second concern. That being - who to interview. At this stage of the research it has been necessary to apply a sampling approach.

Selection of Respondents

The application of a sampling process is significant because it enables a degree of structure and control by the researcher. Useful articles on sampling in field research and ethnographic fieldwork have been provided by Burgess (1982f) and Honigmann (1982). Both theorists argue that sampling has a place in ethnographic /phenomonological research as well as in survey and experimental research. Burgess believes that it is a misconception that fieldwork does not involve sampling and Honigmann remarks that interpretive studies involve sampling a universe of people, situations, behavioral events and objects with which the researcher is occupied.

The argument of Honigmann which has informed the approach to data collection in this investigation is that which was stated in the following way:

> ..it will repay him (the researcher) to be aware of the character of his sample beginning with the basic distinction between non-probability and probability methods of drawing it (Honigmann 1982:79).

Following both authors broader use of the word 'sample', it is the researcher's view that a sampling process has occurred in this investigation by way of the approach to selecting respondents. It has

not been a probability approach. That is, rigid rules have not been followed to ensure that through a random selection of respondents in the population all different categories of respondents have the same probability of being studied (the aims of the case study method, as discussed earlier, show that to attempt to achieve such representativeness would be missing the point of using the case study approach anyway). Rather, a non probability sampling approach has been used in this investigation as the researcher has engaged in judgement sampling, theoretical sampling and opportunistic sampling.

In keeping with the broader definition of the word sampling, the first stage of the sampling process occurred through the selection of the Kingstown DHA as the site of the investigation in preference to other DHA's. In addition, the decision to select the managerial process as the focus of interest has involved selecting groups of organizational actors at the expense of other groups. For example, the members of the management team as opposed to the Medical Records staff or Pathology Department. Indeed, structure and control underpinned selection of focus by way of it following on logically from the identified problem, theoretical background of the researcher and the time constraints impacting upon the whole investigation programme.

The second stage of the sampling process occurred through the selection of respondents in the Units of management of the DHA. This has been greatly informed by the different categories of personnel within Health Authorities. The cultural concerns of the investigation

has ensured that data generated from a respondent needs to be analysed by taking into account categories which the person belongs to. In order to select people, the researcher has engaged in what Honigmann calls 'judgement sampling' and 'opportunistic sampling'. To describe the former, Honigmann remarked that:

> informants selected by virtue of their status (age, sex, occupation) or previous experience and qualities which endow them with special knowledge that the ethnographer values, are chosen by a type of non-probability sampling best called judgement sampling. The ethnographer uses his prior knowledge of the universe to draw representatives from it who possess distinctive qualifications (Honigmann 1982:80)

The major criteria informing the selection of respondents at the initial stages of the data collection process was that of hierarchical status. The organizational charts, appendices B, C and D, obtained at the access negotiation stage were useful in identifying the key actors and positions in the managerial hierarchy. Though interviews were carried out in three distinct phases, the common underlying condition of the first two stages has been that the respondent was a recognised manager in the organizational hierarchy.

The first group of respondents selected were that small group of

senior managers (including the Unit General Manager) in each Unit. These individuals are shown on the organizational charts as members of either the Policy Advisory Group, the Managerial Core Group or the Unit Management Group. The justification for selecting these respondents is that these individuals were directly responsible for developing and implementing the official arrangements in the Units of management. Quite simply, they were leading the introduction of general management and as a result these interviews offered a way to capture the emergent official culture in each organization.

Using the organization chart to inform the initial selection of respondents has been useful, as it has provided a 'map' to steer one's route through the sampling process. However, after the initial stage of interviews, more specific themes and issues began to emerge which needed to be followed up. For example, as will be indicated in chapters six, seven and eight, the official interpretations have differed between Units. Behind these differences were differences between individual managers in terms of the meanings and cultural assumptions which informed their thoughts and actions. Issues emerged, such as the conflict some managers were experiencing between the values and meanings associated with the general management ethos and those which they had traditionally held as administrators or clinical managers. As a result some themes, issues and observer identified categories began to emerge which provided the basis for the next piece of data collection. In the traditions of interpretive study, from this initial phase of interviews, the conceptual framework

began to be developed, the focus of interest sharpened and the key categories of respondent identified. As a result, the researcher used a judgement based on the initial phase of interviews to select the next group of respondents.

The second phase of interviewing was also centred upon those individuals performing a managerial role within the organization. The difference between this phase and the first phase being that, the managers at departmental and ward levels were interviewed. Because of this many of the managers were from a clinical background. This phase was designed to focus on the feelings towards the new emerging official culture, as indicated by senior management, of managers at the 'operational', (those areas where clinical activity occurs) and the middle management level of the organization.

From the first phase of interviews, the professional and occupational background of managers was identified as a key factor in the acceptance or rejection of the new official culture. In this phase, this variable was analysed further. What emerged at this stage was the identification of sub-cultural and contra-cultural activity within the organization. The key issue then became the relationship between these cultures and the official culture, as espoused by the senior management in the Units and embodied in the official arrangements. This was explored through the further refinement of the conceptual framework and the third and final phase of interviewing.

The third phase of interviews was carried out in order to explore the relationship between identified official and unofficial cultures within the organization. By this time general management structures had been in place and all managers in position for over twelve months. Hence, indications of the impact of this cultural interplay within the Unit and on managerial effectiveness could be observed. At this stage, respondents did not need to be managers. For example, the researcher believed that individuals who were part of the old administrative managerial process but were not part of the new official managerial structure could inform the investigation significantly. Hence, because of this judgement by the researcher, a major attempt was made to interview individuals who had played a prominent role in the administration of the hospital prior to general management. The result of this was that interviews occurred with senior members of the medical profession, and key actors in events which were regarded as major indicators of cultural assumptions which operated prior to general management.

In this phase much opportunistic sampling occurred. Honigmann remarked that:

> ...opportunistic sampling can also be called 'chunk sampling', meaning that the researcher resourcefully seizes any handy chunk of the universe that promises to reward him with relevant information (Honigmann 1982:81).

In the case studies provided, key incidents in the lifetime of general management are referred to by the researcher. The information concerning these incidents has been achieved partly through judgement sampling - using the organization chart to locate the person to provide the managerial perspective and partly by opportunistic sampling - making contact with a person whose name has been mentioned in relation to the incident.

When key incidents which appeared to potentially offer an indication of cultural assumptions were identified, or the name of a key actor not included in the managerial hierarchy provided, for example a senior consultant, the researcher attempted to investigate the issues underlying the incident by attaining the perspectives of the different actors involved.

An example of this has been the removal of a clinical service unit from one site within one hospital to another hospital. Having obtained the management view on the reasons for the move, it was necessary to get access to the members of the medical and nursing professions who were affected by the transfer of the Unit, in order to analyse the possible conflict of meanings and values which surrounded the incident. This was done by the researcher obtaining the names of key individuals involved in the incident, from key informants and offering them (by letter) an opportunity to discuss the introduction of general management. This broad opportunity has often been accepted and through this, the more specific issue or incident has been

approached by the researcher. Significantly, an interview with a former Chairman of the NHS Management Board occurred through a social contact and provides a perfect example of opportunistic sampling.

Indeed, due to the organization of the medical profession within the NHS, opportunistic sampling has been necessary in order to reach a group of individuals who are key actors within the NHS managerial process but who as individuals occupy no formal managerial position.

Other examples of opportunistic sampling which have yielded valuable information include the time when the researcher was interviewing a senior medical consultant. The interview was interrupted by a Registrar coming into the room. Rather than sending the Registrar away, the senior consultant asked him to 'join our conversation'. This provided a medical perspective informed by a different hierarchical status, training and generation to that obtained from the senior consultant. Such a contact provided a good indication of the difference in medical opinion about the managerial process and also information containing the awareness which junior members of the medical profession have about the managerial process in the NHS.

By the end of the data collection process, twelve months had passed, 75 interviews had been conducted and five Units of management had been used as cases. However, in this research report only three cases have been detailed. The reason for this is simply that writing five case studies did not allow the researcher to detail the cases

sufficiently. Therefore, it was decided to concentrate on the three Units of management which can be classed as dealing with the acute side of hospital care. The data obtained from other Units is not being wasted and some of it has been used in chapter five. Indeed, because these Units inform us about the Balkanistic and Anomic types of organizational culture described in chapter four and cover quite distinct sectors of the health care - the community and mental health - it only reinforces the researcher's view that these Units should be dealt with in a separate paper.

Conducting Unstructured Interviews

One of the main arguments running through this discussion is that, despite the rejection of participant observation as the prime research method, there is much about this investigation which makes the researcher's description of it as a qualitative piece of research a reasonable one. This is so because of the care taken, in data collection and analysis, to adhere to the particular emphases which characterise qualitative research and studies of culture in the organization.

Useful summaries of the concerns within qualitative investigations have been provided by Van Maanen (1983) and Bryman (1989). Bryman listed seven 'distinguishing features' of qualitative research. First, an emphasis on interpretation and understanding social reality in the light of the respondents interpretations and views, not in

terms of those of an outsider to the organization.

Second, an attention to context - getting to know the organization in which observation is occurring. Indeed, the influence of context on what people do and say is important and differences between what people do and say in different contexts must be accommodated by the researcher in the collection and analysis of data.

Third, being concerned with process - looking at events over time and considering what went before and after an incident or series of incidents. Stated simply, a concern with sequence and dynamics.

Fourth, a rather unstructured approach, enabling issues, hypotheses to emerge as observation takes place and as contact with respondents develops, rather than being pre-determined on entering the field.

Fifth, multiple methods which allow an issue to be considered via other sources and methods.

Sixth, social reality is a product of human process and not something which is not fashioned in any way by the individual. As a result, a necessary to take into the field is that there are always multiple perspectives - differing 'world views' operating for individuals and groups.

Seven, a close proximity of the researcher to the phenomena being

studied. That is a committment to studying human processes in the 'natural context' as opposed to artificial conditions created by the researcher. This is known as 'naturalism'. It is were, researchers aim to observe the social processes as they occur naturally with minimal control and intervention. Through naturalism the emphasis is on understanding the social phenomena and interpreting it within the context it is occurring. Atkinson noted this as a holistic approach which stresses the:

> ... need to see social life within the general context of a culture, sub-culture or organization as a whole. The actions of individuals are motivated by events within the larger whole and thus cannot be understood apart from it (Atkinson 1979:48).

Particular research design and methods have been used because they accommodate the commitments which are essential to qualitative and culture oriented studies. In this investigation, the unstructured interview has offered a way of uncovering feelings, meanings, assumptions, values and beliefs held by individuals as individuals and group members. The issue sheet (appendix E) indicates that a loose discussion structure has been used by the researcher in order give respondents the freedom to develop and elicit their thoughts and feelings and raise issues of importance to them.

Typically, questions to respondents have been posed in the following manner.

* Tell me about the history of this hospital?
* Can you recall any incidents or periods of time in the hospital which have influenced the current policies and direction of the organization?
* Have there been any incidents within the organization which have provoked unprecedented conflict or co-operation amongst people in the organization?
* Can you comment on the traditional role which administration has had within the Service?
* What were your feelings as a nurse when General management was introduced?
* What is your traditional perception of management in the NHS?

An example of how this style of question can elicit responses which indicate feelings, beliefs and taken or granted assumptions is provided by the following extract from a interview with a senior medical consultant.

In response to the researcher's question of "In what ways may Korner information systems affect what you do, to whom you do it and when you do it"?, the Consultant's response was:

> I can see it opening up the organizational issue

of the efficient usage of operating time because you should get figures which genuinely illustrate that this kind of session is not being used fully. That seems right and proper. But the figures I've seen, I do not think can be used to influence what a chap does. That can only be done by standing up and giving managers the power to direct medical staff. I actually wonder what information it is collecting which has not actually been available before.

Researcher: MMMM MMMM

Consultant: I think the medic these days is very amenable and sensible and only too willing to talk of improving the service, until it gets to the point where it is said "you should not do this, or keep patients in for less time" and its there where his whole instinct and training will be challenged. I doubt whether it ever will, can or should be challenged. I think there's a lot to be said for that kind of clinical freedom. However, I do believe we have to be willing to release what we see as our personal facilities. Somebody has to be prepared to say that my operating list can be reduced by others. My colleague is up in arms.

He's hoping to retire and eighteen months ago his waiting list was long. He thought it unfair to pass on a long waiting list to somebody new. So he got extra beds and his waiting list has come down. The returns got him to two weeks waiting list (when actually it was really twenty weeks). So administrators, managers and medical colleagues picked up on this and said "if you've only got that, you do not really need that operating list". He was livid as he said "here I am working my fingers to the bone, getting my waiting lists down and all they want to do is take away my operating time". His immediate reaction was of having something which was his right taken away and he could not accept (if the figures were right) the argument that if the facility was not necessary (two weeks waiting lists for non urgent surgery are perfectly legitimate) then it could be used for something else. He was saying "what do I do, what do I do". I'd probably react the same way and feel I was being castrated or something but that's the side of medical practice that can and should change. People should be prepared to alter their working week, several times a year if necessary, in order to accommodate changing patterns of workload.

This extract indicates that from a broad question a whole range of issues are covered as the respondent talks freely. For example information is gleaned about such things as the:

* Power relationship between managers and clinicians, what managers currently can and cannot do in terms of a doctors work practices;
* What is right and wrong as perceived by doctors, perceptions of what is legitimate and not legitimate with reference to the notion of clinical freedom and medical training;
* A real-life response of an individual to a challenge to what has been taken for granted.
* Scepticism towards an official system (Korner).

The posing of questions in this way has helped the researcher to open up the social worlds of individuals and groups. This has been essential in trying to gather the type of data necessary for a study concerned with culture. However it is only half of the battle. The other half of the battle has been developing a rapport with an informant or respondent so that an insider/ outsider relationship is developed. Schein has argued that:

> ..only a joint effort between an insider and outsider can decipher the essential [cultural] assumptions and their patterns of interrelationships (Schein 1985:112)

This 'joint effort' avoids what Schein calls the 'subjectivity bias' and 'internal invisibility'. These are two major issues facing any researcher concerned with culture in organizations. A joint effort helps to tackle both problems. It does so because cultural assumptions are deep-rooted and have probably dropped out of the awareness of respondents. Therefore, it needs an outsider's perspective to probe and skillfully draw incidents and situations to the attention of the insider which perhaps indicate the meanings which are operating within the organization. Once this is done, it needs the insider to ensure that the outsider is not imposing his or her own categories of meaning onto observed events and making biased interpretations.

The researcher's attempts to manage these issues has involved using the joint effort technique and a particular philosophy towards carrying out the research. The latter reflects an approach articulated more recently by Turner (1988) and Mckinnon (1988). Quite simply the philosophy is that in a study given to culture and qualitative analysis, bias needs to be managed as opposed to eradicated. As McKinnon has argued:

> The nature of observer bias is such that it is a problem of management rather than elimination. Political and philosophical views, background experiences, etc are inextricable parts of an individuals's psychological make-up. The

> individual cannot be separated from them or "de-biased" prior to his assuming role of observer. Consequently, the approach to overcoming observer bias must proceed on an acceptance of its existence, and be directed towards what actions the researcher can take to protect the collection and analysis of data from the contaminating effect of their own bias (McKinnon 1988:38).

In writing about his concern with the relationship between the observer and that which is observed, Turner offered a similar philosophy and a method for achieving the balance between subjectivity and objectivity. He suggested:

> it is helpful to think of the researcher as bringing a distinctive 'perspective' to an enquiry, a perspective which does not deny the possibility of achieving a degree of objectivity in investigation, but one which equally does not deny the presence and significance of the values, the passions, and the subjectivity of the observer. There is no real alternative to this, for research is a human activity, carried out by human beings, who cannot relinquish their values and passions...In admitting the presence and the importance of the observer's 'perspective', we

> acknowledge that the first person stand-point is not erroneous..the recognition of subjectivity as one element of our perspective allows us to accept that we view the world personally and self-consciously, with an awareness of just who is doing the research, or carrying out whatever other activity. But objectivity, too, has to be an element of our perspective if we are to avoid both solipsism and fantasy. Objectivity is not a mechanical recording of the world 'in the way that it is', but it is an achievement, an overcoming of biases and prejudices (Turner 1988:115).

Later in the article he continues:

> In the process of trying to analyse organizational data, the process of actively discovering relevant classes of things, persons and events, and significant relationships between them, the analyst will want to search for appropriate 'conceptual levers': that is to say, for appropriate thinking devices which both distance the analyst from the data and provide a new perspective on it (Turner 1988:117).

To achieve the balance between subjectivity and objectivity, the researcher has spent a great deal of time and effort in planning and conducting the data collection and analysis.

Furthermore, the researcher has taken Schatzman and Strauss's idea of looking for conceptual leverage to help achieve the balance. For this researcher, the methodological perspective, the concept of culture and the relationships between structure and culture and the official/unofficial dimensions of the organization have been the conceptual devices used. The discussion of data management and analysis later in this chapter indicates these have been devices which have moved the investigation along in a cycle of continuous observation-analysis and theorizing.

To demonstrate how the researcher has attempted to achieve the insider/outsider relationship and meet the commitments of qualitative investigation, it is useful to focus on the conduct and tactics used by the researcher in the interview.

The beginning of every interview is a vital time. It is so because the issues of confidentiality and reactivity need to be addressed by the researcher. In this investigation, every interview began with an assurance of confidentiality by the researcher concerning what is said in the interview and by whom. The exact wording used at the start of every interview has been:

> all information given is to be treated with the strictest confidence and its source will not be divulged to anybody.

Therefore, it has been guaranteed that quotations in any report would not be pre-ceded by the respondent's name, though the hierarchical status of the respondent maybe used to contextualise a remark.

These assurances have been made for both ethical and methodological reasons. In the case of the latter, it is necessary to distinguish what is said by a respondent in private from what is said publicly. Public statements are valuable and have been used as evidence in this investigation (Appendix F). However, in using them the public nature needs to be acknowledged by the researcher.

Confidentiality assurances are also important because they can influence the conversation between the respondent and researcher. With confidentiality assured, the interviewer became the respondent's only audience and as a result it is hoped the respondent has been more open to expressing deep views and assumptions than perhaps would be the case if the conversation was not private.

The issue of reactivity has had to be dealt with very carefully by the researcher. Reactivity (Webb et al 1966) can affect the validity of data and must be addressed from the outset of the interview. Reactivity refers to the obtrusiveness of measures which may affect

how a person responds. In the interview situation, the personal manner of the researcher, the dress of the researcher, the use of recording equipment and a lack of knowledge on the part of the respondent about the motives and background of the researcher are all considerations which may cause reactivity on the part of the respondent. Such reactivity is a threat to achieving a relaxed and natural conversation in which the respondent 'opens up'.

Therefore, in anticipation of reactivity and attempt to off-set it, the researcher followed up assurances of confidentiality with information about it being a piece of research financed not by the Health Authority but by the Council and geared not to evaluating or judging individual effectiveness but to understanding certain issues. In addition, all respondents were informed that any results would not be reported to the Health Authority directly. That is, it was anticipated that publications would result from the investigation but the availability of these would be open and not restricted to the Health Authority.

Hence, prior to the start of the interview much effort was made to foster trust and openness from the respondent. This 'impression management' and attention to reactivity have been essential in preparing the ground for the interview. As Mckinnon claimed:

> ..the researcher's first concern on entering the research site should not be data collection;

> rather it should be preparing the ground for data collection. This involves ensuring, firstly, that the participants understand clearly why the researcher is there and, secondly, creating the conditions under which they will be allowed access to the social relationships of the setting (Mckinnon 1988:44).

It was felt that by doing this, the respondent would respond by intimations that were personal and deep set and whether true or untrue, would provide insights into the social world in which the respondent is an actor.

The degree of success which the researcher has had in building up trust is shown by the researcher often coming away from an interview having heard a person's feelings about the organization and life as an employee within it. Indeed, the researcher has been amazed by the willingness of some respondents to open up to an 'outsider.' As one senior manager remarked:

> it is nice to get things off my chest to someone.

Such a comment is significant in terms of indicating that the data gathered is very personal and truthful. It is also useful as an indication of how the respondent viewed the interviewer and if any adverse 'reactivity' towards the researcher had occurred.

The researcher always tried to gauge how a respondent felt about the interview and if the respondent provided no indication of their view of the interview at the end of the interview, the researcher's final comment was:

> I hope you have enjoyed doing the interview as much as I did.

This seemingly innocent friendly parting comment often managed to prompt a response which has yielded vital information concerning the depth of information given and the respondents perception of the interviewer.

Once the interview has started a key issue is that of the nature of the questions asked. Despite the attempts to pose neutral questions, the style of question if not posed carefully, can give information to the respondent which may inform and bias the reply. For example, a major theme in interviews has been the reaction of clinical staff to organizational change. To pose a question to a doctor in such a direct way as 'why do doctors subvert attempts at change' indicates that the interviewer assumes that all reaction to change on the part of the doctors is negative. It is a generalization, indicating a bias and lack of objectivity on the part of the researcher.

The question can be posed another way. For example, 'what are your feelings as a doctor about the changes which are being introduced?'.

This is a less direct question which encourages the respondent to reflect and think deeply about their feelings and attitudes. From such a broad question, it has been possible to give the respondent a lot of freedom to answer. Such freedom has invariably led to the respondent raising other issues and expressing their opinions not only as an individual but often and very importantly as a group member. In getting the respondent to do this the researcher has opened up the social reality of the respondent. It is a difficult thing to do, but one which has to be done in a study committed to interpretation and context. The earlier extract from the interview with the consultant indicates this.

The management of bias is central to the reliability and validity of the findings. Pilot interviews and formal interview training has been useful in developing a confidence to conduct the interview and develop a style which one is happy with. The timing of interventions with the respondent, knowing when and how to follow up on issues and remarks made, not to 'put words into a respondent's mouth' are all skills which the researcher needs to nurture.

The attention which the researcher must pay to objectivity and to one's research activities bears out the following argument of Burgess:

> field research is a learning situation in which researchers have to understand their own actions and activities as well as those of the people they

are studying (Burgess 1982b:1)

Naturalism is another characteristic of qualitative research. As indicated earlier, it is the study of the social life in its natural setting rather than artificial ones created only for the purposes of research. In the interest of naturalism, interviews have been carried out in surroundings and at times which are familiar and part of the respondents 'normal' working day. This has meant that interviews have taken place in hospitals, laboratories, managers offices, the wards and during hours such as the nightshift and at weekends. For the same reasons, respondents were not specifically requested to block out a period of time solely for the interview. (In truth many interviews occurred undisturbed). However, especially with the nurses, doctors and physiotherapists, interviews were often interrupted by telephone calls or other people entering the room. This was welcomed by the researcher because from such occurrences useful observations were made concerning the types of interaction which the respondent typically has as part of their daily life. Such experiences (although not great in number) were fertile ground in terms of non direct observation and brought the researcher that much closer to the phenomena being studied.

It is also worth mentioning how important the researcher's working experience in the NHS has proven to be in fostering the insider/outsider relationship and the natural conversation. For example, because the researcher had a grasp of the language used by

respondents, trust and naturalism was fostered. Also sensitive issues could be brought up in a subtle manner. For example language observed to be widely understood within the context such as "on board", "housekeeping", "the shop floor", "the carers" and "at the end of the day" all helped the researcher to delve deeply into the worlds of respondents and how they perceived their roles in relation to others. Such expressions allowed the researcher to adopt the insider approach whilst operating with a strangers perspective. Such a technique is important to this type of investigation.

Another useful tactic to de-sensitize issues, which were in fact sensitive, was to use the hypothetical question. For example, the researcher often asked a member of the medical profession "How would you feel if your contractual status with the authority changed?" or to a manager "Name one significant change which could make your job easier".

Also the contextualisation of remarks is important from the methodological standpoint. In dealing with any response the social location of the respondent within the organization has been taken account of. As is indicated by the selection of respondents, those chosen had real experience of the implementation of general management. This first hand experience is important because it equates all respondents to a degree and allows the researcher to interpret the data in way that is different, than if it was second hand. Also, there is a clear distinction between the interviewing

phases. For example senior management members where interviewed in the first phase and middle managers followed in the second and third phases. This difference in social position of respondents has to be acknowledged as clearly informing the respondent's understanding, interpretations, motives and interests.

From the above discussion, it is evident that the researcher has tried very hard to counter threats to the validity and reliability of data. Mckinnon defined validity and reliability in the following way.

> Defined broadly, validity is concerned with the question of whether the researcher is studying the phenomena he or she purports to be studying. Validity is impaired if the design and or conduct of the research are such that the researcher is unintentionally studying either more than or less than the claimed phenomena.....reliability is concerned with the question of whether the researcher is obtaining data on which he or she can rely (McKinnon 1988:36).

From the above discussion, it is evident that some of the strategies and tactics identified by McKinnon for counteracting threats to validity and reliability of data have been used by the researcher. Although participant observation has not been used, the number of interviews undertaken by the researcher, the length of interviews and

the use of key informants have done much to counteract threats to the validity and reliability of data which are caused either by insufficient time spent in the field or poor access.

In concluding, the need to adhere to the emphases which characterise qualitative research makes the unstructured interview a very demanding style of interview. Prompts and probes have to be well timed and as objective as possible. The temptation to try to control and structure the discussion to cover what the researcher thinks is important and not what is important to the respondent is always there. At the same time, to not be sensitive to issues which (if pursued) can delve deeply into the social world of the respondent is to miss opportunities which are invaluable to qualitative research. To contextualise comments with what has been said earlier in the discussion, or has been observed elsewhere is another skill that the researcher needs to develop quickly in order to avoid losing (or not picking up on) key themes, issues, meanings, cultural assumptions and multiple perspectives which are operating for an individual or a group of individuals.

To cope with this demanding form of research the researcher has found it vital to prepare well for each interview. Key issues have to be understood, alternative perspectives acknowledged, tactics for asking questions and steering the discussion assessed and appropriate terminology and language planned. A number of things have helped the planning and preparation for an interview. Organizational charts have

provided the researcher with a 'map' of the organization aiding understanding of the 'official' relationships. The Griffiths Report has been analysed in detail and key issues drawn out. Historical issues associated with the hospital have been incorporated into the issues raised. Most importantly, previous interviews have been listened to and analysed whilst in the field. This has been vital not only because of a desire to remember what has been said before but because it has been important to develop the conceptual framework whilst in the field. This has been done by the researcher because when conducting an interview, the researcher has performed the interview armed with structural and cultural knowledge and looking to increased that knowledge. The more it developed the sharper the focus for discussion became. So much so, that by the third phase of interviews there were a much limited range of issues covered than during the two preceding phases.

Therefore, to bear out Palmer's earlier remark the researcher never did an interview 'cold'. This preparation served two functions for the researcher. First, it promoted continuity in the analysis and understanding by the researcher. Second, it helped to foster trust and an enthusiastic response by the respondent. An observation made by the researcher is, that in most cases, the respondent 'opened up' once he/she realised that the researcher was pursuing issues which were pertinent to them (the fact was that the researcher was giving the respondent freedom to pursue the issues they wanted to pursue!). An indication of success on this second issue is often provided by the

length of the interview. Many times the interview went beyond the requested one hour. Indeed, one interview ended after three hours and only when the respondent remembered that 'Sainsbury's supermarket was only open till 7.00 pm'.

Perhaps the best demonstration of success in this area was the instance when the researcher had an appointment to interview a Unit General Manager. On arrival, the researcher was somewhat deflated by the comment:

> I forgot about this, I can only give you twenty minutes !

After twenty minutes, the researcher reminded the General Manager that time was up. In reply, the General Manager remarked:

> Oh it is only paper work I have to do, we can carry on

Eventually the interview lasted 75 minutes!

As well as the unstructured interview other methods of data collection have been used. These other sources of data are essential to a study concerned with culture (Schein 1985, Turner 1988). When inside the Units of management, either on the way to or from an interview, the researcher has carried a small notebook to document aspects of the

setting in which human activity is taking place. Particularly important to supplementing evidence obtained via the interview has been observations about the style and decor of the hospital. These include observations about its age, pattern of interaction, dress variations amongst individuals in the hospital, the style of buildings, the messages on notice boards and the cartoons on office walls.

In addition the researcher's feelings and reactions about how the interview has been conducted have been written up during journeys home. This method of documenting a whole range of feelings and observations allows one to get at the cultural aspects of the organization and go some way to being involved in the organization. Documents indicating the organization structure, historical development of the hospital and organizational mission have all been used as sources of cultural data.

The cases presented in chapters six, seven and eight refer to some of the specific cultural artifacts noted by the researcher. As well as providing data, these methods are significant because they allow the researcher to approach the analysis of an issue or cultural assumption from different angles. This triangulation between methods is vital for building up the reliability of the theory and conclusions generated in the investigation. So much so that within this study many pieces of information gathered in the interview have been checked with reference to information obtained at the lunch table, via

documents or through general observation.

One method which was tried and rejected was that of a questionnaire survey. A questionnaire (appendix H) was developed by the researcher based on the cultural dimensions developed by Schein (1985) (explained in Chapter five). The questionnaire was issued in the two Units of Management which have not been accounted for in this report. The questionnaire was developed to allow the researcher to reach a wider number of respondents and aid the triangulation process. However, it was rejected because the researcher felt that the data generated was not in keeping with the qualitative emphasis discussed earlier. Furthermore, to use this information on its own as evidence of culture is dangerous. As Schein has argued in a discussion of the use of questionnaires in a culture study:

> At best what one would get with such an instrument is some of the espoused values of group members. If these were treated as an artifact to be deciphered along with other artifacts, one is probably on safe ground; but if one took the data to be a measure of the culture in the sense of undertaking taken-for-granted assumptions one would be skating on very thin ice indeed, and worst of all, would not know how thin the ice actually was (Schein 1985:136).

The common factor linking the three phases of interviewing and research methods has been the analysis that the researcher has been constantly doing whilst in the field. It is to this that the discussion is now directed.

Data Management and Analysis

Literature concerned with the management and analysis of qualitative data (Miles 1979, Halfpenny 1979, Bryman 1989) has raised a number of concerns. Three concerns in particular are covered in an excellent article by Miles (1979) entitled 'Qualitative data as an attractive nuisance: The problem of analysis'. He argues that there is a danger with qualitative data because first, the collection, writing up and coding of this data is a highly labour-intensive process, especially so for the single researcher.

Second, it is an attractive nuisance because there are few guidelines about the data analysis phase to help the researcher. Recalling Sieber's (1976) review of major texts about field research, Miles states that Sieber found proportionately minimal attention to the data analysis process as compared with preparation and collection processes. Indeed, Miles recalls that Sieber's conclusions were that:

> there was little suggestion in the texts as to how analysis modes might vary according to varying purposes of fieldwork...few guidelines were

> suggested as to when particular analytical approaches might be employed or why...texts tended to confuse and blur concepts of reliability, validity, generalizability and analysis (Miles 1979:125).

Third, there appears to be a tension between the need for the researcher to have a focus and the qualitative commitment to letting issues and themes evolve in the field as encouraged in the grounded theory approach of Glaser and Strauss (1967).

It is useful to discuss the management and analysis of qualitative data because some interesting insights have emerged as the researcher has carried out the investigation.

In gathering data, the use of an audio tape to record interviews is an approach that the researcher believes is worth persevering with. The recording of interviews has suited the objectives of this investigation. The interview transcripts have afforded the storage of rich qualitative data, especially the nuances of language and the stories particular to the context under investigation. Such concerns are vital to a study given to culture. The use of tapes has facilitated a more natural conversation and guarded against the reactivity which may result from note taking by the researcher. It has also provided a security for the researcher against a lack of sensitivity to issues during the interview. On playback of the tape,

any undue researcher bias at the data collection can be addressed as can the interviewing style and technique that is being used. Overall, the tape has provided feedback not only on the interview but on the conduct of the interviewer. It has been a tool used by the researcher to review the process and conduct of the data collection process. As the reliability and validity of qualitative data rests largely on how data has been collected, it has proven to be a particularly valuable tool.

In total, the benefits of using a tape have outweighed the disadvantages. However, the tape has borne out the 'attractive nuisance' description by virtue of the volume of data generated. For this researcher, the volume of data generated could have proven to be disastrous because of the workload required to handle it. For example, in this investigation, a one and a half hour interview has typically amounted to the following work-load for the researcher. Transcription of the interview (approximately six-eight hours work), review of transcript and consideration for the next interview (two to three hours), coding of the data contained within the interview (one day, at least). Typically, one interview keeps a researcher busy for no less than two working days. With seventy-five interviews conducted, this demonstrates how highly labour-intensive qualitative data collection and the management of that data can be.

The disaster has been avoided because the researcher has taken a loose framework of issues and hypotheses to the field. Should one have

strictly followed the grounded theory approach, it is likely that the workload would have been significantly greater and some dire consequences could have resulted.

The loose framework of issues which the researcher has entered the field with has offered a very broad control and structure to the data collection and data management processes. For example, the early conceptual framework was based on the official/unofficial distinction discussed in chapter three. From this, further definition and focus has occurred as the variables of structure and culture began to be considered more and the organization culture types began to emerge. Hence, the management of the data has occurred alongside the generation of hypotheses and conceptual frameworks. In this respect, the approach of this researcher has been more akin to that adopted by Miles (1979) than Glaser and Strauss (1967). The former's approach was outlined in the following manner:

> the need to develop grounded theory usually exists in tension with the need for clarity and focus; research projects that pretend to come to the study with no assumptions usually encounter much difficulty. We believed - and still do - that a rough working frame needs to be in place near the beginning of the fieldwork. Of course it will change. The risk is not that of "imposing" a self-binding framework, but that an

> incoherent, bulky, irrelevant, meaningless set of observations may be produced, which no one can (or even wants to) make sense of. Thus, we chose the strategy of developing explicit preliminary frameworks quite early; even so, we revised them repeatedly over the life of the project (Miles 1979:119).

The management of the data as it has been collected has been a demanding task. However, it has been done within a framework of concepts and foci. For example, the data has been initially segmented according to the Unit of management in which it was collected and the official and unofficial conceptualisation used throughout this investigation. From this basis, the compartmentalisation of data has developed as the structure and culture relationship became increasingly prominent. By the end of the first phase, the four compartments of official culture, official structure, unofficial culture and unofficial structure began to emerge as clear 'pigeon holes' by which data could be stored. As such, the segmentation developed from being substantive to being theoretical. Each Unit of management was a separate data storage file and within this there was a segmentation of information under the headings of official culture, official structure, unofficial structure and unofficial culture.

As the second phase of interviews developed, identified themes were elaborated and taken into the field. Consequently, more issues

emerged, particular stories and incidents were related which served to either further establish or weaken the conceptual coherence between categories. For example, the types of organizational culture began to emerge out of the testing of issues developed from the conceptualisation of official/unofficial interplay. Hence, more 'pigeon holes' were developed in which data was stored. In total each type of organizational culture was a 'pigeon hole', in addition to those developed initially. Cross referencing information became more of a concern, especially as the organizational culture pigeon holes contained information from more than one Unit. By the third phase of data collection, the emphasis on managing the data had shifted to one were the data collected was stored in relation to the generalizations and theories being developed. For example, information about the relationship of two distinct cultures in the same organization, such as that described in the 'dualism' type of culture.

Therefore, a framework for managing the information has been absolutely vital. A safeguard against this approach becoming an imposition of a framework has been flexibility on the part of the researcher to alter and re-define the pigeon holes in accordance with theories which have been generated and issues which have emerged. Indeed, one suspects that should re-definition not be necessary, then it is open to question whether a grounded approach to theorizing is being adopted. Although the strictly grounded theory approach has not been adopted in this investigation, sufficient data analysis, whilst in the field, has occurred for the researcher to argue that the

commitment and requirement of qualitative research has been adhered to.

Indeed, an issue which the researcher feels has really come to the fore in the process of investigation is the need for the researcher to be constantly analysing. Not only the taped interviews but other field notes made from the unstructured observation, secondary sources or official documents of the organization being studied. So much so, that the 'model' of conducting research which the researcher held at the outset of the investigation has proven to be artificial. The original model was developed on the basis of the three distinct stages of research outlined earlier - preparation, data collection, data analysis. In practice, the distinctions between these phases have been somewhat blurred, especially between the data collection and data analysis phases. That this should prove to be the case is welcome because the ecological validity of data and contextual commitments render this as essential. As Turner suggested in his article 'Connoisseurship in the study of organizational culture', the process of observation-analysis-theorizing overlap in a cycle which continues until the researcher decides to end it. Similarly, Burgess argued that:

> Traditionally, social science research has been sub-divided into stages'. However these stages occur simultaneously and are complementary in their field research (Burgess 1982c:235).

In support of this statement he cited the study of Becker et al entitled "Boys in White" and noted that in this study the authors commented that:

> in this research analysis was not a separate stage of the process which began after we had finished gathering our data. Rather ..... data-gathering and analysis went on simultaneously (Becker et al 1961, reported in Burgess 1982c:1).

In concluding, chapters six, seven and eight are a snap-shot provided by the researcher's lens, of perspectives, meanings and cultural assumptions operating for individuals and groups within the social setting being studied. The pictures presented are an outcome of data collection methods, designed to focus on understanding the perspectives, motives and cultures and simultaneous data analysis undertaken using conceptual devices to understand these phenomena in terms of the broader social situation within the organization. The conceptual framework which has steered this investigation has developed as the phases of data collection have occurred. This has in turn ensured that the researcher has worked with concepts which the respondents themselves have used to explain their social situations. In this respect, the data presented in this investigation adds up to a narrative constructed by a complex process of interpretation based on the researcher's knowledge of a particular context and the multiple perspectives within the context. The value of this narrative is that

it is contained within a model which has been constructed as events and issues have been analysed and explained. In this respect, the model offers a scheme to explain similar events and issues in other settings.

CHAPTER THREE

ORGANIZATION, MANAGEMENT AND ORGANIZATIONAL CHANGE - A CULTURAL AND MICROPOLITICAL PERSPECTIVE

All social scientists bring particular methodological assumptions to the subject of investigation (Burrell and Morgan, 1979; Van de Ven and Astley, 1983). The core methodological assumption of this investigation is that social (human) activity is an outcome of the interplay between humans' mental functioning and environmental circumstances. Individuals both contribute to and extract from the environment in which they exist. In attempting to satisfy their material and meaning needs, individuals, acting both alone and as group members, exercise a degree of choice in defining their own situations and creating their own meanings.

This investigation is set within a social action framework in which the organization is seen as an arena of negotiated order (Silverman, 1970). That is, individuals are regarded as competing and co-operating with each other in order to satisfy their diverse and often opposed interests. This assumption underpins the conceptual framework of the investigation. This framework is explained in chapter four. The present chapter concentrates on the theoretical background to the framework.

The main issues addressed by this investigation are managerial

effectiveness and organizational change and the focus of study is the National Health Service (NHS). The central argument of this chapter is, that the conceptualisation, empirical investigation and understanding of these issues is greatly enhanced by the use of the cultural and micropolitical perspectives of organizational sociology. These perspectives are complementary as they both afford the acknowledgement of the role of human subjectivity within organizational functioning. Through these, there is a recognition that organizations are formed of individuals and groups with competing aims and interests and that individuals are creative and interpretive beings who exercise a degree of choice in the ways they think and act.

This methodological stance and the use of these perspectives, indicates the researcher's rejection of the 'objective' conception of the individual contained within the 'mechanistic' and 'systems' strands of organization theory. These "orthodox" bodies of work assumed a status of ontological autonomy of organizations. That is, within the organization, individuals have been viewed as objects to be manipulated towards the organization's specific goals. Notions of rationality, neutrality and goal orientation have been emphasized and the image fostered has been one of the organization being a co-operative and rationally devised system with specific goals which are met as individuals are fitted neatly into a pre-given structure.

This view of the individual, found in "orthodox" organization theory,

has had a significant effect on the previous conceptualising of the three major issues being pursued within this investigation. First, there has been an inadequate conceptualisation of organizational functioning generally, due to the lack of recognition given to the presence of human conflict and plurality within the organization. Second, this has fostered an inadequate conceptualisation of the political nature of the management task and the function of management. Third, an artificial view of organizational change has been provided which has not paid enough attention to human process and the 'context' of change.

This orthodoxy and its view of the individual as a relatively passive and manipulable being has come under attack, particularly in the last decade (Salaman, 1979; Watson, 1980). An outcome of these and other criticisms of organization theory (Clegg and Dunkerley, 1980) is that notions of power, control, conflict of interests and exploitation, have been incorporated into organization theory. The significance of this is that these notions recognise the human 'processual' nature of organizations. In doing so, the organizational image of rationality and co-operation is balanced by the recognition of human choice, conflict and politics. Hence, organization theorists have moved towards a fuller conceptualisation of organizational functioning through viewing differently the relationship between the individual and social structure. Theories emphasising micropolitics (Burns 1961, 1977); power (Perrow,1970; Hickson et al,1971); strategic choice (Child,1972); political-economic interplay (Miles,1980; Littler and

Salaman,1984); culture (Pettigrew,1979) have all emerged as a reaction to the inadequacies of the orthodox organization theory.

Increasingly, the views of organization go beyond the rational and goal-based approach. It is increasingly recognised that conflict is a fundamental organizational phenomenon. In doing so this does not mean that the purposive dimension of the organization is disregarded. For example, Watson has conceptualised organizations as:

> ..social and technical arrangements in which a number of people are brought together in a relationship were the actions of some are directed by others towards the achievement of specific tasks (Watson 1987:169).

Similarly and several years earlier, Burrell and Morgan remarked that:

> The organization is viewed as a plurality of power holders who derive their influence from a plurality of sources (Burrell and Morgan 1979:203).

These definitions reflect the growing tendency to give the individual an "active" status within the organization. Contained within these definitions is a recognition of the power and conflict dimensions of organization life and the task element recognises the existence of

'imperative co-ordination'. This notion acknowledges that in organizations there are tasks in common but not goals per se (Weber 1968).

They also raise the conceptual challenge for the researcher in this thesis. This is, accommodating this plurality in a conceptual model concerned with managerial effectiveness. It is towards this issue that the analysis is now steered.

Cultural and Micropolitical Perspectives

The cultural and micropolitical perspectives are part of the increased acknowledgement within organizational theory of subjectivity and individual assertiveness. Through these perspectives, theorizing on management and organizational change is being dramatically altered. This is because these perspectives afford the opportunity to recognise the subjective, qualitative and expressive features of organizational functioning. They help us to meet the challenge of recognising the human element in organizational life and the impact of this on managerial effectiveness.

The idea of groups of individuals being socially integrated through cultural assumptions is not new. It is one basic to the Social Sciences. It is just that its role within organizations is being increasingly recognised. Weber, for example, acknowledged the human composition of the organization and the implications this has for the

workings of the 'bureaucracy' (Albrow 1970). Van Maanen and Barley (1985) noted that Weber spoke of 'consciousness of kind' and 'consciousness of difference'. Mayo (1949) differentiated between the norms and symbols of two groups within one organizational unit and Jacques (1951) in his study of the factory used the term 'culture'. More recently, Harrison (1972) used the notions of values and ideologies within organizations in identifying types of organizational cultures.

Whilst welcoming the recent upsurge of interest in organizational culture, it is the view of the researcher that it needs to be treated with a large degree of caution. This is because 'organizational culture' is becoming an all-embracing term for many diverse and methodologically opposed approaches and theories (Allaire and Firsirotu, 1984; Smircich, 1983c). McNulty and Filby referred to organization culture as:

> being a descriptive umbrella for a highly diverse body of literature....gathered beneath this umbrella are managerially oriented texts that examine culture as an instrument for improving corporate performance, (e.g Ouchi,1981; Peters and Waterman,1982; Deal and Kennedy, 1982); studies that attend to organizations as networks of shared meanings, (e.g Gouldner,1964; Smircich,1983a; Fine,1984); and also research that

> takes a more critical view of culture and symbolism, (e.g Silverman and Jones,1976; Burawoy, 1979), (McNulty and Filby 1988:3).

It is worth briefly considering this diversity because the mapping of the diverse interests and assumptions underlying approaches to studying culture allows the researcher to identify the interests and assumptions of this research in its immediate theoretical context.

Two particularly useful reviews of the approaches to studying culture in the organizational setting are those of Allaire and Firsirotu (1984) and Smircich (1983c). The main message of both reviews is that there is a major difference of interests and methodological assumptions amongst those studying culture. Smircich described the differing approaches in terms of two polar opposites - the 'root metaphor' approach and the 'critical variable' approach. These approaches are regarded as being underpinned by differing interests and opposed methodological assumptions.

It is argued that those theorists who adopt the "root metaphor" approach view the organization as a culture. The key assumptions here are, that organization, the social world and culture do not have any degree of concrete reality which imposes itself upon individuals. Rather culture is ideational, in that it is located in the minds of individuals and is inter-subjectively negotiated. The strong subjective emphasis renders the direct management of culture

impossible. Smircich notes that:

> The social world is not assumed to have an objective, independent existence which imposes itself on human beings...This is distinct from the views....which encourage theorists to see organizations as purposeful instruments and adaptive mechanisms (Smircich 1983c:353)

This latter view represents the "critical variable" approach. With this approach, culture is a subjective variable interrelating with other organizational variables. Organizations are viewed as having a culture. The key assumptions here are that the organization, the social world and culture do have a degree of concrete reality which shapes social activity. Consequently, it is possible for culture to be directly shaped and managed. Those using culture as a critical variable treat it as another contingent factor which has to be managed effectively. Fisher and McNulty (1988), remarked that those of a root metaphor stance view this as a limited, manipulative and modernised conception of culture which facilitates our attempts at changing organizations by domesticating their cultural complexity.

These two diverse emphases were succinctly summed up by Smircich in the following way:

> when culture is a root metaphor, the

> researcher's attention shifts from concerns about what organizations do accomplish and how they may accomplish it more effectively, to how organization is accomplished and what does it mean to be organized ....they leave behind the view that a culture is something an organization has, in favour of the view that culture is something an organization is (Smircich 1983c:353).

The present researcher's interests in this investigation are akin to those pursued by theorists gathered under the variable label. Indeed, the conceptual framework presented in chapter four treats culture as a phenomenon which needs to be influenced by strategic managers, if they are to attain organizational effectiveness.

However, the methodological assumption of this investigation leads the researcher to criticise much existing literature which treats organizational culture as a variable, Peters and Waterman,1982); Deal and Kennedy,1982). The researcher believes that this work has two major faults.

First, culture is treated as a contingent factor in itself, which individuals, labelled as managers, can directly manage and control. This is inadequate because the nature of culture makes this impossible. As Jelinek et al, remarked:

> Culture - another word for social reality - is both product and process, the shaper of human interaction and the outcome of it, continually created and recreated by peoples' ongoing interactions (Jelinek et al, 1983:331).

This definition is an acknowledgement that culture is a phenomenon which indicates both the subjective capabilities of individuals, and the objective constraints which are placed upon them. In much of the literature viewing culture as a variable within the organization, the objective element has been stressed at the expense of the subjective. The result is that culture is treated as something which managers make and control. Consequently, theorizing on the management of organizational culture or the management of culture change has been characterised by a dangerous trend of de-humanising culture into a neat package of objective criteria for managers to manipulate and use as quick-fix solutions to whatever barriers stand in the way of productivity. This approach epitomises the worst aspects of the 'variable' usage and tends to revert back to the "orthodox" approach to organization and management theory with its lack of adequate recognition of individual subjectivity and its view of organizations being pre-given structures into which individuals fit. This treatment of culture as a unitary, manageable phenomenon is dangerous because it misunderstands the nature of culture.

Westley and Jaeger examined the concept of culture and its

relationship to productivity and confirmed that claims of direct management and changing of culture misconstrue the essential nature of culture. They have claimed that:

> Cultures as anthropologists know and as consultants recognise, are not easy to change. This is because cultural formulation and transformation are essentially social processes and difficult, if not impossible, to direct (Westley and Jaeger 1985:10).

A second major criticism of the variable approach has been voiced by Van Maanen and Barley who noted:

> ...the phrase "organizational culture" suggests that organizations bear unitary and unique cultures.....Such a stance, however is difficult to justify empirically. Moreover, culture's utility as an heuristic concept maybe lost when the organizational level of analysis is employed. Work organizations are indeed marked by social practices that can be said to be 'cultural', but these practices may not span the organization as a whole. In this sense, culture is itself organized within work settings..(Van Maanen and Barley, 1985:33).

This criticism is reasonable because organizations are potentially 'cultural milieux' (Louis, 1983). They are so because cultural phenomena can be observed at various locations within the organization (Louis 1985a, 1985b). Hierarchical status, geographical location, social allegiance and occupational status are all 'loci' of culture. Indeed, with varying commitment, individuals may belong to several cultural groups. In this sense, every organization is potentially a cultural arena, comprising of many individuals and groups who are cultural groups.

According to Schein cultures form on the basis of:

> ....a pattern of basic assumptions which a given group has invented, discovered or developed in learning to cope with its problems of external adaptation and internal integration, which have worked well enough to be considered valid, and therefore to be taught to new members as the correct way to perceive think and feel in relation to those problems (Schein 1985:9)

Culture serves to function for these groups through giving order, meaning, identity and stability to their lives. These cultural assumptions act as cognitive and behavioral references and guidelines which provide a necessary sense of order, understanding and a mechanism for coping with existential issues. They give cultures

their distinctive character, and these assumptions are held onto until a time that the function of them is no more.

These two criticisms indicate that though the interests of these variable theorists are valid, managerial effectiveness and organization change cannot be usefully conceptualised without regard to the presence and function of culture in organizations. Managerial effectiveness can only be adequately conceptualised by the accommodation and empirical analysis of this cultural plurality. To do this, one has to identify and analyse assumptions and values that are present and operating for groups throughout the organization. Subsequently, to then assess the nature of the management task and speculate on the likelihood of management effectiveness, it is necessary to distinguish between those cultural assumptions, ideologies and values which function to serve management interests and those which function to oppose management. In doing this, it is evident that treating organizational culture as another organizational variable, which can be manipulated and managed in its entirety is inadequate.

Having offered this argument, this raises the challenge for the researcher within this investigation, of using culture to understand how organizations work in practice and how it impacts upon managerial effectiveness, whilst not denying its essential nature.

This challenge is to be met through the conceptual framework which is

presented in chapter four. At the heart of the framework is an understanding of organizational culture as networks of at least minimally shared meanings that shape and sustain organizational action and interaction (Smircich 1983a). However, it is recognised that such meanings are not unproblematically given and/or reproduced. Rather, in recognising the ideological nature of meanings, it is acknowledged that in the continual negotiation of meaning, it is those actors most able to infuse meaning with forms of power that tend to be most adept at naturalising and legitimising their sectional interests as universally held features of organizational culture (Giddens,1979). In this way, organizational cultures are understood to be instituted and re-produced through asymmetrical relationships of power, where the ability of actors, to influence the course of organizational development through the control of valued material and symbolic resources is, by and large, dependent on their positioning within the social relations of production.

By treating organizational culture in this way, the traps of other variable approaches are avoided. Organizational culture is viewed as a subjective phenomenon, developed and maintained through a political process and done so by individuals with competing ideologies and interests. Consequently, it accommodates this cultural plurality whilst treating organizational culture as something which can be shaped by strategic managers (and other individuals). Understanding organizational culture in this way is much more in keeping with its reality.

To actually analyse and conceptualise about this empirical reality and its impact on managerial effectiveness and organization change, it is necessary to use culture through its associated concepts. As Pettigrew noted:

> While providing a general sense of orientation, culture treated as a unitary concept lacks analytical bite. A more useful approach is to regard culture as the source of a family of concepts and to explore the role that symbol, language, belief and myth play in creating practical effects (Pettigrew 1985:44).

This idea of breaking the concept up into other culture-related concepts is very useful. In this way culture can be used as an all embracing conceptual label, through which aspects of it can be analysed, and the impact of these aspects on managerial effectiveness and organizational change can be investigated, understood and evaluated.

In this investigation three culture related concepts in particular are used to handle empirical evidence. These are ideology, sub-culture and contra-culture. The researcher's interest in ideology is in assessing how ideological behaviour affects organizational functioning. Westley and Jaegar provided a particulary useful discussion of ideology as a sub-system of culture. Their key argument

being, that unlike culture, ideology is directly manageable and controllable by an individual, such as a strategic manager. They argued that:

> ... ideology is reality defining in its most fundamental sense and strategic in the sense that it is tied to the articulation of over-arching and fundamental system purposes and values .... ideology unlike culture is subject to formulation by leaders and often intimately tied to their goals and purposes (Westley and Jaeger 1985:6).

They continued to say that:

> Essentially the building of a culture is the institutionalising of an ideology. The leader's philosophy is the message. Whether or not it is correctly communicated or heard and whether or not, once received, it is elaborated upon, turned into action, repeated and visualized, is a group process somewhat beyond his control...managers can make powerful ideologies, but organizations make cultures (Westley and Jaeger 1985:10).

This argument is useful because it stresses the functional capabilities of ideology. That is, people use it as a mechanism for

creating and developing shared meanings, and encouraging individuals to act in support or defence of their interests and what they value.

Professionalism is a powerful ideological tool in any organization and no more so than in the NHS. In chapter five, the conflicting ideologies are evident when the reactions to the Griffiths Report are discussed.

A useful paper on professional ideologies has been written by Elliot who made the point that:

> Professional ideologies face both inward and outward; in Dibble's terms they are both 'parochial' and 'ecumenic'...both Sorokin and Whitehead stress the parochial aspect, the limited frame of reference through which members of any profession approach their work and, by extension wider issues in society. The ecumenic aspect of a professional ideology, however, is founded on particular interests of the group and on their need to address others with different, maybe competing interests (Elliott 1973:211).

These arguments are useful because they indicate that focusing upon ideology in the organization is a way of understanding conflict beyond the idea of personality clash. Professional ideology, raises

shared learning experience and social situation as vital factors which underlay conflict.

To attempt to examine this conflict and the implications of it for the introduction of organizational change and managerial effectiveness, it is useful to use two further culture-related concepts. These are sub-culture and contra-culture. These concepts are valuable in avoiding the trap of treating organizational culture as a homogeneous management biased organizational phenomenon.

Sub-culture is used here to focus upon the wide diversity of cultural assumptions, values and beliefs in an organization. The concept facilitates a consideration of the cultural differences between groups. It is regarded as a particular set of assumptions informed by values, beliefs and interests, which are collectively integrated and adequately shared by a group of individuals, and which constitute a variant way of thinking to those espoused by other cultural groups in the organization. Sub-culture is not being used to analyse conflict, as in the model of Yinger (1970). Rather, it is being used to identify the shared learning and social situations which make groups different.

The conflict dimension of cultural plurality in organizations is understood and described through the use of the concept of contra-culture. A contra-culture is a set of assumptions informed by values, beliefs and interests, that are adequately shared and

collectively integrated, and which constitute a direct opposition and threat to the assumptions of the official power holders in the organization, for example senior management. More will be said of these two concepts and how they inform the analysis when the conceptual framework is presented in chapter four.

The conceptual framework is an extension of a model developed by Watson (1986) and this is presented in the next section.

Managerial Effectiveness and Organizational Change - A Cultural and Micropolitical View.

Watson developed a model concerned with the 'nature and tasks of management'. The model is a reaction to much orthodox management theory which he regards as being characterised by the 'myths' of unbounded rationality and unchallenged legitimacy of management. Watson incorporates some of the recent empirical observations about management which are helping to break down the myths surrounding the management task. For example, the 'brevity, variety and fragmentation' of the managers role (Mintzberg,1973) and the conflict inherent in the decision-making process (Pettigrew,1973). Consequently, the model is set in a social action framework and it recognises the political nature of the managerial task and the influence of subjectivity within organizations and upon managerial effectiveness.

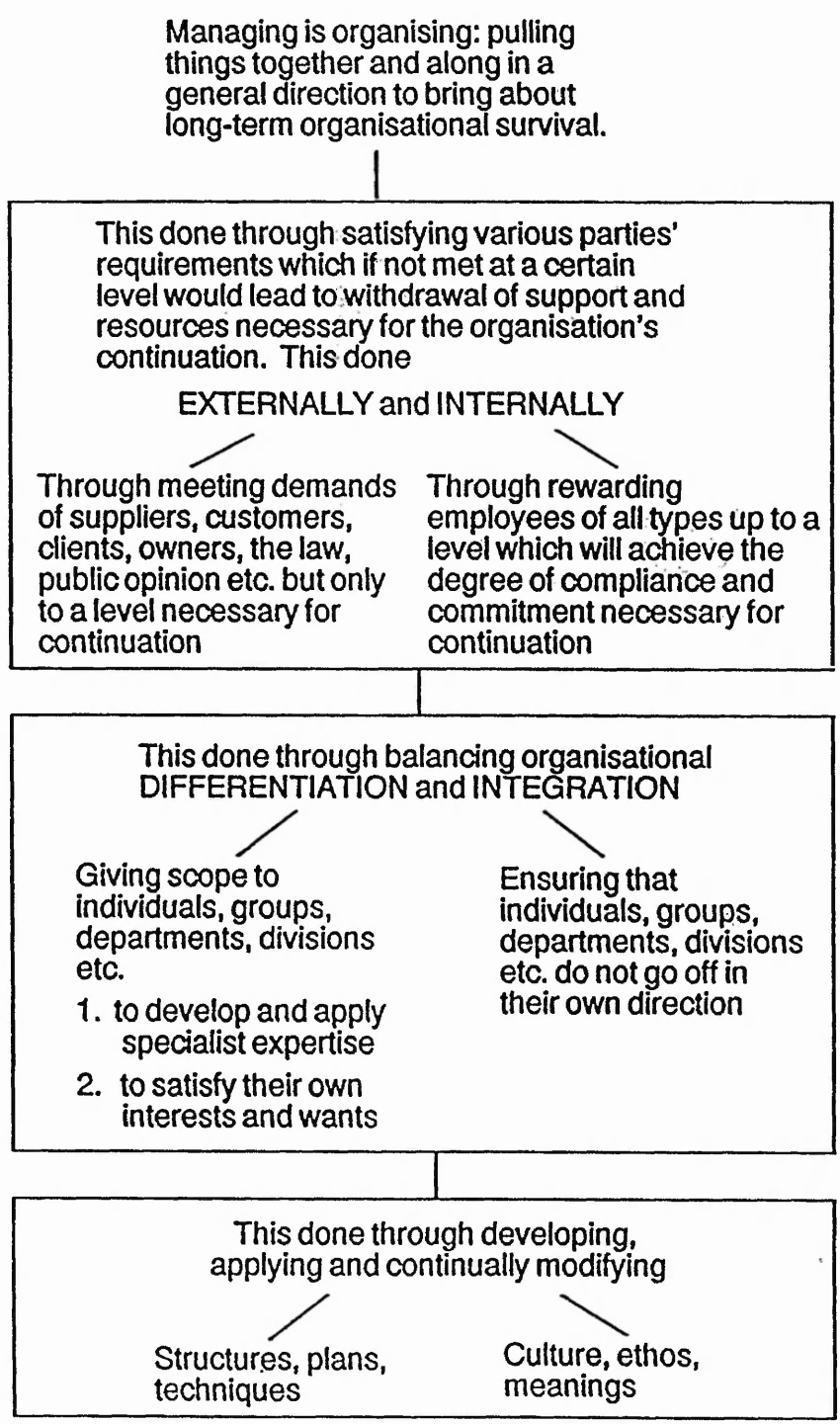
Organizational effectiveness is evaluated by the criteria of organizational survival in the long-term and Watson views that this depends on the effectiveness of managers in the organization. Their task is conceptualised in the following way:

> Managing is organising:pulling things together and along in a general direction to bring about long-term organizational survival (Watson 1986:41).

In order to do this, there are 'social','economic' and 'political' processes central to the management task.
From Fig 3.1 it is clear that the organization is conceptualized in terms of the relationship between structure and culture. The structure contains the 'technical' features such as organizational charts and techniques, whilst culture is the subjective phenomenon, for example, meanings and ethos. Managers are viewed as overt social actors, who need to be constantly involved in the management of the structure and culture. They need to use both structure and culture to shape individuals meanings and direct their behaviour. To achieve other individuals compliance and co-operation, managers have to attempt to manipulate meanings and re-create them in line with their own interests.

The interesting feature of the model is that Watson conceptualises managerial effectiveness in terms of the relationship between

Figure 3.1 The nature and tasks of management



Taken from T J Watson, Management Organization & Employment Strategy (1986)

structure and culture. As such, he is concerned with managing culture but does not fall into the trap of approaches which treat it as just another variable to be directly controlled at will. He does not do so because it is recognised that individuals and groups with diverse and even opposed interests impact greatly upon managerial effectiveness. Therefore, the legitimacy of the managerial position and interests amongst non management individuals and groups is not taken for granted.

The value of the model is two-fold. First, as a result of recognising that organizations contain groups with diverse interests to management, Watson affords us the opportunity to use the cultural and micropolitical perspectives together to understand managerial effectiveness. He does so through the recognition that managers have to play the 'social' actor role in order to establish and maintain legitimacy with other individuals throughout the organization. They do this by attempting to manage meanings through the espousing of an ideology and particular values and beliefs. As Pettigrew claimed:

> The acts and processes associated with politics as the management of meaning represent conceptually the overlap between a concern with the political and cultural analyses of organizations. A central concept linking political and cultural analysis is legitimacy. The management of meaning refers to a process of symbol construction and value use

> designed both to create legitimacy for one's actions, ideas and demands and to delegitimise the demands of one's opponents (Pettigrew 1985:44).

Second, Watson uses culture as an analytical device through which human activity is accommodated. Consequently, this allows the scope to use culture-related concepts. This is what is done by the researcher in the conceptual framework of this investigation. Culture is broken into conceptually distinct components which are empirically observable and analytically manageable. For example, ideology, sub-culture and contra-culture.

The limitation of the Watson model is that it only affords the opportunity to acknowledge the presence of cultural diversity and conflict. It does not provide sufficient conceptual detail to uncover the extent and content of the cultural differences. Consequently, it needs to be developed in order to explore the extent and basis for conflict in the organization. This is what is done by the researcher in chapter four.

In conclusion, the aim of this discussion has been to provide the theoretical background to the conceptual framework being used in the present investigation. In doing so, the researcher has argued that the culture and micropolitical perspectives are now occupying a valuable role in organizational analysis. They are doing so because

they enable theorists to analyse the complexity of the "people element" of organizational life and to understand both why and how individuals do not simply fit into a pre-given structure. Through this, a more dynamic and processual approach is being adopted to organization and management theorizing. Naturally this development is being extended to the the body of theory concerned with organizational change.

This is another major concern to the researcher in this investigation and it is worth discussing it before moving to the presentation of the conceptual framework in chapter four.

A valuable review of the vast body of literature on organizational development and strategic change has been provided by Pettigrew (1985) and must be referred to here as justification for the argument being offered here. The comprehensiveness of the review is such that to rehearse the whole set of arguments again is unnecessary.

The present study is not one of change processes in general but a specific study of three organizational settings and in particular the attempts to improve the effectiveness of management within the settings. However, Pettigrew's conclusion about change theorizing is highly relevant given the significance of change in this study. Pettigrew concluded that:

..theoretically sound and practically useful

> research on strategic change should involve the continuous interplay between ideas about the context of change, the process of change, and the content of change. Formulating the content of a strategic change crucially entails managing its context and process. Without sensitivity to and apposite action on the what, the why, and the how of introducing major change more than likely the change idea will either die shortly after birth or be emasculated at the later stages in the processes of formulation and implementation (Pettigrew 1985:19).

In reaching this conclusion, Pettigrew argued that existing literature on organization change is largely inadequate due to the ahistorical, acontextual, and aprocessual approaches used. Paralleling comments made by the researcher earlier in the discussion he argues that:

> In this respect the area of organizational change is merely reflecting the biases inherent in social sciences generally and in the study of organizations in particular (Pettigrew 1985:23).

From the above comments,it seems that the value of infusing change theorising with the cultural and micropolitical perspectives is, that

they afford the opportunity to extend conceptualising about change in organizations, beyond purely 'structural' considerations (Morgan,1986). These two perspectives are integral in giving a central role to the complexities and human dynamics of the organizational change attempts. In doing so, attempts at change are not removed from the context in which they are taking place.

This is particularly important when as it is increasingly acknowledged that change is a complex human process and it is typically met with resistance by some and welcomed by others. Previous research, (Stewart 1983), has shown the resistance which people have towards change. Lorsch (1985) argued that 'strategic myopia' can set in amongst managers themselves, and culture can act 'as an invisible barrier to change'.

Having outlined earlier the social nature of culture and its function in giving order, consistency and meaning to individuals, it maybe viewed that resistance to change on the part of individuals is perhaps inevitable and natural. Howver, it is the human element of the change process which brings resistance and has not been paid sufficient attention in previous change theorising. There has been a reluctance to understand fully the nature and extent of the human resistance to change.

It is a recognition of this which helps the researcher to understand the challenge facing those implementing general management in the NHS.

As will be shown by the reactions to the Griffiths Report (chapters six, seven and eight), there is current resistance to change in the NHS. Similar resistance has greatly contributed to previous NHS re-organizations only achieving structural change (Thompson 1986). It was the evidence of past re-organizations which perhaps led Griffiths to remark that:

> To the outsider it appears that when change of any kind is required, the NHS is so structured as to resemble a "mobile": designed to move with any breath of air, but which in fact never changes its position and gives no clear indication of direction..the NHS needs the ability to move much more quickly (Griffiths 1983:12).

So, to apply this thinking to health organizations in particular, effective management of the organization will not follow from the introduction of the recommendations contained in the Griffiths Report if managers are unable to ensure that the cultural features of their organizations support the structural features. In other words, managers throughout the organization will need to accept the recommendations and in turn convince staff that the new official arrangements are legitimate. To do this they will need to manage the structural and cultural features of their organizations.

The researcher will now give attention to the conceptual framework,

which following the considerations outlined in this chapter, has been developed during the course of the present investigation.

CHAPTER FOUR

MANAGERIAL EFFECTIVENESS: A CONCEPTUAL FRAMEWORK

The objective of this chapter is to describe the conceptual framework which steers the progress of this investigation. The framework is a development of the model presented as Fig 3.1 in chapter three. It is an analytical tool identifying four highly inter-related components of an organization.

There are two core relationships underlying these basic components. These are, first, the structure and culture relationship within the organization and, second, the relationship between the official and unofficial dimensions of organizational functioning.

An argument presented in chapter three is, that managerial effectiveness within the organization has to be understood in terms of the relationship between the cultural and structural elements of the organization. In this chapter, the researcher develops this relationship and extends the conception of an effective organization to one in which not only is the structure and culture mutually supportive but so are the official and unofficial dimensions of these elements.

In order to establish the reasons why it is useful to develop the model, it is necessary to discuss these two relationships in greater

detail beginning with the structure/culture relationship. The conceptual distinction between structure and culture follows on from chapter three in which organizations were viewed as 'social' and 'technical' arrangements (Watson 1987). The structural elements of organizational life are the 'technical', behavioural and action-oriented phenomenon within the organization. The cultural elements are the 'social', cognitive and ideational phenomena. In short, the structural is an indication of the way people act, whilst the cultural is an indication of the way people think.

To distinguish between structure and culture in this way is to support the separation of the 'socio-structural system' from the 'cultural system'. This separation was encouraged by Allaire and Firsirotu (1984) and supported by Bate (1984). Harrison whilst discussing the management culture of the NHS, and the introduction of management budgets, also used the distinction and remarked that:

> ..One of their (Allaire and Firsirotu) basic distinctions...is between, on the one hand culture as a sociocultural system including behaviours, ideas, values, and meanings, and on the other hand culture as an ideational' system only. The crucial difference is that the former definition, by including both behaviour and ideas assumes that the two are always in consonance. As Bate notes, this assumes too much, for it is quite

> conceivable that behaviours and beliefs diverge. Indeed, Allaire and Firsirotu note that such a divergence is most likely to occur at times of change. It is therefore this second notion of culture, as an ideational system, which is employed ... ; in Bate's words, "culture is predominantly implicit in the minds of men...it is shared - it refers to the ideas, meanings, and values people hold in common ...(and) it is transmitted by a process of socialisation (Harrison 1986:6).

To separate thought from action in this way is methodologically complementary with the assumption of social activity outlined in chapter three. That is, that one's behaviour is not purely an outcome of one's own choice and free will. Therefore, in an organization, one's ideas, beliefs and preferences may not be shown in one's action due to the objective constraints which exist. Stated simply, the argument is that individuals do not always act in accordance with how they think. Hence the separation, analytically, of thought and action.

It is also a useful distinction for the body of work labelled as organizational theory, as it takes us beyond partial explanations of organizational functioning. To attempt to assess organizational functioning by looking at either purely cultural factors or purely

structural factors is to discount one side of the equation. The interrelationship between the two has to be considered, as practice is an outcome of the interrelationship between the two sets of features.

As outlined in chapter three, organization theory has traditionally been characterised by an emphasis on the 'hard' structural features of organization such as the hierarchy, organizational charts, and systems. Only recently has an appreciation of the subjective, 'soft' human features of organizational functioning such as values, beliefs and cultures been a central concern. In terms of understanding organizational functioning the proposition is that the two go hand in hand. Consideration of one without the other leads to a partial analysis.

Though this conceptualisation of structure and culture is analytically useful, it is potentially dangerous. This is so if it is not recognised that much behaviour and action within the organizational setting, occurs outside of and as a reaction to structural arrangements. Therefore, the model needs to be extended. This raises the second core relationship underlying the conceptual framework. This is the one between those thoughts and actions labelled as 'official' and 'unofficial'.

This conceptual distinction is particularly important bearing in mind two arguments which were expressed in chapter three. These arguments were, first, that management activity is ideological and second, that

organizations are culturally pluralistic.

These two arguments present the organizational theorist with the challenge to consider fully, the existence of diverse interests and cultures. In doing this, it is also necessary to consider the expression and impact that this diversity has upon organizational functioning and managerial effectiveness.

To meet this challenge it is useful to use and adapt another model developed by Watson (1987). The model considers a conceptual distinction between the 'official' and 'unofficial' aspects of organization structure. The former being described in the following way:

> Official control aspects of structure - Patterns designed to fulfil dominant interests whilst also coping with challenges arising from 'unofficial' activities, e.g reporting hierarchy; departmental divisions; rules and work procedures; technology; reward systems; budgets, etc (Watson 1987:209).

The latter being described as:

> Unofficial aspects of structure - Patterns emerging in spite of and in reaction to the official control structure (helping and hindering

> it), e.g.informal inter-departmental arrangements; career strategies; informal groups; cliques and cabals; trade union, shop steward and occupational organizations, etc. (Watson 1987:209).

In all organizations there is an individual or group of individuals perceived by others, as in control of the official aspects of organizational structure. These are usually the strategic power holders and are usually labelled as senior management. The structural features represent channels through which they pursue their interests both as individuals and as a group. In their design and constant adaptation, these features are intended to perform an ideological function for senior management.

The value of this distinction is that it is in line with viewing management activity as ideological and potentially in conflict with other ideologies which maybe present within the organization. It also facilitates a consideration of thoughts and actions which are a reaction to senior management's interests and ideology. As such, it enables the avoidance of the inadequate notion of there being one 'single' organizational goal operating for individuals throughout the organization. As Watson has claimed:

> Organizational structures are the outcomes of interplay between official and unofficial

> influences. The organizational structures within which individuals both contribute to organisational performance and pursue sectional interests are in part an outcome of their own initiatives (Watson 1987:198).

Further, Watson comments that the view of organizations as social and technical arrangements:

> ..encourages a view of the organization less as a pre-given structure into which people are 'slotted' and more as an on-going and ever changing coalition of people with quite different and often conflicting interests and purposes who are willing, within rather closely defined limits, to carry out tasks which help to meet the requirements of those in charge (Watson 1987:169).

The model is a very useful model in itself. However, it is necessary to extend it. Watson acknowledges the diversity of interest and conflict of goals through the model. However, it could be criticised because it tends only to acknowledge the expression of differences and conflict, not the underlying meanings behind the differences.

Therefore, it is necessary to examine more fully the differences and conflicts at group level and assess how individuals' shared learning

and meanings underlie conflict.

As discussed in chapter three, the cultural perspective is very useful in accommodating these issues. Hence, it is valuable to extend the Watson model to include official and unofficial aspects of culture as well as structure.

The official culture is the basic assumptions and meanings espoused by those in control of the official structure. Through these, the official power holders attempt to manipulate, shape and manage the meanings and assumptions of other individuals and groups throughout the organization. In short, the official culture attempts to influence behaviour by affecting how people think. In an effective organization, the culture, made up of ideologies, values, beliefs and norms will be supportive of and supported by the official structural arrangements.

The unofficial culture is the meanings and basic assumptions espoused and operating for groups and individuals which are an alternative to or a direct challenge to those espoused by official power holders. Such meanings and assumptions are expressed and operate through both official and unofficial structural channels. Sub-cultures and contra-cultures are included within this unofficial dimension.

An important feature of this model is that the two components of culture and two components of structure are dialectically related.

Each one is influenced by the other and contributes to the other.

Hence, the researcher's conception of an effective organization is one in which not only is the structure and culture mutually supportive but so are the official and unofficial dimensions of these elements. Figure 4.1 indicates diagrammatically the relationship between these four organizational components.

Using Organizational Culture to Assess Managerial Effectiveness.

The basic conceptual framework, represented in figure 4.1 is a static model of related organizational dimensions. An understanding of their relationship is fundamental to our understanding of how organizations function.

The model enables us to consider the two issues noted at the end of chapter three. First, the official and unofficial distinction make it possible to isolate the content of the official culture and structure within each Unit of management and understand senior management's treatment of the Griffiths recommendations.

Second, bearing in mind the conception of managerial effectiveness being applied by the researcher, through the analysis of the interaction between official and unofficial activity, an indication is provided of whether the conditions for achieving managerial effectiveness are present within the organization. This is so because the relative strengths and weaknesses of the official and unofficial

Figure 4.1 Conceptual Framework

	STRUCTURE	CULTURE
OFFICIAL	Procedures Policies Organisational Chart Rules/Regulations Systems	Norms Values Beliefs Ideologies Symbols Sub-Cultures
UNOFFICIAL	Systems Procedures Rules/Regulations	Norms Values Beliefs Ideologies Sub-Cultures Contra-Cultures Symbols

patterns of organizational functioning can be compared. Through this comparison, it is possible to assess the amount of shared meaning which exists throughout the organization and whether the sectional interests of management have been legitimised and naturalised as universally held features of the organizational culture. Arising out of this is the information which is required in order to assess whether the structure and culture of the organization in both the official and unofficial dimensions are in a state of mutual support. Such a condition has been identified as a necessary one for managerial effectiveness.

Types of Organizational Culture

Figure 4.3 is a scheme identifying seven ideal types of organization culture. It treats organizational culture as both a product and part of the process in the interaction between the official and unofficial patterns of organizational functioning. Through these types, micropolitical and cultural processes observed to be operating in the Units are described and an indication of is provided of whether the necessary conditions for achieving managerial effectiveness are present within the organization.

Before describing the types, it is worth briefly mentioning the value of using the 'ideal type'. Watson has described an ideal type as:

Figure 4.2 Expansion of Figure 4.1

Official Structure

This refers to: the set of hierarchical relationships within the organization; the sets of rules, regulations and procedures which act as frameworks and guidance on the appropriate ways to behave as espoused by the official power holders; the formal policies of the official power holders including the objectives and policies which come together and maybe announced as the organizational "mission" and the systems which operate in the organization. These include the reward and punishment system and the formal decision-making systems and channels.

Official Culture

This refers to those basic assumptions and meanings which function to legitimise the authority of the official power holders and inform individuals throughout the organization as the most appropriate ways to think. Underlying these basic assumptions are values, ideologies, beliefs and norms. By employing the concept of culture and its concomitants, it is possible to describe and analyse the official espoused way of thinking. These features are indicators of the official culture and are constantly on display and re-inforced by official statements, documents and symbols.

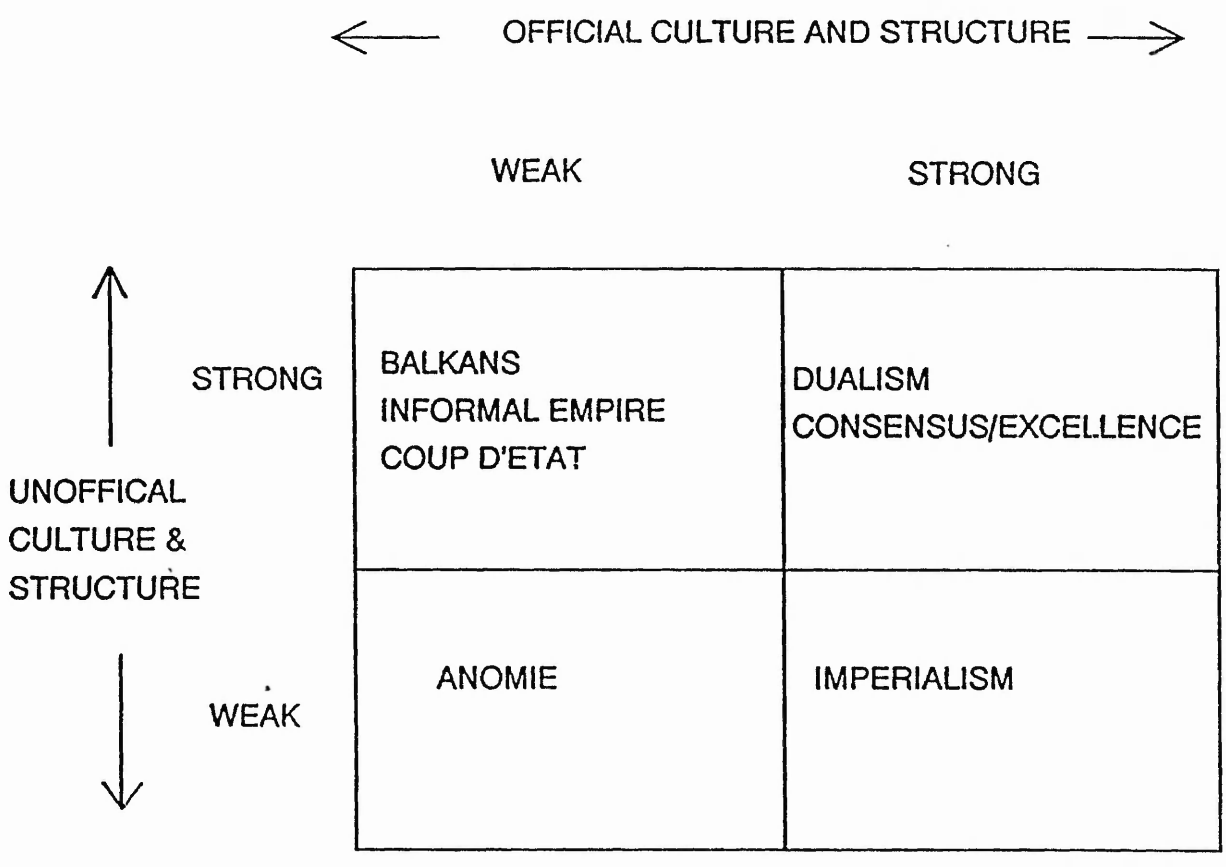
Unofficial Culture

This includes those basic assumptions and meanings which indicate alternative or opposed ways of thinking to the official power holders. These sub-cultural and contra-cultural aspects are underpinned by values, ideologies, beliefs, norms and symbols.

Unofficial Structure

This refers to those sub-cultural and contra-cultural arrangements present in the organization. These include decision-making arrangements, agreements and the manipulation of official systems such as information, budgetary, and accountability systems.

Figure 4.3 Ideal Types of Organisational Culture



A model of a phenomena or situation which extracts its essential or 'pure' elements. It represents what the item or institution.....would look like if it existed in a pure form (Watson 1987:287).

These ideal types enable the researcher to simplify the social worlds being studied. Because they are ideal types, they do not exist in reality. However it is not the 'trueness' of these types that is of value to the researcher. Rather, it is the effectiveness of these ideal types in helping to explain the social phenomena observed. They help the researcher to do this because through these types the general features of the social circumstances being studied are extracted and these general features are held in the researcher's mind whilst the particular circumstances of the case are understood and explained.

The resultant explanations are such that the organizational culture of each Unit of management is understood in relation to one or more of the ideal types These types have emerged out of the cultural and micropolitical processes observed to be present and impacting upon the implementation of general management in the Units. These processes and the types of organizational culture are useful as they provide an indication of the amount of change which has occurred, its compatibility to the change which Griffiths has recommended and whether the necessary conditions for achieving managerial effectiveness exist within the Unit.

The labels given to the types include metaphors from historical

analyses of power and conflict. These seem appropriate to describe the human dynamics of the Units of management of a District Health Authority (DHA) that have been studied through a micropolitical and cultural lens.

Figure 4.3 is based upon the axes which bring together the dimensions contained in the conceptual scheme (figure 4.1). Additionally, the terms strong and weak are used to discuss the interaction between the official and unofficial dimensions. This terminology is appropriate as the variables of power and influence are fundamental to the interaction.

Before describing the types it is necessary to elaborate upon the assumptions underpinning the axes. These are:

Strong official culture and structure

The official culture and structure can be viewed as strong when management personnel at all levels of the organization have cultural cohesion. That is, they operate from a shared ideology and pattern of cultural assumptions. Further the managers transmit the culture to staff, whose actions in turn embody the official culture and are within the official structural arrangements. Hence, the officially espoused ways of thinking and acting provide an adequate understanding of the way people actually behave and cognitively function in the organization.

In a health care context managers may occupy differing positions in the structure of the organization, from senior management to the point of health care delivery. It is likely that they are from a range of professional and experiential backgrounds and be members of differing sub-cultural groups. For example, a manager at ward level, from a nursing background is likely to be influenced by the professional culture and possibly a ward culture. However, so long as these influences do not become contra-cultural by taking precedence over and undermining the official ideology and assumptions it is reasonable to argue that the official culture and structure is strong. That is, it is being upheld by the actions of managers and other individuals throughout the organization.

Weak official culture and structure

The official culture and structure can be viewed as weak when managers in the organization do not have cultural cohesion. Throughout the managerial structure, managers may be influenced by differing ideologies and cultural assumptions. Some of these may even be opposed to those which are labelled as the official. A weak official culture and structure exists when official assumptions are undermined and contradicted. The structure is weak because staff and perhaps managers themselves are acting largely outside of or against official structural patterns, systems and procedures. Therefore, there is not a cohesive official culture being transmitted and in operation throughout the organization. Hence, the official way of acting and

thinking does not provide an adequate description of the actual behaviour within the organization. As such, the official culture and structure are largely cosmetic and official structures do not adequately fulfill the function of being guides to action. In this situation, the official culture is not shared by organizational members.

In a health service context such conditions would exist if the nurse manager mentioned earlier, allowed professional values and ideology which were contra to the official ideology, to take precedence over the official culture. Similarly, the senior management group may be beset by internal conflict, which is based upon individuals operating on opposed ideological and cultural assumptions. In this case, the official culture and structure is weak because there is not a shared official set of assumptions being developed and transmitted from the official power holders.

Weak unofficial culture and structure

Alternatives to the official culture and structure may be classed as either subcultural or contracultural. It is likely that behaviour in the organization contains both subcultural and contracultural elements. The term subculture is used here to indicate alternative patterns of behaviour, which do not necessarily contradict or undermine the official espoused culture and structural arrangements. As the Watson model presented in chapter three indicated, senior

management may encourage this in order to allow groups the necessary scope for diversity and specialisation which they need. For example, in a professionally pluralistic organization such as the NHS, the notion of clinical freedom, may make this sub-cultural presence inevitable and widespread. However, if it is accepted and accommodated by the official power holders and complements rather than undermines the official culture and structure it is not classed as unofficial. Subcultural activity becomes contracultural if it undermines the official cultural and structural arrangements. However, if contracultural behaviour is minimal or non-existent then the unofficial culture and structure can be regarded as weak.

Strong unofficial culture and structure

The unofficial culture and structure can be said to be strong when contracultural behaviour is constantly observable and widespread. That is, the patterns of behaviour of individuals throughout the organization are outside of and contradictory of those espoused as official. Consequently, these undermine the legitimacy and influence of official arrangements.

Organizational Culture - Ideal Types

The four quadrants in figure 4.3 indicate a number of ideal types of organizational culture. Throughout the remainder of the thesis the types are used to describe and understand the cultural and

micropolitical circumstances observed to be present within the Units of the DHA.

Coup d'etat, Balkans and Informal Empire

The three types identified here are useful for describing an organization in which there is interplay between a weak official culture and structure and a strong unofficial culture and structure.

Coup d'etat

This description has been taken from political history. Numerous examples of this process can be drawn from the international political arena, particularly in South American countries. Within an organization the coup d'etat description may be useful to describe a situation when a powerful subcultural or contracultural group seizes control of the official structural arrangements and cultural channels of the organization. Through this newly acquired strategically dominant position, they attempt to legitimise and naturalise their sectional interests as universally held features of the organizational culture. As such, their ideology and cultural assumptions underpin the official culture. Consequently, the official structural arrangements are used to embody and transmit the new official culture as this group now have control of policy and procedural mechanisms at the strategic level of the organization.

When this position is achieved, the new official power holders are likely to be open to challenge by the same process. Their survival depends on the strength of their material and symbolic resources vis-vis those resources held by other groups in the organization.

It is possible to image the cultural and micropolitical processes associated with Coup d'etat being present within a Health Service organization, especially so at Unit management level where there are several powerful semi-autonomous clinical groupings. For example, doctors and nurses possess valuable material and symbolic resources which they can use if they feel that their interests are threatened or being de-legitimised by a group, such as senior management, who hold the official positions of authority. In such circumstances, they may attempt to use these resources to gain control of these strategic positions in order to promote and legitimise their sectional interests whilst at the same time as undermining the legitimacy of other sectional interests.

Balkans

This label is taken from the period of European history when the Ottoman Empire was increasingly powerless and crumbling. The process of this decline was one underpinned by several states demanding autonomy and independence from each other and from the higher power. Indeed, their demands and behaviour were contracultural as they undermined and threatened the power of the sovereign. The weakness of

the official power holders, did little to quell such a threat or prevent the endemic warfare between the emergent states. Eventually the empire crumbled amid fragmented and warring states.

Within the organizational sphere this type is useful to describe a situation when there is an organization populated by several subcultures. These groups desire autonomy from each other and from the authority of a higher power, for example, senior management. Importantly, these groups possess sufficient cultural strength through their material and symbolic resources to resist the interference and authority of the higher power. They do so because the official power holders, who are the senior management, have not succeeded in legitimising their own sectional interests amongst these groups. Therefore, senior management are the official power holders within the organization, but in reality they wield little power as their interests have been de-legitimised by these other groups who are acting contraculturally.

It is possible to use a health setting to illustrate such a culture. In a health organization such as a large Acute Services hospital or Community Services Unit, there are likely to be many cultural groups, based upon a profession or discipline within a profession. For example, there is the medical profession with its range of specialties and disciplines; the nursing profession with its different disciplines such as Midwifery and Health Visiting and the Professions allied to medicine, such as Physiotherapy, Pharmacy, and Chiropody.

Professional ideologies may lead the members of these disciplines to demand occupational independence, hierarchical (accountability) independence and autonomy in clinical decision-taking. Should senior management be unable to satisfy these demands whilst at the same time fusing the groups into a workforce which is able to provide a co-ordinated clinical service, then the organization could resemble the Balkans type of organizational culture. In such as scenario each subculture develops into a contraculture by behaving in an independent manner, irrespective of the demands of the official power holders who are senior management. Hence, in relation to the official arrangements, the unofficial arrangements are strong because they undermine the official arrangements. This process stops short of the coup d'etat because as the unofficial arrangements are the outcome of a mass of competing cultural groups, non of the cultural groups have the individual strength through their own symbolic and material resources to take over the official strategic positions. Therefore, the organization is in effect left with no effective strategic guidance and official arrangements.

Informal Empire

This label is taken from the 1800's when the British government obtained informal supremacy in Latin America and elsewhere (Gallagher and Robinson 1953). The terminology is a description of a process in which one group establishes control of the economy and society, whilst leaving the official institutions intact. These institutions

in reality are a symbol of previous rule, as effectively the nation is governed by another force. As such, the power of these official institutions is a sham as the real power base and control of the country is held by a group not occupying official power positions. This type differs from Balkans because there is a single group sharing an unofficial culture which is powerful enough to take the official positions of power if desired. However, the feature of this type is that the cultural group involved are content not to attain the official positions.

In this type of organization action is guided through an unofficial set of arrangements and is underpinned by unofficial cultural assumptions. The official arrangements, although existing, are not perceived as legitimate and play no part in directing the behaviour of the real power holders.

This process may occur in organizations populated by groups of specialists and professionals. These individuals may respect each other's demands for autonomy from each other and from senior management. Therefore, they may agree to use their specialist knowledge as a symbolic resource to de-legitimise the involvement of non specialist/professional individuals and groups in their work.

The potential for this process to occur in a health setting is evident because there are many clinical subcultures with a unique professional input, but who are potentially bound together by an ideology based on

clinical autonomy. Health care practitioners, for example, doctors, nurses and para-medical professions have their own individual subcultures. However, they may also share a belief in individual patient care and value clinical autonomy. Therefore, in some areas of a hospital, professionals may negotiate amongst themselves the boundaries of each other's work interaction and, in turn, provide mutual support against interference by a group perceived as having differing interests. For example, if they perceive the official arrangements as being an attempt by senior management (the official power holders) to infringe upon this autonomy, they may unite and refuse to co-operate in management inspired exercises such as financial planning, budgetary devolution and patient information exercises. By not co-operating, they are undermining the authority of official power holders, undermining official arrangements and demonstrating the strength of their power resources. This situation is not inconceivable, due to the differing beliefs which senior management may hold regarding patient care. As Thompson (1986) noted, the clinical professionals as a 'practitioner coalition' may function with a belief in individual patient care whilst they perceive the 'administrative' coalition as working from a belief in patient care at a group level, in order to satisfy political and economic criteria such as waiting list initiatives and value for money concepts.

Indeed, it has been argued that in health organizations, the power of the Doctor and prevalence of the notion of clinical autonomy in hospital life has meant that the dominance of the medical profession

has remained unchallenged for many years (Heller 1979). Such a situation reflects the processes which make up the informal empire. It does so because it indicates that the real power base of the organization rests with individuals and groups who are not recognised as the official power holders on official structural artifacts, such as the organizational chart.

Dualism. Consensus/Excellence

The two types identified here occur out of the interaction between a strong official culture and structure and a strong unofficial culture and structure.

Dualism

The metaphor of dualism is taken from economic history. Boeke (1952) used the term when analysing the Dutch plantations in Indonesia. Fisher (1970) also used the term in a study of the Indigo industry in Northern India. In both situations, the term has been used to discuss the relationship in a third world country between an indigenous peasant economy and an imposed plantation (super power) economy. The relationship between the two systems is one of co-existence of two culturally distinct sectors operating in the same economy at the same time. In the case of the Dutch in Indonesia, the situation was that the Dutch developed a plantation sector based upon capitalist principles and economic concepts, whilst the peasant economy was

primitive and based on subsistence ideas. The important thing to note is that each economy is distinct from the other in its cultural basis and interaction between the two is not harmonious. However, if each economy is to survive on its own terms both need to work well and complement each other.

In an organization the processes associated with Dualism exist when there is cultural strength at official and unofficial levels. However, these cultures are not entirely congruent. Rather, as with the economies described above, the official and unofficial dimensions are distinguished because they reflect distinct cultural assumptions.

Essentially, each culture functions on the basis of its own strength and interface with the other culture. This interface is required for the cultures to develop and for the relationship to be considered as dualistic. Because of the need to feed off each other the interaction between the two contains both subcultural elements (respect for each other differing cultures and interests) and contracultural elements. If it were purely the latter, this would lead to either the 'informal empire' or 'imperialism' type of organization identified and to be described later in the chapter.

The cultural and micropolitical processes which underlie dualism are possible in professional bureaucracies such as health authorities due to the clinical and non-clinical interaction which needs to occur. Thompson's (1986) scheme indicated that the NHS has traditionally

contained a 'practitioner coalition' and an 'administrative coalition' working from different beliefs and with respective strengths from different material and symbolic resources. Such an argument supports the 'dualism' theory being developed here. This is further supported by Harrison (1988b) who suggests that the administrative structure of the NHS has facilitated interaction between clinical professional and the adminstration and rather than the relationship being necessarily conflictual it has in fact been mutually supportive. He remarked that the NHS is one of the organizations in which professionals and managers do not inevitably clash. He argued that:

> ..conflict will only occur when and if the groups are pursuing different objectives. Professionals may be perceived as technical experts and managers maybe content to assume that professional decisions are the best available .... despite being surrounded by overall bureaucratic controls, professionals are substantially left to get on with it (Harrison 1988b:2).

In such a set-up the two cultural systems work together, but are clearly distinct and have different spheres of functioning. Therefore, they can both co-exist and function effectively without wholly compromising the objectives of each other. The relationship is not based on cultural harmony. Rather, it is based on the need to work together in order to protect and develop one's distinct culture

and associated objectives. In a Health Service setting, dualism may occur when clinical practitioners and non clinical personnel have negotiated each others distinct roles and spheres of authority.

If the relationship is sufficiently developed that it became culturally harmonious then it could be labelled as a Consensus or Excellent type of organization. It is now appropriate to discuss this type of organization culture.

Consensus/Excellence

This type differs from above because there are a pattern of cultural assumptions which all groups perceive as legitimate and which functions for them as guides to thinking and acting. For purposes of diversification and specialisation subcultural activity is perceived as positive and accommodated in the official arrangements. In such an organization, the legitimacy of senior management and official arrangements is taken for granted by other organizational members, and the organizational culture is rather monolithic and functions to both maintain and develop the dominant position of senior management. Such an organizational culture is a unified one and best illustrated by those companies referred to as 'excellent' (Peters and Waterman 1982). It is the idyllic type of organization and very few organizations reach it. In a health setting, it maybe that administration/management and clinical professionals pursue the same objectives or have effectively negotiated each others sphere of

activity in such a way that the interaction of the different spheres is entirely complementary. However, in view of resource shortages and managers increasingly being seen to act as 'agents of the government' (Harrison 1988b) it appears unlikely that Health Service organizations can be described as a Consensus type.

Anomie

The anomic type of organization culture arises out of the interplay between a weak official culture and structure and a weak unofficial culture and structure. The term differs from the other labels in that it has no conflict or political history connections. However, it is not difficult to see that it maybe useful to understand a country which has lost a war. The term is a sociological one made famous through the work of Durkheim (Pearce 1989).

An organization labelled as experiencing an anomic organizational culture is one suffering from a strategic aimlessness. This may occur when the senior management do not share cultural assumptions. As such an official culture and ideology has not been developed. Also the official structural arrangements reflect more ritualism than reality. Hence, there is a lack of effective guidance of thought and action coming from the official power holders. The result is a lack of strategic direction and clarity from the official positions. Additionally, there is no unofficial strength within the organization. Unlike in the Coup d'etat there is no subcultural group

and/or contra-cultural group of sufficient strength to seize official positions and import their own culture to strategically dominant positions. Therefore, despite being weak there is no threat to those in official positions. In this situation, there is no clear difference between official and unofficial activity.

The cultural and micropolitical associated with this type of organizational culture maybe evident within organizations which have suffered several major crises, numerous unwelcome re-organizations, threat of take-over or widespread redundancies at all levels. More specifically in the NHS, hospitals threatened by closure, or winding down for imminent closure may experience such processes.

Imperialism

Imperialism describes a scenario where there is interplay between a strong official culture and structure and a weak unofficial culture and structure. It is a term which could apply to numerous historical situations. For example, it could apply to the period when the Romans exercised an influence over the British society. When the Romans took control of Britain they became the official power holders. Unofficial behaviour occurred through subcultural and contracultural groups. However, the unofficial level of activity was weak in relation to the strength of the Romans. Hence official control was not challenged and cultural and structural channels were used to legitimise and naturalise the Roman culture as universally held. Inevitably, the

Roman culture filtered down into British society at that time to greatly influence societal behaviour and values.

This label is a useful description for organizations which experience similar political and cultural processes. These types of organization have a strong official culture and structure which acts as the guide to thought and action for individuals within the organization. The official power holders, for example, senior management, exert full control and influence over the social activity within the organization. Therefore, the strategic direction and operational functioning of the organization are compatible and mutually supportive. Subcultures may exist, but contra-cultural behaviour is minimal, covert and ineffectual in terms of undermining the position of the official power holders. Accordingly the dominant position of official power holders is perceived as too powerful to challenge.

Hence, there is minimal contra-cultural behaviour or challenge to the official power holders. As a consequence, the dominance and strength of the official power holders is maintained and increased. Structural arrangements are used to demonstrate and transmit the cultural assumptions and ideology of the official power holders.

In the case of the NHS, this state reflects an organization with a strong management team and a clear and shared management ideology which is pervasive throughout the organization. Such as situation is unlikely to prevail in the large acute services hospital due to the

power of clinical groups such as the Doctors. However it may occur in smaller organizations in which the cultural strength of clinical staff is not so strong.

Within the chapter the researcher has presented the conceptual framework and ideal type construct which steers the investigation in the Units of the DHA. The discussion will now move on to chapter five in which the Griffiths Report is analysed and the debate between official and unofficial cultural assumptions pursued further.

CHAPTER FIVE

THE GRIFFITHS REPORT: IMPLICATIONS FOR CULTURE IN THE NHS.

This chapter is a discussion of the recommendations contained within the 'NHS Management Inquiry' (Griffiths Report,1983). There are two main aims of the chapter. First, to present the argument that the recommendations contained in the Report are intended to establish an official culture in the NHS based on cultural assumptions which are different to those which have traditionally been dominant in the NHS. By using a typology of cultural dimensions developed by Schein (1985), the researcher describes how the managerial arrangements recommended in the Griffiths Report challenge particular values and assumptions which have traditionally been dominant in the management process of the NHS. Following on from the conceptualisation of managerial effectiveness developed in chapters three and four, the discussion is concluded with the argument that changes in the structural features alone are not sufficient for general management to achieve all that is intended by Griffiths. Rather, structural change must be accompanied by cultural change. For this to occur, the assumptions and values of individuals which inform the Griffiths recommendations need to be shared by individuals and groups within the Service.

The second aim of this chapter follows from this argument. This is, to discuss some of the reactions of individuals and groups at national level to the Griffiths Report. In doing so, insights are offered into

the difficulty of achieving the conditions necessary for managerial effectiveness, as conceptualised in this investigation. From this discussion there is a basis to analyse, in chapters six, seven and eight, the implementation of general management in the Units of Management of the District Health Authority (DHA).

An analysis of the Griffiths recommendations through a "cultural lens" is appropriate because much comment about the introduction of general management has been couched in terms of culture change. In a useful speculative discussion concerning the beliefs which the new 'general manager' coalition may hold, Thompson focused upon the introduction of general managers at District Health Authority (DHA) level and remarked that:

> The implementation of a new philosophy of management within the NHS is now under way in earnest. The new incumbents have an almost unparalleled opportunity to transform the managerial culture within their health authorities (Thompson 1985:158).

Also, Dimmock (1985a,b,c,d,e) produced a series of articles using the culture excellence idea developed by Peters and Waterman (1982) with the aim of comparing the NHS culture to those of 'excellent' companies. Indeed, there has been explicit reference to the need to effectively manage and change the culture of the NHS. The National

Health Service Training Authority (NHSTA) (1986a) emphasised that involving clinicians in management can change the culture of the NHS. Similarly, in a document detailing the new managerial structures for the Units of management, a District General Manager (DGM) remarked that:

> emphasis should be given to clarity of responsibility and accountability down to and including first level managers ... structures and titles should reflect the culture change in the Griffiths report.

However, despite all of this attention there has been little attempt to discuss culture per se in the NHS. Harrison made this poignant remark in an article entitled "Management Culture and Management Budgets".

> ..the notion of management "culture"...has figured rather frequently in debates about NHS management...Unfortunately much of this latter debate has been cast in rather general perhaps rhetorical terms...(Harrison 1986:6).

In addition to the publicity given to the culture implications of the Griffiths recommendations, a further and perhaps more significant reason for a detailed consideration of the Griffiths Report from a

cultural perspective is that there appears to be some clear value judgments and assumptions informing the criticisms and recommendations contained in the Report. This point was made by Harrison in the most comprehensive discussion to date of the change nature of the Griffiths Report. Harrison argued that the recommendations contained in the Report are the "prescription" and the criticisms contained within the Report the "diagnosis":

> the notion of diagnosis rolls together two elements which are, at least, partly separable from each other: firstly, a set of 'facts', and secondly a value judgement that these are in some way undesirable or unsatisfactory. The scare quotes around the word 'fact' serve to emphasise that facts and values are never wholly separable since the selection of relevant facts is itself the consequence of a value judgement (Harrison 1988b:67)

Later in the discussion Harrison continues in the same vein:

> The value judgement entailed by the Griffiths Report is that these facts are undesirable, that the state of affairs which they present is illegitimate...The prescription is of course, aimed at changing this prevailing model of

> management, and it is possible therefore to infer from it the authors' assumptions about why managerial behaviour had hitherto assumed a diplomatic character; in stressing, as they do, such factors as the need for individual accountability, review, and incentives for managers, they make the managers themselves responsible (Harrison 1988b:69).

Therefore, throughout the remainder of this chapter, it is appropriate to attempt to uncover these values and 'facts' which are underpinning the Griffiths recommendations and arrive at some indication of the new model of management envisaged by Griffiths. Prior to doing this, it is useful to note that there is little specific evidence on management culture in the NHS. Culture per se has not been used in empirical work. Therefore, it is valuable to follow Harrison's (1986) lead and speculate on some of the dominant cultural assumptions which have underpinned the NHS managerial process in recent years. This is possible by using existing NHS literature, empirical sources and the perceptions of individuals within the Units of Management of the DHA providing the cases for this investigation.

To structure the discussion, a typology of cultural dimensions developed by social anthropologists (Kluckholm and Strodtbeck, 1961) is used. The dimensions are based on existential issues such as the 'organization's basic function/mission', the 'relationship to nature'

and the 'nature of truth'. Social anthropologists have found that these issues form a pattern which helps to make up the culture of all societies. These have recently been adapted for organizational analysis by Edgar Schein (1985).

Throughout the application of this model to analyse the cultural assumptions, each dimension is conceptually separated. In reality, the dimensions mix together (to varying degrees) into patterns of meanings upon which the culture is based at group and organizational level.

A benefit of the typology is that it provides the opportunity to use the concept of culture to identify differences between individuals and groups within the organization. It does this by isolating the particular meanings which unite or differentiate groups and individuals within the organization. Consequently, it affords the opportunity to explore human activity and the rich pattern of meaning which exists in organizations and impacts upon managerial effectiveness. Further, it shows that organizational politics does not have a basis purely in personality differences. Rather, issues such as shared learning, professional/functional roles, location in the organization, age and gender do inform differences in the activity of individuals and groups and the meanings which form a basis for action.

In terms of our understanding of the NHS, the typology of cultural

dimensions allows the researcher to compare the NHS management culture recommended by Griffiths, with that existing in the NHS prior to the Report. The latter is indicated by existing literature, empirical evidence and individuals at local level. The result is an "ideal type" model (Fig. 5.1) of general management in its purest form. Against this model, the implementation of general management in the Units of Management can be analysed and an indication provided in chapters six,seven and eight of how much the official culture in the Units of Management is informed by the Griffiths culture.

Schein uses five dimensions. The initial title is the one developed in the anthropological work, the title bracketed is Schein's adaptation and organizational equivalent.

Dimension One - Humanity's Relationship to Nature. (the organization's relationship to its environment).

Schein argues that on this dimension there are two main issues which indicate the cultural assumptions which are informing activity. First, the perception within the organization about the organization's relationship with its environment. This can be uncovered by finding out whether individuals within the organization perceive the organization to be capable of dominating and changing the environment by its own actions or being "submissive" and at the mercy of environmental fluctuations. Schein notes that:

The organizational counterpart of this core

> assumption is the group's view of its relationship to its defined and perceived environment within the larger host culture..Just as individuals vary in the degree to which they feel they have control over their own fate so do organizations vary in this regard ... At this level we are talking about the assumptions underlying an organizations "primary task", "core mission", or "basic functions".. If the organizations assumptions about itself at this level is out of line with environmental realities, it may sooner or later face a survival problem (Schein 1985:87).

Second, the basis of the organizational and environmental relationship. For example, do individuals within the organization perceive the link to be largely economic, technological, political or sociocultural? Schein notes that:

> ..the organization may make assumptions about whether the most relevant dimensions of the environment to be taken into account are technological, political, economic or sociocultural. Not every aspect of the environment will be given equal attention by a given organization (Schein 1985:88).

In order to uncover the cultural assumptions operating on this dimension, the important questions and key issues to be explored are: how individuals within the organization view the basic function and mission of the organization and how they identify the organization in the context of other organizations?

On this dimension, it is the researcher's view that the Griffiths recommendations challenge two closely related cultural assumptions which have traditionally been dominant in the NHS. First, they challenge the claim to organizational uniqueness which has traditionally been shared by many NHS personnel from a variety of professional/occupational and functional backgrounds. Many within the NHS see it as a complex organization with distinctive management competencies required. This claim to uniqueness has recently been articulated when the NHS has been likened to private sector organizations. This is indicated by some of the reactions to the Griffiths analogy of the NHS and private sector business organization. The analogy was explicitly stated by Griffiths in the following manner:

> We have been told that the NHS is different from business in management terms, not least because the NHS is not concerned with the profit motive and must be judged by social standards which cannot be measured. These differences can be greatly overstated. The clear similarities

> between NHS management and business management are much more important. In many organizations in the private sector profit does not impinge on large numbers of managers below board level. They are concerned with levels of service, quality of product, meeting budgets, cost improvement, productivity, motivating and rewarding staff, research and development and the long-term viability of the undertaking. All the things that Parliament is urging on the NHS. In the private sector the results in all these areas would normally be carefully monitored against pre-determined standards and objectives. The NHS does not have a profit motive, but it is, of course, enormously concerned with control of expenditure (Griffiths Report 1983:10).

The claim of uniqueness is an ideological assumption for many NHS personnel. As a result, Griffiths attempt to lessen perceptions of difference between the NHS and private sector institutions has not been received favorably by many individuals in the Service. The contention that there are many similarities has produced the following reactions. Dunwoody remarked that:

> The NHS is bigger and more complex than Sainsbury's. Running out of cream is not like

running out of blood (Dunwoody 1984:30).

Similar sentiments have been echoed at local level. A medical consultant in one of the units used as a case study remarked that:

> ...the joke has been that, you really take grocers from Sainsbury's and ask them to run a structure which really depends on a great deal of co-operation and goodwill to run smoothly. This is the big mistake they have made. It is very easy to put a manager into, for example, laundry and say "right, we do 50,000 items a week, and it is costing us this much. Can we do 50,000 a week and it will cost us less by doing such and getting rid of some restrictive practices". But you cannot say "let's take 50,000 patients and we will put them through in six weeks compared with eight weeks" because it involves so much in clinical understanding and inter-relationships.

Also, a current manager (with a medical background) at unit level remarked that:

> The NHS is a unique organization. It is not Unilever or ICI or the Coal Board. We do not have a product to sell, in fact it is the other way

> around. I think that Roy Griffiths failed to grasp that basic concept. I mean even the economics of the NHS are different from commerce. I mean, it's not in our interests commercially speaking, to treat more patients because it will cost us money. Whereas if I'm selling baked beans then it's in my interest to sell more because I get two pence a tin.

These reactions indicate that the Griffiths analogy has affronted a collective perception of organizational uniqueness. More specifically, it has affronted the caring ideology which individuals within the NHS from diverse professional and functional backgrounds share and which is a fundamental feature of the culture of the NHS. The message from the Service appears to be that patients cannot be managerially conceptualised in the same manner as baked beans. As Brahma noted:

> The needs of the ill cannot be managed like packets of groceries (Brahma 1984:201).

In terms of this investigation, the important issue is not evaluating the appropriateness of the analogy between the NHS and business organizations. Rather, it is in understanding and appreciating the meanings, values and interests which have provoked these reactions. The prevalence of the notion of clinical autonomy and the traditional

facilitating role of administration have ensured that the medical ideology, values and interests have been "officially" maintained as the dominant ones of the NHS from its inception up to the present day. As one current manager at a senior management level in one of the case units remarked:

> ..the clinical freedom element which over thirty years or whatever has said to the Consultant "the patient is your responsibility, the system is designed so that you can decide what the best treatment is and order it", is not compatible with strict management aims, objectives and directions.

Such a 'system' is now considered by many to be under threat from analogies which are perceived to treat the mission of the NHS in a way similar to the mission of private sector organizations.

A further difficulty associated with this challenge is that the shared learning experience of Clinical professionals such as the doctors and nurses has traditionally paid scant attention to economic concepts or concepts which move beyond assessing patient needs in any other terms than the needs of the individual patient. A medical consultant confirmed that:

> you can go through your hospital life as a consultant, managerially inactive and without

knowing what your budget is. You are not part of that picture.

This remark moves the discussion to a second argument of Griffiths which challenges the traditional assumptions and values within the NHS.

By challenging the uniqueness identity of the NHS manager and clinical professional, a second change assumption, clearly related to the first is revealed. That is, whilst maintaining the service ethos, the Report stressed the need for a greater business awareness amongst managers in the NHS. As such, the traditional dominant "social" responsibilities placed upon the NHS by the population are being increasingly joined by "economic" considerations. Therefore, Griffiths is doing two things, first, challenging the identity of the NHS and secondly, qualifying the traditional service identity with economic considerations. Other re-organizations have attempted to do this but up to the eighties there has been much lip-service paid to economic criteria. However, during the 1980's economic concerns in the public sector have been brought sharply into focus. (See Harrison 1988 chapter five for a discussion of variables which have led to the Government requiring a different policy towards management in the NHS).

The Griffiths Report challenges taken for granted beliefs about the key recipients of health care. It does so because whilst clinical

staff maintain that the emphasis should be on the care of the individual patient, Griffiths argues that responsibilities to other 'groups' should also be included in the equation:

> Our advice on management action is not directly about the nature of the services provided to patients. But the driving force behind our advice is the concern to secure the best deal for patients and the community within available resources; the best value for the tax payer; and the best motivation for staff. As a caring quality service, the NHS has to balance the interests of the patient, the community, the taxpayer and the employee (Griffiths Report, 1983:11).

This broadening of mission is a challenge to the culture of clinical professional staff in particular. The training and education of doctors and nurses has fostered a belief in satisfying the needs of the individual patient. This is their ultimate aim as professionals. By asking them to adopt a greater awareness of economic constraints and other interest groups, Griffiths is perceived to be challenging the clinical professional's belief system. Previously the system has not prepared them for having to take into account such considerations.

Support for this argument comes from the comment of a consultant in a

Unit, who spoke of colleagues' perception of economic concerns. The consultant commented that:

> A lot of consultants have one ideal - the patient. That is our first priority. However, sometimes people hide behind that and do not look at what is happening in other areas. Some people lose their perspective a bit and become blind to the realities of the real world. The realities of the real world being that they have to pay for the service in the end and at the end of the day.

Furthermore, traditionally the culture in the NHS has seemingly facilitated clinical professionals, especially the medical profession, having economic concerns as a low priority. This has been indicated by the following comments at local level. A senior manager from a nursing background, in one of the Units, indicated that the nurses shared learning process in recent years has not prepared them for concerns other than individual patient care:

> I do not think anybody brought up in the nursing hierarchy since the 1960's has had the preparation for what I call the housekeeping role. It disappeared in the sixties with Salmon. We got a honeymoon period in the 60's and 70's when money seemed no object. Non-disposable items were

> replaced by disposable and nobody seemed to know the value of anything and the waste was phenomenal as they were not accountable for what they were using.

Similarly a Unit Accountant noted that:

> before the recent shortage of money and cash limits, you could spend forever. If you had a budget you just overspent. This can't be the case now of course but we still have people around who believe that they can spend what they like.

Hence, as these economic concerns are an increasingly fundamental feature of the managerial process of the NHS there is increasing pressure on practicing clinical professionals to take on other concerns, alongside the needs of the individual patient. Griffiths' reference to the management of budgets and information needs is evidence of this.

In conclusion, we can say that the traditional perception of organizational identity and mission held by many individuals in the NHS has been challenged by Griffiths. The response from within the Service to this challenge will greatly impact upon the response to Griffiths inspired changes along other dimensions. It is to these

that the analysis is now directed.

Dimension Two - The Nature of Reality and Truth. (basis for decisions)

An indication of 'officially' dominant cultural assumptions within an organization is provided by the decision-making process. Schein noted that in every organization there are particular assumptions which provide a basis for decision-making. He distinguished between decision-making which has either a "physical", "social" or "subjective" basis. He argued that decision-making has a "physical" basis when factual and objective criteria is used as the basis for a decision. A "social" basis when decision-making processes stress consensus, principles and dogma and a "subjective" basis when individual opinion, bias and taste criteria is applied. According to Schein, in order to understand and analyse these assumptions it is necessary to focus on:

> ..how members of a group take an action, how they determine what is relevant information and when they have enough of it to determine whether to act and what to do (Schein 1985:88).

In terms of decision-making at the Unit level of management, the Griffiths Report made two significant observations and recommendations. First, it stressed the necessity of directly involving individual clinicians in the managerial process. It was stated in the Griffiths Report that:

> We believe that urgent management action is required, if units are to fulfil their role and provide the most effective management of their resources. This particularly affects the Doctors. Their decisions largely dictate the use of all resources and they must accept the management responsibility which goes with clinical freedom. This implies active involvement in securing the most effective use and management of all resources. The nearer that the management process gets to the patient, the more important it becomes for doctors to be looked upon as the natural managers (Griffiths Report 1983:18).

Second, at senior management level, it challenged the reliance on a 'social' consensus decision-making process by recommending the introduction of a Unit General Manager (UGM). It is necessary to discuss these recommendations further beginning with the involvement of clinicians in the management process.

Focusing upon the use of resources by the doctors and following on from the desire to introduce a greater awareness amongst key groups of staff of the "economic" constraints upon the NHS, the Griffiths Report challenged the culture of the clinical decision-making process at Unit level, by promoting the need for a greater emphasis upon "physical" criteria as a basis for decision-making. In the Report, it

was stressed that clinicians need to accept managerial responsibility for their decisions:

> Clinicians must participate fully in decisions about priorities in the use of resources...Clinicians need administrative support, together with strictly relevant management information, and a fully developed management budget approach. This approach should prompt some measurement of output in terms of patient care..(Griffiths Report 1983:6).

The involvement of doctors in the decision-making process has been a central issue in NHS organization and management initiatives for many years. The "Cogwheel" Reports in the 1960's and 1970's provided a structural framework for the formal involvement of the medical profession as a group in the administrative process of the hospital. The more recent emphasis has been on formally involving individual clinicians in the direct management of financial resources. Griffiths illustrates this by the encouragement of demonstration Districts in which 'Management Budgeting' exercises should occur. According to Griffiths the general aim of these exercises is to:

> ensure that each unit develops management budgets, which involve clinicians and relate workload and

> service objectives to financial and manpower allocations.. (Griffiths Report 1983:7).

This emphasis on the direct involvement of clinical staff in management information and measurement of output is significant from a cultural perspective. It is so because doctors are being urged to utilise physical objective criteria and information to inform and complement their professional 'subjective' basis of clinical decision-making. This trend and the emphasis on managing information in the decision-making processes is underpinned by the assumption that an increased physical basis for decision-making is needed in the NHS.

There is evidence that this physical input has traditionally been lacking in the NHS at care delivery levels. As Bourn and Ezzamel concluded in recent article:

> ..there is little doubt that performance evaluation is an ambiguous art in the NHS. There is no satisfactory definition, let alone measure, of outputs. The proxy used in the costing analysis is the number of patients. Without much finer categorisation this workload measure is of limited service as an output measure (Bourn and Ezzamel 1986:209).

They also cite the research work of Rees (1985) in two clinical units in a Southampton hospital as evidence that the use of information in the decision-making process is minimal and inadequate. They note that:

> [the] system is grossly incomplete and the quality of much of the underlying data is often dubious..there are no formal standard costs which might guide the development of budgets, and provide a basis for comparisons (Bourn and Ezzamel 1986:210).

The lack of a physical basis for decision-making has also been confirmed at Unit management level by the following comments. A manager with a medical background commented:

> I think part of the exercise we are now seeing in the Health Service is actually trying to define what something costs. I mean nobody can really manage without raw data in terms of what activities are going on and how much they are costing, and that information is obviously very lacking and it is now going to need a management revolution to achieve it.

Additionally, a surgeon with many years' medical committee experience

in the NHS also remarked about the absence of management information in clinical activity. Furthermore, the surgeon clearly indicated the micropolitical element of information by the comment:

> What the NHS needs is management that says "look your waiting list is five times longer than surgeon B's, so let us spread the load". Management that looks at the surgeon and says not "you must be doing" but "why is it that your activity is so different from your equivalent in the other hospital or District". We've never had that and I'll find it as difficult to accept as the next man - I won't like it, but there is part of me that says it is the only way.

Similarly a current manager claimed:

> I am not sure that doctors are prepared for spending their money for reasons other than their whim and fancy.

A glance at existing literature supports the view that much decision-making has been subjective and little of it has been infused by a physical basis. In his description of the power of the medical profession, Heller notes that:

> Insistence on total autonomy has given rise to the current situation, in which the treatment for similar conditions differs widely and apparently depends only on the whims of doctors in charge. The variation in days spent in hospital for the treatment of similar conditions is the simplest example where savings could be made by the use of a medical audit or some guidelines for doctors on patients management (Heller 1979:13).

The significance of these latter remarks extends beyond confirming the lack of physical information within the clinical decision making process. They also indicate the micropolitical implications of an increase in physical criteria in the decision-making process. As Alex Bourn remarked:

> The relationship between management information and operational information is crucial...there has to be a trade-off between the generality of information and the detailed explanatory power of it in any MIS (Management Information System). This is compounded in the NHS by the vague nature of its multiple objectives, the conflict of cultures between the new general manager concept and the clinical freedom culture of the medics. The culture conflict is important to understand.

> Information is not neutral. If the introduction of information management to further the 'business' of health care is used to challenge or to modify the traditional 'clinical freedom' of doctors, it runs the risk of opposition from the medical profession (Bourn 1987:121).

Certainly, the usage of this information could challenge the traditional doctor/manager relationship in certain areas of clinical activity. As another consultant remarked:

> ...the thing about waiting lists is it is not just a simple numbers game. It is the anatomy of the waiting list. If you know that Joe Bloggs' waiting list is so long as compared to Bert's next door, then you can find out what Joe Bloggs is doing. So it becomes a bit of a clinical audit and that is a big threat to a lot of people. Lot's of people will not like it, but I'm sure it is going to happen in time.

The real infusion of physical information into a traditionally professionally dominated and subjective process of decision-making requires clinicians using economic concepts and criteria in their decision-making.

This is a culture challenge because it is alien to medical education

and training. Furthermore, it has implications for managerial control, especially if it involves some element of accountability to management. The significance of this from a cultural and micropolitical perspective is evident when it is remembered that the official culture of the NHS has ensured that the accountability of clinical professional staff is to professional peers through a professional hierarchy, not to managerial peers through a managerial hierarchy. Hence, the move to increased physical criteria to inform clinical decision-making could also challenge the traditional basis of control. This is of major significance and will be discussed in dimension five.

The second cultural challenge on this dimension concerns decision-making at senior management level. The recommendation that each Unit should have a general manager, challenges the traditional reliance of the NHS on a collective and consensus (social) basis of decision-making. Griffiths criticised consensus decision-making on the following grounds:

> A general manager should be identified from within the existing team..this is not intended to weaken the professional responsibilities of the other chief officers, especially in relation to decision taking on matters within their own spheres of responsibility. It is intended to sharpen up the process, first of decision-taking

> on other matters where there is a disagreement and second, of identifying personal responsibility to ensure that speedy action is taken....In this context, it certainly appears to us that consensus management can lead to "lowest common denominator decisions" and to long delays in the management process. It has been suggested to us that the absolute need to get agreement overshadows the substance of the decision required. We therefore propose the identification of a general manager to harness the best of the consensus management approach and avoid the worst of the problems it can present. The general manager would be the final decision taker for decisions normally delegated to the consensus team, especially where decisions cross professional boundaries or cause disagreements and delay at present. (Griffiths Report 1983:17).

This is a genuine challenge to the culture of decision-making at senior management level. To illustrate this it is useful to look at other recent NHS organization and management initiatives which rejected the chief executive idea in favour of a collective responsibility and consensus management. In 'Patients First' it was stated that:

> The government has rejected the proposition that each authority should appoint a chief executive responsible for all the authority's staff. It believes that such an appointment would not be compatible with the professional independence required by the wide range of staff employed in the service (DHSS, Patients First) 1979:11).

This radical change recommended by Griffiths and supported by the Government has led Thompson to remark that:

> This decision can be seen as a dramatic transformation of policy towards NHS management decision-making arrangements within the lifetime of the present Government. It can also be seen as somewhat perverse in the light of widespread endorsement of consensus decision-making before 1982 which had been accepted by this Government (Thompson 1986:3).

To further indicate the previously official belief that a chief executive is inappropriate for the NHS, it is useful to recall the rejection of the Farqueson-Lang Report in 1966 (Dimmock 1985d, Harrison 1988b).

Therefore, it is reasonable to conclude that through the

recommendation that the general management principle should steer the decision-making process, the Griffiths Report has challenged a major assumption of the official culture of the NHS. As Dimmock remarked:

> The appointment of people, at every level, with powers to take decisions affecting many professions cuts across existing management arrangements (Dimmock 1985b:29).

Dimension Three - The Nature Of Human Nature.

Schein argued that in every organization there are assumptions about the type of behaviour best suited to satisfying the purpose and mission of the organization. These assumptions inform the officially desired human nature of individuals employed at operational and managerial levels of the organization. Within organization theory, there have been theories of motivation which have been concerned with the assumptions that employees apply to their work. For example, Maslow (1954) and McGregor (1960). However as Schein notes:

> Most current theories are built on another set of assumptions - namely, that human nature is complex and malleable and that one cannot make a universal statement about human nature; instead one must be prepared for human variability. But this variability makes it essential for organizations to develop what their assumptions are, because management strategies reflect those assumptions (Schein 1985:100).

Such strategies are related to the official structural features such as the rewards and sanctions systems as well as recruitment and promotion criteria.

By noting the possible implications of the Griffiths recommendations in these areas, it is possible to consider the type of changes which

Griffiths envisages are necessary for the NHS along this dimension.

Before doing this, it is worth noting that Griffiths re-iterated the caring and pro-organization qualities which seemingly characterise the nature of individuals working in the NHS, by the following remark about:

> ..existing high levels of dedication and expertise among NHS staff of all disciplines.... (Griffiths Report 1983:13).

Indeed, the caring and pro-organization approach amongst Health Service workers is well recognised by both those inside and outside of the service. For example, Victor Paige, formerly Chairman of the NHS Management Board, remarked within a short time of taking up post that:

> Everywhere I have gone, I have met staff - not only doctors and nurses, managers, but at all levels - utterly committed to producing the best possible service for their patients. That level of commitment is an asset of which any corporation..would be rightly envious...(Paige 1985:205).

Also, a manager with a nursing background made a very similar point when claiming that:

> ..there is an awful lot of people working in the NHS who believe in the concept of the NHS. There is an awful lot of goodwill in staff. You do not get many organizations where most employees believe in what is going on and they are committed to it. There is an awful lot of goodwill in the NHS and it makes you wonder what would happen if it was withdrawn. The NHS has survived on goodwill for a long time.

However, from a cultural and micropolitical perspective, it is significant to note some Health Service employees perceptions of colleagues within the Service. These indicate that there is a degree of mutual mistrust between professional clinical groups who consider themselves as the "carers", for example, doctors, nurses and paramedical staff and those from non-professional clinical backgrounds, such as, administrators and managers have been described by some clinical professionals as "non-carers". The presence of this conflict was remarked upon by Victor Paige when taking up the Chairmanship of the 'NHS Management Board'. He noted that:

> A like antipathy seems just occasionally, to exist between major groups. The doctors, the nurses, administrators, treasurers, who else? There seems to be a need to protect themselves from the hostility of the other group. Sometimes

> by covert attacks; sometimes by subtle invasion (Paige 1985:206).

At the Unit level of management, the NHS is an organization comprising of highly qualified, semi-autonomous professional groups of employees who perceive themselves as 'carers' and espouse the belief in the best possible patient care for every individual patient. There is evidence that they share a perception that those at the administrative/managerial levels are 'non-carers' whose beliefs do not comply with individuals patients' needs.

For example, a consultant echoed the sentiments of many of his colleagues when he claimed that:

> there is a tremendous degree of cynicism towards management, it is true doctors are very suspicious of bureaucrats. We've had our fill of them in the NHS. They do not understand the complexities of looking after patients. We are jockeying for position and managers have to be credible.

Evidence of the mutual mistrust has been provided by a Unit General Manager who claimed that:

> I think all professionals would always claim that they are first and foremost caring for the

patient, I do not believe they are all as benevolent as that.

This mutual mistrust has been perpetuated through the functional management structures which have characterised the official structuring of relationships. This will be discussed in dimension five. Briefly however, this basis of structuring has officially separated the clinical professionals from the non clinical professionals. Hence, it is no surprise that there exists a mutual mistrust about each others objectives and beliefs.

The Griffiths attempt to establish overt managerial leadership through a single general management structure really brings to the fore these perceptions of each other. The future maintenance of these perceptions of each other is being challenged by a single managerial structure which will officially encourage greater formal interaction between those labelled as the 'caring' clinical professionals and those regarded as 'non-caring' non-professionals.

Additionally, further analysis of the Report along this dimension indicates two interrelated messages which further challenge the assumptions about the type of person which is needed to manage the NHS. These messages are related to the need for an increased business ethos and identity discussed in dimension one. First, NHS management can be enhanced by the introduction of managers with non NHS managerial backgrounds. Second, it is necessary that the existing

dedication is maintained through individuals being motivated within structural frameworks encompassing incentives and sanction processes.

Culturally, these two messages are important, because underlying them is a recognition that outsiders (individuals without experience of working in the NHS) can possess the personal and managerial qualities to enhance management in the NHS and that incentives and motivations traditionally associated with the private sector can also enhance managerial and employee performance. Previously, the absence of both the recruitment (in significant numbers) of people from non-NHS backgrounds to senior managerial positions and the introduction of more individualistic and results based rewards and sanctions has been conspicuous. Prior to general management being introduced, a shared cultural assumption seemed to be that only those inside the Service can understand it and manage it at senior management level. The Griffiths Inquiry was an open challenge to this assumption. This was no more emphasized than by the appointment of Griffiths as inquiry team leader. Such an appointment indicated that the spirit of the Report was going to be one in which it was viewed that the NHS could learn a great deal from the private sector. As such, Griffiths and other private sector team members offered the opportunity for fresh eyes and ears to be applied to the NHS. The idea was seen as essential to achieving change at all levels of the NHS. It was further supported when it was recommended that the Chairman of the newly created NHS Management Board and the Personnel Director would:

> ..initially almost certainly have to come from outside the NHS and the Civil Service Griffiths Report 1983:4).

Additionally, in the attempts to recruit general managers and other key management professionals there has been an emphasis on attracting "outsiders". The explicit description and labelling of people as "outsiders" indicates the element of culture shock within the Service raised by this issue. For many within the NHS, the scope of the potential change resulting from Griffiths was only realised when "outsiders" were appointed. One manager claimed:

> when they appointed the "outsider" here that was when the penny dropped, that it was going to be rough and the paranoia set in, as we realised that we could end up with a whole load of people managing us who did not know anything that was going on.

The significant issue here is the amount of mistrust and scepticism towards those individuals recruited from outside of the Health Service. As with the claim to uniqueness, this indicated the widespread perception that to be an effective NHS employee one has to be a particular type of person and one has to have a background which is steeped in the Service.

Indeed, at the time of the introduction of general management there was also a great deal of attention given to the style of managerial behaviour which general management may encourage. One conference seminar revolved around the issue of management style and the title of 'Rambo or Romance' for one seminar indicated the worries concerning the management style which general management may encourage. Within one region a initiative was inspired by a Personnel Officer with the heading of 'Caring for the Carers'. Hence, these are all evidence of the challenge to assumptions of human nature which general management has inspired in an organization such as the NHS were the caring ethos has been taken for granted in the official culture.

The issue of management style moves the discussion to a second assumption of Griffiths along this dimension. The issue of performance evaluation, rewards and sanctions was also at the forefront of Griffiths' thinking. Griffiths remarked upon the 'lack of incentive in the present system' and the 'inability of chairmen to reward merit or take action on ineffective performance'. He also emphasized the need for performance appraisal, career development, reviews of appointments, dismissal, grievance and appeal. He viewed that general management would be important in:

> securing proper motivation of staff. Those charged with the general management responsibility would regard it as vital to review incentives, rewards and sanctions. Merit awards would be

> considered. Redeploying the non-efficient performer would also be important, with dismissal as a last resort (Griffiths Report 1983:13).

Such an approach is intended to up-grade the quality of management. However, more widely it has implications for the management culture of the NHS because it has a performance and result based orientation. Griffiths did recognise that this was a long-term task but one that is essential for the future of the effectiveness of management in the NHS.

In the terms of Harrison (1972) this approach is more akin to the 'task' culture rather than the 'role' culture description which has been applied to bureaucracies like the NHS. In this respect, Griffiths appears to be encouraging a different managerial approach to evaluating the performance of staff as compared with the paternalistic, approach which one Personnel Officer indicated has traditionally prevailed in the NHS.

> I think we have been wrong in the past as we have put up with underachievers. Our attitude has been 'oh he is a very nice chap, but you know he's not actually very good at this job.

Such a change will take a long time to permeate the organization but the emphasis on fixed-term contracts for general managers and

performance related pay signals the beginning of this shift in assumptions. It is also an acknowledgement that the altruistic basis of motivation of individuals is not sufficient for many individuals in the NHS.

Dimension Four - The Nature of Human Activity

Schein suggested that human activity is characterised by one of three orientations: "doing", "being" and "being-in-becoming". He perceived that the former is underpinned by the attitude that "the impossible just takes a little longer", whilst the 'being' orientation is rather 'fateful' and 'subservient'. Similarly, Harrison (1972) distinguished between types of organizational culture and a major distinguishing feature used has been that of human activity within the organization. For example, a 'task' culture or a 'power' culture organization has been viewed as requiring a different type of behaviour than a 'role' culture.

Bearing in mind the conceptualisation of managerial effectiveness being used in this investigation, it is important to establish whether the Griffiths Report has attempted to alter the nature of managerial activity in the NHS. Certainly, the conceptualisation of managerial effectiveness presented in chapters three and four, implies that pro-active behaviour is required of managers if they are to effectively manage individuals' meanings and achieve organizational effectiveness.

It is the researcher's view that in terms of managerial activity, the introduction of general management is an attempt to change managerial activity within the Service from a reactive 'being' orientation to a pro-active 'doing' orientation. Indicative of this is the Griffiths

emphasis on the need for "management" as opposed to "administration". These two words mean very differing approaches (Dimmock, 1985d).

The language contained in the Report emphasises pro-activity and explicitly states the need for leadership, planning, objective setting, evaluating and achieving a consistency and drive in the long term management of the NHS. In this respect it is a 'prescription' to the following 'diagnoses':

> (lacks) direction and dynamic (Griffiths report 1983:2).
>
> (does not contain) a driving force seeking and accepting direct responsibility for developing management plans, securing their implementation and monitoring actual achievement (Griffiths Report 1983:12)
> is extremely difficult to achieve change (Griffiths Report 1983:12).

That these criticisms of the inquiry team correspond closely to the findings of empirical studies into managerial behaviour in the NHS, only reinforces the appropriateness of the diagnosis and the culture change required to make the prescription work. It is necessary to elaborate further.

As a result of a survey of empirical work concerned with managerial behaviour in the NHS, Harrison used the label of 'reactiveness' to sum up the traditional approach to management in the NHS. By this description he meant that:

> managerial behaviour was problem driven rather than objective driven, in character (Harrison 1988b:31).

Support for this conclusion of Harrison comes from studies into the planning function within the managerial process of the NHS such as those of Barnard et al (1980) and Hunter (1980). Other support comes from studies concerned with the activity of chief officers. For example, Stewart et al (1980) studied the behaviour of District Administrators and concluded that most of their working days comprised of re-acting to issues and problems brought to them, as opposed to the pro-active activity of objective setting and strategy formulating. Haywood's (1979) study of management team agenda items indicated a similar orientation and led the authors to describe the role of chief officers as 'directors of process'. More recently, Harrison concluded after studying seventy-two Service managers that:

> their actions are stimulated by 'problems' rather than aimed at the pursuit of objectives (Harrison 1986:7).

Harrison's approach to studying the reactive nature of managerial behaviour is very useful for the purposes of this investigation for two reasons. First, it provides a summary of existing NHS research and is a useful reference map through the NHS management literature. Second and more important is the conclusion that he offers. He argues that between 1948 and 1982:

> ..the pre-Griffiths NHS manager both was, and was supposed to be, a diplomat rather than a manager of the kind portrayed in textbooks. He or she was concerned not to procure major change in the shape of health services, but rather to minimise internal conflict and to facilitate the work of health care professionals (Harrison 1988b:30).

Significantly, within the District Health Authority being studied, former Unit administrators and current managers from an administration background confirmed Harrison's argument. Several former administrators described their previous roles with an emphasis on being

a "catalyst", "arbitrator", "facilitator" or "Co-ordinator". A former Unit Administrator, who is currently a Unit General Manager, confirmed that a pro-activity was never explicitly required of administrators:

> before Griffiths the NHS did not manage full stop we administered which is different. As administrators we were never on top of the organization in the sense of leadership. Management structures always said it was consensus, we were sharing and we were only ever asked to co-ordinate.

Further evidence of the official culture in pre-Griffiths times is provided by reference to official documents. For example, the management ethos of the "Grey Book" and "Patients First" was that of a facilitator role. In 1979 it was stated that:

> We consider that the Chief Administrator in a hospital should be clearly responsible for co-ordinating all services in a institution. This means that staff who are part of a functional hierarchy in hospital, while remaining professionally answerable

> for their services, should be responsible to the administrator in charge for their day-to-day work (DHSS Patients First 1979:319).

Clearly, the official structuring of relationships has ensured that the power relationship between administrators and the clinical groups has been such that the "system" provided little scope for anything more than a facilitator role for administration. This was recognised by former administrators and professionals. One senior medical consultant with many years' experience of district committee work remarked that:

> I think my experience of the general standard of administration within the NHS was that it was locked into a system whereby however good the administrators were, the system would defeat them. They did not have the power to make the decisions and they spent little time in executive situations and all their time facilitating and discussing.

This is where Griffiths departs from traditional assumptions about the role of the manager in the NHS.

The Griffiths emphasis on the need for management as opposed to administration embodies a challenge to the traditional pattern of relationships and managerial activity within the Health Service. As one Unit General Manager from a medical background remarked:

> Administration was responsive, not leading. Perhaps that is the major difference in the management change that has taken place. One looks to see whether general management can take the lead and start offering some direction and initiative.

Whether this new managerial style develops will depend on many things. The officially dominant status of the Unit General Manager within the official structure is likely to be a symbolic and material resource to be used by managers in adopting a more pro-active managerial style. However, whether it is used will depend largely on the perception which the managers themselves have of their role. A differing perception is required of managers by Griffiths to that which has been officially fostered when many of them were administrators of the Service. The request for pro-activity and not re-activity from managers is a major culture change.

Dimension Five - The Nature of Human Relationships.

The assumptions dealt with on this dimension are those which underpin the relationships between individuals within the organization. These assumptions inform us about the issues of power, control, conflict and influence within the organization. With regard to control and conflict, the Griffiths Report has implicitly made some significant observations and recommendations.

As noted earlier in the discussion, the need for explicit leadership of the managerial process of the NHS has traditionally been rejected. It has been rejected in favour of a consensus approach to decision-making and functional management structures.

The functional management structures have been based on a belief that whilst service co-ordination is needed, one's accountability should be to one's professional peers as opposed to hierarchical (managerial) peers. Professional accountability as distinct from a hierarchical (managerial) accountability has traditionally been taken for granted within the Service and suggestions to change this basis of structuring have been rejected. This is clearly illustrated by 'Patients First', the 1979 Government Consultative paper on re-organization.

The outcome of this official thinking has been an organizational structure which has comprised of a bureaucratic element and a professional element. This has led Harrison to describe the NHS in

the following way:

> organization structures are customarily portrayed in a 'family tree' type of diagram which purports to show a hierarchy of authority flowing from one source (hence unitary) at the top; the proposition that the NHS is pluralistic asserts that the service cannot be represented in such a fashion (Harrison 1988b:36).

It was this 'pluralistic' structure that led the Social Services Committee in their inquiry into the Griffiths Report, to say that the organization of the NHS is one of its unique features.

> The major difference is that the organization of the NHS in management terms does not coincide with its professional organization. A senior consultant may be, in managerial terms, at or below the lowest level of unit management, but still be independent in his use of resources, not accountable to management for his clinical decisions and earning more than the Secretary of State' (Social Services Committee 1984:viii).

Previous re-organizations have only served to create in the first place and subsequently perpetuate the pluralistic structure. The

functionalism trend became formalised through reports such as Salmon (1966), which introduced a hierarchical structure for nursing staff. This trend was further officially entrenched in functions such as Personnel, Supplies, Building and through the 1974 re-organization which provided management hierarchies for professions allied to medicine such as Physiotherapy, Occupational Therapy, Speech Therapy and Dentistry. As a consequence, health care has been administered through a partnership of professional and administrative representatives, as opposed to being managed through a single line management structure. This professional/bureaucratic partnership has been central to NHS management initiatives from Bradbeer up to the 1979 re-organization. The latter created the 'Unit' level of management but on the basis that Unit management was to be performed by a unit administrator acting as a co-ordinator alongside representatives of the nursing and medical professions.

This pluralistic structuring has led several theorists Harrison (1988b) and Thompson (1986), to argue that within the NHS, issues of influence and control have been ambiguous in the sense that the official structuring of relationships has not provided a clear picture of what really happens.

Whilst confirming the Griffiths criticism of a lack of accountability for decision-making, Klein indicated this ambiguity:

> ..clinicians are free to determine whom they

> select for treatment and how they treat them...the hierarchical model of decision-making ..is an inadequate account of what actually happens..there is a mismatch between the distributions of nominal authority and effective power. The hierarchical distribution of authority implies a top-down view of decision-taking, while the diffused distribution of power implies a bottom up interpretation. Given the degree of autonomy enjoyed by those working in the NHS, it is those engaged in the delivery of health care who have the power to determine what actually happens. To the extent that the medical model of accountability to one's peers as opposed to one's hierarchical superior applies to the NHS as a whole ..it is inevitable that decision-making power is diffused and that the search for specific individuals or groups who take the decisions becomes a baffling hunt for the snark (Klein 1985:15).

Harrison believes that the practical effect of this has been to ensure that managerial personnel have not been the most influential people within the hospital. Rather doctors have been the most influential actors. he cites other research to supported the argument. For example, Kogan (1978) Rathwell (1978) and Linstead (1984) have all

indicated the power of veto which medical consultants have used to protect and further their interests in particular situations. Interestingly, the following comment of a consultant in one of the Units supports these arguments.

> every consultant is a baton-wielding general, he can spike the plans for a whole unit.

Other writers have noted this albeit in less colourful language. Champagne et al viewed that:

> Hospitals are professional bureaucracies, that is organizations were most of the influence lies with the professionals who actually deliver the services rather than with management (Champagne et al 1987:77).

Hence, concerning the issue of control, functional management structures have ensured that it has been exercised through a professional hierarchy as opposed to a general administrative hierarchy. Bourn and Ezzamel described it as 'clan control'. They hypothesized that due to the notion of clinical freedom, management and control in the NHS has been exercised through clan form. They perceive clinical freedom in the following way:

> ..the vehicle for attaining medical care. It has

> two main elements: freedom of medical practices and caring, trust based relationships between clinicians and their patients. These elements are harmonised and controlled essentially through self-regulation by the medical profession as reflected in the ethos and professional training of its members, rather than by hierarchical systems of financial control and accountability (Bourn and Ezzamel 1986:213).

Similarly, Thompson has argued that:

> In the NHS it has long been recognised that the clinicians i.e the general medical practitioners and the hospital consultants - occupy a major place in the managerial process by virtue of their predominant influence over the use of resources. Yet as a body they are not hierarchically organised nor do they integrate hierarchically with other components of the organization. Their characteristic form of organization is collegiate, in which representatives are elected to speak and negotiate on behalf of their colleagues...the ambiguity implied by this measure [clinical autonomy] of professional independence within a managerial hierarchy was not resolved

> when structural re-organizations were implemented in 1974 and again in 1982. Doctors were explicitly seen to take part in the managerial process, yet could not clearly be held accountable for their clinical judgments even when there were managerial consequences (Thompson 1983:214).

By explicitly introducing the leadership concept, Griffiths has challenged the traditional basis for structuring relationships in the NHS. The need for a General Manager was summed up in the following way:

> At no level is the general management role clearly being performed by an identifiable individual. In short, if Florence Nightingale were carrying her lamp through the corridors of the NHS to-day, she would almost certainly be looking for the people in charge (Griffiths Report, 1983:12).

Symbolic of the cultural challenge to the traditional basis of structuring relationships within the Service is the language contained within the Report. Throughout the Griffiths Report there are references to a need for leadership, control of performance, executive authority, and the involvement of clinicians. Further, initiatives such as, extending the accountability review, developing management

budgets are all aimed at identifying specific areas to locate managerial control and power in the hands of identifiable individuals.

Indeed, the spirit of the Griffiths Report is one of managerial responsibility and accountability. That is, giving responsibility to individuals, whilst making them managerial accountable. In this respect Griffiths embodies the principles contained within Peters and Waterman (1982) tight/loose scheme. This is indicated by the remark that:

> By general management we mean the responsibility drawn together in one person, at different levels of the organization, for planning, implementation and control of performance (Griffiths Report 1983:11).

The view that general management challenges the traditions of NHS management is shared by other writers. Dimmock remarked that:

> In organizational terms the NHS is a professional bureaucracy ..the introduction of general managers into the NHS is very significant. Methods that require one person to make decisions affecting the interests of many professional groups strike at the roots of a professional bureaucracy. They challenge the hard won

tradition that decisions should be agreed between professions (Dimmock 1985a:28).

The introduction of a single managerial structure places a new emphasis upon issues of trust and conflict within the managerial process. As the Bourn and Ezzamel quote earlier indicates, the basis of trust has rested in professional backgrounds. By reducing the need for functional management structures the basis of trust is being shifted to the managerial relationship from the professional relationship. The recommendation that functional management structures be reviewed and reduced is a major cultural challenge. It challenges the firmly entrenched assumption that individuals should only be managed within the professional control structure. In a traditional professional bureaucracy such as the NHS, this is a major challenge to the traditional basis of relationships between individuals and groups.

Through these changes, it is the view of the researcher that implicitly Griffiths makes some very significant statements concerning the management of conflict. The official view has traditionally been that conflict is a thing to be avoided, and if present, resolved by the consensus approach to decision-making. As such, agreement has been the pre-requisite of action. In a general management system, it is implied that consensus agreement is not an essential pre-requisite for managerial action. By acknowledging the 'power of veto' by one individual or group of individuals, the general management process

recognises the presence of conflict within the managerial process and makes recommendations about the management of conflict. The ability of a General Manager to resolve conflict without it automatically watering down or preventing the final decision is a change informed by a belief in clear leadership and one which has major implications for the culture and structure of the NHS.

Other theorists believe that the role of conflict and the approach to managing it are undergoing major change as a result of the Griffiths Report. Day and Klein remarked in an article in the British Medical Journal that general management represents a:

> ... move from a system that is based on the mobilisation of consent to one based on the management of conflict - from one that has conceded the right of groups to veto change to one that gives the managers the right to override objections (Day and Klein 1983:1813).

In concluding this part of the discussion, the arguments in each dimension make up the researcher's case for believing that the NHS management inquiry is an attempt to introduce a new model of management into the NHS. This model is based on a different set of cultural assumptions to those which have previously underpinned the official culture within the Service. Figure 5.1 indicates some of the old and the new assumptions.

The structural changes recommended by Griffiths are intended to facilitate the development of this new official culture. However, recalling the argument expressed in chapter three, that unless the values and assumptions underpinning the philosophy of change are perceived as legitimate by organizational actors, the intervention is unlikely to be effective. This means that the structural changes can only be viewed as the means for the change attempt, not the ends of the change attempt. Structural changes alone are not sufficient to achieve managerial effectiveness. Rather, cultural change which is informing, accompanying and re-inforcing the structural change is needed. An indication of the difficulty which may be experienced in attempting to achieve this cultural change at Unit level is provided by the reactions of professional bodies at national level to the recommendations. These reactions show conflict between some of the cultural assumptions informing the Griffiths recommendations and those held by professional groups.

They also provide a flavour of the cultural plurality and conflict of cultures which exists in the NHS. This cultural plurality is significant to note because it indicates the potential for conflict between individuals and groups at the Unit level of management. Given the argument presented in chapter three, that there is a need for key actors to perceive the change as legitimate, it is reasonable to argue that should this potential for conflict materialise at Unit level, it is going to significantly impact upon attempts to attain managerial effectiveness and introduce organizational change. As the Social

Services Committee remarked:

> The report can only be successfully implemented if the detailed provisions of any scheme of implementation command the same general assent (Social Services Committee 1984:vii).

The potential for conflict is indicated by the dissatisfaction expressed about specific recommendations of the Report by some representative bodies. The basis of the discontent appears to be rooted in the perception that Griffiths is challenging professional interests. For example, the Royal College of Nursing (RCN) (1986a,b) mounted a national campaign in protest against the recommended replacement of functional management structures by general management structures. They have perceived this as an attack on the status and professionalism of nurses. At the heart of the RCN's objections has been a concern about the possible impact that a Unit General Manager may have upon the relationship between the senior member of the nursing management hierarchy, the Director of Nursing Services (DNS) and other nursing officers. They have perceived that if this relationship is altered, then a lay person, for example the UGM, may have a voice in professional standards and this could adversely affect professional control of standards. The separation of professional and managerial responsibilities has been perceived as a threat to professional interests. Self-regulation, a much valued and taken for granted assumption of the clinical professional culture has been

perceived as being challenged. This is demonstrated by several comments in a document designed to present the RCN's concerns, entitled "Feeling Better : Getting Better" - 'why the nursing voice must be heard'. In the document it was remarked that:

> What we object to is the exclusion of nurses from any management decisions. Nurses are being given no say in deciding health policy. They are even being given no say in how nursing is being run. We accept that a professional administrator can run a hospital. But we passionately believe that only nurses can run nursing...nurses have felt the chill wind of Griffiths. It has taken us from a prestigious, influential position in the Health Service...to the other extreme. It has rocked the self-confidence of a profession which is only just beginning to find its feet. And it will take a while for us to again be sure of the ground we stand on (RCN 1986a:8).

In the same document, an indication of the perceived gap in beliefs between the 'carers' and 'non carers' (a distinction discussed earlier in dimension three) was provided. The RCN's belief in individual patient care, and what they perceive as the conflicting beliefs between their culture and the new managerial culture is clearly revealed by the following remark:

> ..the Griffiths crisis is the spark that has set the professional light...general managers are being appointed..in itself this is not necessarily a bad thing, but what we are seeing in many parts of the country is a naive assumption on the part of these people that they know best. They seem to be saying that management skills can sort out all the Health Services' problems. Skills combined of course with a dose of common sense. It's the sort of common sense that says .....that if a 30 bedded old people's ward appears to be surviving with two untrained auxiliaries, a student nurse, then that's the level of staffing we should go for...the sort of common sense that says if people in their own homes wash out bandages ready for re-use why can't nurses ..that says if a woman in Esher can be in and out of hospital in 24 hours after having a baby, why can't every woman....we say common sense is not enough. It takes professional skills and knowledge built up after years of training and practical experience to understand the needs of people when they are sick or dependent (RCN 1986a:4).

These remarks indicate that there is conflict in the minds of

professionals because professional knowledge and expertise is perceived by them as becoming secondary to managerial beliefs. As a consequence, the RCN have attempted to de-legitimise managerial concerns by ridiculing the 'common-sense' notions which these economic concerns are seen to be built upon. Thus, it provides a clear example of one group's interests clashing with another's interests, with the outcome being that one group attempts to de-legitimise the interests and beliefs of the other group. From an investigative angle, it is evident that some of the RCN's beliefs have been relegated to subcultural status, and by launching this response the RCN are acting contraculturally. That is, they are using a set of variant (subcultural) assumptions, in a contra-cultural way. It is contracultural because they are attempting to undermine the new official culture in defence of the own culture and pursuit of their own interests.

The feeling that general management is an attack on professional interests is not confined to the RCN. The Association of Nurse Administrators (ANA) and the Royal College of Midwives (RCM) have expressed similar worries.

Another source of discontent is evident from the reactions of professional bodies to the possibility of clinical services being directly managed within the Unit as opposed to at District Health Authority level. The bodies representing Chiropodists, Psychologists, Physiotherapists, Health Visitors and the Works function have all

expressed discontent at the possibility that these services may not be managed at District level by a manager with the same clinical background. Again the belief that only professionals should control the levels and standards of service is at the heart of the concern.

Traditionally, the official culture has supported this belief. Prior to general management, services provided by the professions allied to medicine, for example, Chiropody, and Physiotherapy have been delivered in the Units but have been managed at District level by a manager from that clinical background. As a consequence of developing managerial responsibility to Unit level, there is a possibility that services are likely to be no longer managerially co-ordinated by a clinical manager at District level. Rather, they may be managed separately within each Unit, according to the wishes of each Unit's management, with purely professional advice from District level concerning the professional standards required. Hence, it has been perceived that self-regulation is being threatened by the devolving of responsibility to Units.

A third example of a dissentful reaction to the Griffiths Report is provided by the reaction of the British Medical Association (BMA). It has perceived that the Griffiths Report is an attack on clinical freedom. The BMA used the belief in the interests of the individual patient to express a concern with arrangements which offer the possibility of control by and accountability to managers. The BMA clearly perceive that at Unit level in particular, the introduction of

general management is a recipe for conflict. Their views led to the Social Services Committee to remark that:

> Such a manager from whatever professional background would be as close as any manager to the day to day issues directly affecting the care of individual patients and therefore impinging on the way individual clinicians work. All the most sensitive possibilities raised in evidence - a restriction on tests or x-rays, a limitation of the time allowed for post-operative recovery, the change of use or closure of a ward - would have to be implemented, if not always decided at unit level. A general manager would need an ideal working relationship with doctors, nurses and all the other professions and skills involved. The potential for conflict at unit level is greater than at any other..(Social Services Committee 1984:xxix).

As well as perceiving that the introduction of general management is an attack on professional interests, members of the medical profession have seen it as benefitting the interests of other groups. For example, Dr Horner at a medical conference remarked that the medical profession:

> is being taken apart by the administrators and treasurers (who) are gleeful about it....there is no doubt that administrators believe that they have entered the promised land (Horner 1984:262).

Additionally, Anonymous viewed that administrators:

> aided perhaps by Health Authorities, are high jacking the managerial reforms before the health professionals can get their act together (Anonymous 1984:1331).

These comments are significant to note because they re-inforce the perception of mutual mistrust which the researcher has argued characterises much interaction between groups in the NHS.

Indeed, in a statement of support for general management, Tom Evans at a conference organised by the Chartered Institute of Public Finance and Accountancy (CIPFA) and the Association of Health Services Treasurers (AHST) noted the diversity of response to Griffiths and used this to support his argument that:

> the NHS (needs) to put a coherent and positive response to the Minister around the themes that the Griffiths Report has identified...if we are to put forward a serious response which is coherent

> and positive, we must stop immediately, the kind of inter professional strife which has already shown up in discussions following Griffiths. Indeed, there could be no more adequate demonstration of the validity of the Griffiths critique, which is essentially that when faced with problems the NHS responds in its professional colours rather than as management. There can be no more convincing validation of that than the way we have already responded to Griffiths. We have retreated largely into professional camps and have allowed ourselves to be caught out arguing the primacy of each profession's claims rather than the managerial wisdom of the proposals (Evans 1983:4).

The significance of this comment is that it is a public recognition that the cultural pluralism within the NHS has led to a diverse and opposing reception for the Griffiths Report and its recommendations.

In concluding, from the preceding discussion of the recommendations and reactions to the Report, it is evident that the present researcher perceives that Griffiths challenges some of the cultural assumptions of professional groups within the Service. The researcher is not alone in this view. Harrison (1988b) listed several developments which he believes challenge the professional status and interests.

For example, he argues that the creation of the general manager to counter the professionals ability to veto management decisions is seen as an attack on the authority of the medical profession. Further, performance information and measurement attempts currently being attempted in the NHS may be regarded as a challenge.

> Systems of management budgets could, if managers choose ... be used as a vehicle for imposing management priorities on clinicians and for controlling the costs of each type of case (Harrison 1988b:72).

Additionally, Grimes and Allen perceive it as an attack on professionalism and a re-organization that:

> ..is instinctively more attractive to administrators than to their professional colleagues (Grimes and Allen 1985:1367).

Indeed they predict conflict by the remark that:

> A major headache that they (General Managers) face, and one that will test the nerve and capabilities of every general manager, is how to bring clinicians into a management system that among other things seems destined - if not

> designed - to lessen doctors traditional power and influence (Grimes and Allen:1985:1368).

Therefore having provided an indication of what the official culture may look like and some of the potential culture conflicts, it is necessary to examine how general management has actually been interpreted and implemented in the Units of management. By doing so, the issues of managerial effectiveness and organizational change can be further explored. The remainder of the research report is given to doing this within the conceptual and theoretical apparatus developed in earlier chapters.

Figure 5.1 The Griffiths Report: A Cultural Perspective

Dimensions	Official Assumptions Pre-Griffiths Report	Official Assumptions Post Griffiths Report
Organization's relationship to its environment	Social	Social/Economic
Nature of reality	Social Subjective	Physical
Nature of human nature	Altruistic	Instrumental
Nature of human activity	Re-active	Pro-active
Nature of human relationships	Functional	Line

Official arrangements and managerial effectiveness in the Units of management of the District Health Authority

Having developed the theoretical framework of the investigation and discussed the cultural implications of the Griffiths Report, it is now necessary to analyse the actual implementation of the Griffiths recommendations at the Unit level of management. Chapters six, seven and eight each comprise of one case study, each of these detailing the implementation of the Griffiths recommendations in the Units of the District Health Authority (DHA). Within each case, two particular issues are addressed by the researcher. First, the official culture and structure of each Unit is analysed in order to gain an indication of the extent to which the cultural assumptions of the Griffiths Report, as discussed in the previous chapter, are informing the official arrangements of the organization. Second, through the observation of cultural and micropolitical processes operating in the Units, the relationship between the official and unofficial dimensions of the organization, as identified in chapter four, is discussed. Through this relationship, the Unit is described in relation to the types of organization culture which were also identified in chapter four. This provides us with an indication of whether the necessary conditions for achieving managerial effectiveness, exist in the Units.

CHAPTER SIX

KINGSTOWN HOSPITAL

In terms of the conceptual framework introduced in chapter four and the discussion of the Griffiths Report in the preceding chapter, it is reasonable to argue that in this hospital the official culture and structure embody some of the cultural assumptions and values contained within the Griffiths Report. Through the official arrangements, the Unit General Manager (UGM) and the Managerial Core Group (MCG) are attempting to establish the general management culture as official and dominant throughout the organization. At the heart of the official culture and structure are the beliefs in managerial accountability and cost-effectiveness.

With regard to managerial effectiveness, evidence indicates that the behaviour of individuals occurs largely within the official structural arrangements. Cultural and micropolitical processes observed to be operating within Kingstown Hospital resemble those which underlie the 'imperialism' type of organizational culture. That is, there is a strong official culture embodied within and re-inforced by the official structural arrangements, whilst in relation to these, unofficial arrangements are weak. There is some evidence of sub-cultural and contra-cultural behaviour. However, this does not significantly impinge upon the effective management of the hospital. Hence, the official culture and structure being espoused by senior

management is perceived as being increasingly influential and powerful throughout the hospital. This includes at those levels of the hospital at which care is delivered to patients. Evidence indicates that beliefs which are at the heart of the general management culture, such as cost-effectiveness, are increasingly impacting upon professional practice and behaviour. Therefore, this suggests that senior management, led by the Unit General Manager (UGM), are beginning to "pull the organization together and along" in the direction which they feel is appropriate.

In order to fully appreciate the content of the new official culture, the context of its development and the interaction with unofficial dimensions, it is necessary to elaborate on observations which have led the researcher to make the above statements about the introduction of general management in Kingstown Hospital. The forthcoming analysis is an account of identified cultural patterns and behaviour at official and unofficial levels of the organization.

As a management entity, the Unit comprises of a main hospital and several small health care locations. The hospital dates back to the 1700's and has a history as an institution of medical excellence. A former employee involved in the management of the hospital in its heyday recalled that:

> Kingstown was a superb large old hospital with the accident and emergency department. It was

> where it all happened, the nearest thing to soap opera stuff. It was a great place to work and you would get caught up in it...the whole place created loyalty.

The use of a cultural perspective in this investigation, means that the history of the hospital is of major significance. Reminders of its history emerge from its physical appearance, interior design and location. At the main entrance, a plaque commemorates the opening of the hospital and a large sign issues the order of 'Hospital - Quiet Please'. The fascination of this latter symbol is the caring ethos that it signals to the outside world. It is symbolic of the amount of change that the image of hospital life has undergone, in that it is a reminder of the old-fashioned image of hospitals as being tranquil and orderly places immediately distinguishable from the hustle and bustle of normal everyday life and of typical modern organizations. This image is in stark contrast to the levels of activity and the appearance of large acute general hospitals such as the Municipal Hospital, described in chapter eight, which, more typically, one encounters in the 1980's. In current times, demands for quiet at the main entrance of a hospital would appear both unrealistic and old fashioned.

Also, the disused reception desk is a symbol of the demise of the hospital in terms of the range and volume of medical services provided. Perhaps, the most interesting reminder of the past comes

when one's journey through the hospital is guided by surnames. This is a consequence of all the wards being named after prominent medical professionals who have practiced on the site and helped to establish the medical excellence of the site and District as a whole.

Many argue that history is all the hospital has in its favour. In recent times, the hospital has undergone a lot of changes as much of its previous role has been taken over by Kingstown Municipal Hospital. Currently, the hospital provides only services for the mentally handicapped and elderly sections of the population. The budget of approximately £11 million and the number of beds (approximately 430) ensure that it is now the smallest Unit within the District Health Authority (DHA).

Its recent history has been marked by the threat of total closure and its long term future looks bleak. Subsequent to the period covered by the present researcher, the acute specialty services were being re-located to the other acute units of the DHA and this movement is to continue. Immediately prior to the introduction of general management, evidence indicates that the Unit had lost its strategic direction. Evidence of cultural and micropolitical processes from that time indicate that the Unit resembled the 'anomie' type of organizational culture identified earlier. Management was divided between the three main interest groups: medical; nursing and administration. There was a lack of shared outlook and strategic direction from senior management level. Thus, the official culture

and structure throughout the hospital was weak in terms of guiding thoughts and behaviour. The hospital was functioning in terms of the delivery of care but there was an increasing aimlessness developing at the strategic level of the Unit. Therefore, rather than a shared official culture, the hospital functioned through the practice of clinical sub-cultures. Indeed, it is possible to conceive that the hospital may have been experiencing micropolitical and cultural processes associated with 'informal empire'. Certainly, the cultural weakness of senior management facilitated this. However, it more resembled 'anomie' because cultural unity at care delivery level was also weakened by factors such as professional divisions, and the threatened closure of the hospital. The weakness at strategic levels did not encourage the development of an 'informal empire' or even 'Coup d'etat' type of organizational culture. Rather, the Unit stagnated strategically and clinical professionals practiced without strategic ambitions. Many perceived that strategic power and influence were not worth fighting for as they had no future at the hospital anyway. Many clinical professionals from the medical, nursing and paramedical professions still hold this pessimistic outlook. An indication of professionals' attitudes and perceptions about being part of the hospital are provided by the following remarks. One Consultant remarked that:

> The hospital is half-closed. The major services it supports will soon move and it's not got the loyalty of staff. We are isolated here and we

are in a declining hospital.

The above remark is an indication of how clinical professionals' morale has suffered, largely as a consequence of the demise of the hospital. The feeling and collective spirit amongst clinical professionals varies greatly and much of that traditional professional loyalty has been lost. One current manager noted that:

> Many of the medical fraternity do not want to be here. The hospital is no longer synonymous with medical expertise or good contacts. They would prefer to be on one of the big general hospital sites and rub shoulders with their clinical colleagues. The nursing staff are often struggling and would benefit from the support and flexibility of manpower afforded by a bigger hospital.

These perceptions are important to note because this cultural weakness at care delivery levels has appeared to facilitate the attempts of the Unit General Manager to introduce a managerial ideology as the official and dominant ideology throughout the Unit. This is because there appears to not be the strength of opposition presented by existing professional groups to resist the cultural and structural changes which the UGM has introduced and which senior managers are transmitting. Many of these changes have challenged and undermined

previously taken for granted assumptions of professionals. If the processes associated with an 'informal empire' state were observed, this would have indicated that clinical professionals at care delivery levels were effectively resisting the new official arrangements. However, such processes are not evident because this has not happened and the introduction of general management has been underpinned by assumptions which underpin the Griffiths recommendations.

Unlike in the Kingstown Royal Infirmary, described in chapter seven, where a conservative approach to change has been adopted in order to preserve the existing culture and the dominance of the professional clinical ideology, the UGM has relished the opportunity which general management has provided to introduce major change. The UGM summed up the philosophy towards change by the remark that:

> The culture of general management implies the active simulation of change and the anticipating not responding to problems. I do not think in the past the Administrators thought how they could use the culture and attitudes to develop strategy. They just made decisions and never really thought about implementation and how to get from where they are to where they wanted to go. I have attempted to change the culture of my organization quite radically from an

administrative model to a managerial model.

The perception of the UGM having increased power vis-a-vis the Unit Administrator in pre-Griffiths times, accompanied by particular contingent factors of the Unit such as the small size of the Unit, the small number of senior medical staff with full-time commitments and the lack of cultural strength amongst professional clinical groups within the hospital prior to general management, have ensured that the existing culture has not proved to be a major barrier to change. Indeed, the aimlessness which had developed within the hospital has facilitated the imposition of a new official managerial ideology underpinned by values of cost-effectiveness, managerial accountability and individual responsibility.

Illustrations of how the UGM and the MCG have used existing contingent factors and cultural features are numerous. However, two are particularly interesting in terms of a micropolitical and cultural perspective.

First, the size of the hospital and the small number of powerful medical professionals has clearly reduced the threat of resistance to the grand aim of introducing a whole new management culture into the Unit. A member of the MCG remarked how the dynamics of management are helped through these two factors. The manager claimed that:

The doctors are represented through the Medical

> Advisory Committee (MAC). The UGM takes advice from clinicians through this forum. However, there is minimal tension in this Unit between management and clinical staff partly because there are very few specialties here and the competition for scarce resources is not so great. Unlike in the larger Units were the numbers are great and the stakes higher, we have not suffered from bad relationships with the clinicians. A lot of this is due to the way issues have been handled in the past here, we have always identified the key actors in the decision-making process and involved them. This has been possible largely due to the small numbers.

Indeed, because the Unit is managerially compact with only a small number of full-time practicing medical professionals based on the site, the UGM has personally dealt with the demands of members of the medical profession. As one member of the MCG remarked:

> ..the link with the medics is something the UGM deals with outside of the Core Group.

Clearly, the small number of medical staff allow this possibility but it is significant because it is indicative of the pro-active leadership style of the UGM as well as a political awareness of the

impact which the medical profession can have on a culture change initiative. This approach is an example of a manager acting politically and trying to manage conflict. It has been necessary to appease some members of the medical profession who initially resented the introduction of the line management structure which the UGM has introduced into the Unit. They perceived the concept of managerial accountability to challenge their right of clinical autonomy in decision-making and their premier status within the hospital. Indeed, their behaviour was contra-cultural when they refused to be managerially accountable to any person other than the UGM. As one senior manager recalled:

> If they had to be managerially accountable to anybody, it was the UGM.

The persistence of contra-cultural activity as a response to this change has seemingly been averted by this personal contact between the UGM and medical staff. As one Consultant remarked:

> My impression is that the UGM does consult medical staff. I find him very approachable and he does take things on board in a very constructive way. Certainly one gets this impression from the MEC.

Hence, there is evidence that the medical profession are largely operating within official arrangements whilst perceiving themselves to

be preserving the things they value most - their clinical independence and prime status. Indeed, the management of the issue of managerial accountability by the UGM, has been such that their behaviour could now be regarded as sub-cultural as opposed to contra cultural. That is, it is not undermining official arrangements.

Second, a particularly interesting feature of the introduction of general management is the manner by which the UGM has tried to exploit features of the hospital's history and culture in order to strengthen and legitimise official arrangements. The following remark by the UGM is evidence of this:

> The history of the hospital is something that can be worked in your favour as a General Manager. This hospital has a long standing 200 year old reputation for high quality care and you can play on this to keep standards up. Whereas if I had moved into somewhere where the standards were low, you actually have to talk about striving for excellence rather than returning or maintaining excellence.

This emphasis on past professional excellence is indicative of the strategy of change which essentially marries a new managerial ideology to the central belief of professionals - quality individual patient care. The whole approach of General Management was summed up

in the following statement of a manager:

> A new management culture has been superimposed on good existing practice and care. The assumption has been that care is good at grass roots and the intention is too improve the management side. At management level, the hospital has been radically changed through new ideas associated with general management and local issues.

The key values of this new management culture are cost-effectiveness and individual accountability. These are both contained on the public statement of espoused values and identified objectives (appendix F). This is one of the most symbolic of all current artifacts reflecting the new official culture. Its ideological significance is noted through its publication and transmission of its content through structural channels such as staff seminars, newsletters and the organizational chart. A member of the MCG remarked that:

> through the document and things such as 'unitline' (a unit newsletter) we have clarified the role of the Unit and that has helped people to understand what the Unit is for and what it is doing.

The statement of corporate objectives allow senior management to espouse the official way of thinking within the Unit. It is a symbol

of the high profile leadership style of the UGM. It is also an outcome of the UGM's diagnosis of the Unit which was inherited as a management entity. Remarking upon the contents of the statement, the UGM noted that:

> All of these things were not here when I came. These core values were certainly not written or known as such. However, to what extent we were achieving them is a difficult question to answer. I would say we were achieving some of them - perhaps on the quality of care side but very little else.

The process by which the MCG took two days 'time-out' to agree a shared set of corporate values and objectives is perceived by managers involved as a significant event in the managerial development of the Unit. By this process, the nature and extent of change required was identified and communicated amongst key individuals. It is now perceived as a milestone in the process of developing group strength and a shared commitment to the introduction of general management within the Unit.

The process of 'time-out' and the production of a formal statement of values is an interesting phenomenon when compared, for example, with the management style and processes in the Royal Infirmary. In the Royal Infirmary, there has been no perceived need for a publicised

agreement and public statement of the values and objectives of the Unit. Rather, it has been taken for granted that everybody works for patient care and that is the key value. It appears to the researcher that the need for the process to occur within the Kingstown Hospital is a recognition on the part of the UGM that there was an aimlessness about the strategic direction of the Unit symbolised by a lack of leadership and agreement amongst senior management about the way forward.

The document represents an attempt by management to re-state the values and objectives of the Unit in order to re-build some of the past beliefs and values and form a basis for the future. Its ideological function is to provide management at all levels with a sense of purpose and direction. The document reflects many of the cultural assumptions of the Griffiths Report and challenges some of the cultural assumptions traditionally taken for granted by professional groups. For example, the identified values of communication and staff development are intended to attract attention to fact that the hospital is a multi-disciplinary forum. The emphasis on communication is an attempt to breakdown communication barriers (described in dimensions three and five of chapter five) which have developed through functional management. The need for management to demonstrate "visibility" and "openness" is an espoused value of the MCG intended to begin to break down the "us" and "them" distinction between managers and staff. As one manager reported:

> Although I am an administrator by background, part of my responsibility is the Out-Patients department. I go in there daily and see patients. Our Financial Director is also Site Services Manager. There is no doubt that we are getting involved much more and we are far nearer to the patient than in the past.

These values and cultural assumptions are embodied in the official structural arrangements. For example, the organizational chart (appendix C), budgetary systems, and structural channels such as staff seminars, the Unit newsletter and public relations exercises.

Within Kingstown hospital, the official culture and structure is based on many of the assumptions contained in the Griffiths Report and as such general management has been implemented in a very radical way. The culture and structure are mutually supportive and emphasize the concept of general management. The developing strength of the official arrangements stems from the interaction at both senior management level and ward level between professional values and managerial values. Cost-effectiveness and economic criteria are being worked together with the ultimate professional value - individual patient care. The belief in the need to provide a cost-effective service is prominent in official thinking. The UGM remarked that:

> Anybody could provide a service by spending loads

> of money. The need is not just to provide a quality service but also a cost-effective one.

This belief has been embodied into structural recommendations such as budgetary responsibility for ward managers. As an MCG member remarked:

> If the ward manager wants a piece of equipment it's no longer just a case of writing a requisition order. They need to specify and cost it and find out where they will get the money from. This requires a fundamental change in their behaviour.

In turn, the application of budgetary considerations to inform decision-making apparently involves the necessity for using 'physical' objective information on the costs and benefits of action. This suggests an official desire to increase the application of 'physical' criteria in the decision-making process.

Another indicator of the similarity between the official culture of the hospital and the Griffiths culture is the acceptance of the concept of the "customer" by the UGM. In chapter four, the researcher noted that this was language that provoked a lot of dissent amongst NHS groups. However the concept of the "customer" is very much a part of the official philosophy of the MCG. This is indicated by the

following remark of the UGM:

> Visitors, relatives, general practitioners, staff and taxpayers along with patients are all customers of this hospital.

The consumerism element of the Griffiths Report is prominent and a shared objective amongst the MCG is labelled 'The Kingstown Hospital Customer Care Initiative'.

The fundamental change in the official culture of the Unit, which reflects the Griffiths assumptions, concerns the structural basis of managerial relationships. The major emphasis is upon introducing a general management culture into the Unit. An analysis of the organizational chart (appendix C) shows that administration and nursing structures have been dismantled in favour of a single managerial structure. This structural change has embodied the Griffiths philosophy to reduce functional management. Simultaneously, it has challenged the traditional cultural assumption that a manager has to be from the same professional background as those being managed. Whilst nurses have been appointed to ward manager positions it has been emphasized that one's skills as a manager come before one's professional background. If this appears to be fudging cultural change, there are a number of examples where a manager is not from the professional background of the staff being supervised. One example is at senior management level. A former Director of Nursing Services

(DNS) is now a service manager and managerially responsible for all aspects of care and staff groupings such as nurses, physiotherapists and occupational therapists.

At ward level, Physiotherapists and Occupational Therapists are managerially accountable to Ward Managers who are from a nursing background. Clearly, the approach is new because the traditional functional management structures of the NHS has ensured that people have managed according to their professional groupings.

It is evident from the management structure (appendix G), that are the Griffiths values of individual accountability and responsibility are forming the basis of official structural arrangements. The UGM labels the thinking informing this structure as "tight/loose" (the terminology of Peters and Waterman, 1982). In explaining that this is the philosophy which is underpinning the official structure, the UGM remarked that:

> I've pushed authority and delegation down and tightened accountability up. I have tried to take the shackles off managers and give them the confidence and authority to manage. It is essential that if you are going to free peoples ability to do things, then you have got to be certain you know exactly what it is they are doing. So you tighten up in terms of what you

> expect of them in terms of objectives but you free them to go away and achieve things. You have to take away the rules, boundaries and shackles that stop them achieving.

The UGM calls this a philosophy of "maximum delegation" and clearly it is one that is complementary to the Griffiths emphasis on clear individual responsibility and accountability. Also, the language contained within the job titles of managers indicates the official desire to replace an administrative ideology and functionally based culture with a managerial ideology and general management culture. "Administration" has been replaced by "management" and managers are titled according to the service for which they are responsible. For example, "services manager elderly" as opposed to a professional group, such as the Director of Nursing Services (DNS).

The emphasis on ward and departmental management (level 3) is also in line with the Griffiths belief that management should be placed as near to the bedside as possible. Indeed, through ward management, a genuine attempt is being made to locate management at service delivery levels. This is a contradiction to those recent trends of nurse management which have taken managerial responsibility away from the point of service delivery (Salmon:1966). The devolving of budgetary responsibilities to ward managers is also indicative of the official belief in the need to be cost-effective in the use of resources and the need for staff in management positions to broaden their

perceptions of the consequences of their professional actions.

Clearly, empirical evidence indicates that the official culture and structure of the Unit reflect the model of management recommended by Griffiths.

It is to the second major question posed at the start of the chapter to which the analysis is now directed. The concern here is the effectiveness of management as indicated by the relationship between the official culture and structure and unofficial culture and structure. At the outset of this description, it was noted that cultural and micropolitical processes observed to be operating in the Unit are those which underpin the 'imperialism' type of organizational culture identified in chapter four. The processes observed indicate that the Unit has changed from being one experiencing the conditions of the 'anomic' type of organizational culture to one experiencing the 'imperialism' conditions.

Two observations in particular show that the official arrangements are strong. First, the MCG, and the UGM form a culturally strong group. At senior management level, the managerial ideology has been legitimised as the dominant ideology of the organization. There is a common purpose and shared way of thinking amongst members of the MCG. The administrative backgrounds of the UGM and all but one of the "level two" managers (see appendix G), has been important in the process of developing shared cultural assumptions at senior management

level. Indeed, only the manager with a clinical background expressed conflict between particular values associated with the managerial ideology and the professional value system. For example, the manager expressed unease about managing other professional groups because as a clinical professional the manager was "happier" with functional management.

The attention which the UGM has given to creating shared values and capturing the "hearts and minds" of all concerned through staff seminars and 'time-out' sessions, appears to have been successful amongst senior management in strengthening the commitment to establishing the managerial ideology as the dominant ideology throughout the Unit. This is significant because it is an example of how the leader of an organization can manage meanings for individuals. As one MCG member remarked:

> I am here to implement the culture of the general management philosophy and particularly the ideas of our General Manager.

It is a perfect example of how one person has developed an ideology with the long-term intention of it developing into a deep-seated culture. The beliefs and values of the Griffiths Report have been legitimised in the mind of the UGM, who in turn has attempted to legitimise them in the minds of senior management and other managers throughout the organization.

The cultural strength amongst senior management is such that the Unit Management Team dynamics have also changed greatly in comparison to the Pre-Griffiths consensus style. The impression given by the dynamics between senior management and the UGM is one which indicates that the UGM is perceived as a strategic figure who steers the organization in terms of the key ideas and concepts of management as well as in its relationship with the District Health Authority (DHA). In turn, the daily functioning of the Unit is devolved to the "level-two" managers. This was partly borne out by an observation made by the researcher when interviewing the UGM. Upon the researcher's questioning about the clear desk of the UGM (which was in stark contrast to the other UGMs' desks in the Units researched) the UGM replied that:

> This is an example of what general management is all about.

On picking up two pieces of paper the UGM continued to say that:

> ..its all open door, not tons of paper, a nice clear desk. It's all much more up front.

To bear out this last remark, the researcher noticed that during our conversation the UGM's office door was wide open!

As such, the UGM is not regarded as part of the team <u>per se</u>. This is

apparent from appendix G which indicates the status of the UGM as level 1. This is in stark contrast to the Royal Infirmary, in which as we will see in chapter seven, the consensus management ethos is still valued and as a consequence the UGM is a recognised member of the team.

Concerning the role of the UGM an MCG member remarked that:

> the UGM is "outside of the team".

Another remarked that:

> The UGM works in a co-operative manner. In the final analysis the UGM has the last word. We are allowed to have our say but there is a cut-off point.

An essential thing to note about the impact of the UGM and senior management upon the Unit is that overt leadership of the Unit is being provided. A key characteristic of Kingstown Hospital is the overt leadership style of the UGM. Whereas in other Units senior management are still perceived by some as an invisible force to many individuals, in the Kingstown Hospital management personnel are identifiable and observable. Through their presence and function, they are constantly spreading the legitimacy of official arrangements. However, this strength at senior management levels alone is not enough

to turn an espoused ideology into a culture. For this to happen, individuals throughout the organization have to perceive the official arrangements as legitimate and use them to inform their behaviour. This brings the discussion to the second source of strength of the official arrangements. That is at "level three" of the organization.

Senior management are in no doubt as to the amount of change which will eventually be achieved, they only question the pace. As one MCG member remarked:

> The first 25% over the culture barrier are the easy ones. We've got the strategy, the structure and we are developing the systems. The next thing is the skills of the people. This will take a long-time because peoples' ability to develop skills is different. The amount of change at the end of the day will be considerable but the pace of change is a difficult one.

Structural change indicates that the managerial ideology has been introduced, but the attitudes and behaviour of "level three" managers is a significant indicator of change. Having stated this, there is evidence to indicate that the managerial ideology is becoming increasingly legitimised and naturalised at this level. Individuals from diverse professional backgrounds have responded positively to managerial responsibility and accountability. For example, one

clinical service department is managed by a nurse whilst another is managed by a doctor who is managerially accountable to the UGM. For many Ward Managers, the legitimacy of the change is indicated by the acceptance of the managerial style and responsibility required. Some ward managers believe that their managerial position complements and reinforces their professional interests. One Ward Manager with many years experience in the Unit claimed that:

> We are pleased with the extra power given to Ward Managers through our own housekeeping team and ward budgets. Basically, this has satisfied the nurse because they are in control.

Another remarked in a similar vein that:

> This style of management is helping us as a profession. We have more control over what we do and we are not just dogs body to the doctors.

Particular values associated with the Griffiths model of management are increasingly being perceived as legitimate and becoming naturalised through budgetary devolution and responsibility to ward level. One Ward Manager claimed that:

> It is a different way of life around here now. It has made me more aware and critical of waste, and

> I'm harder on staff because of it. However, as long as you give them a good explanation, they see the position I'm in and the extra responsibility I now have.

Another manager indicated the perception of senior management's power and authority within the Unit when remarking that:

> We know the brakes will be put on if we overspend.

This comment is particularly interesting as it indicates that a feature of the management process is the perceived ability of senior management to apply sanction and control if necessary or at least offer the threat of a capability to do so. Such credibility of management is what Griffiths is striving for and which the administrative culture could apparently never purvey.

However, to employ these comments as evidence that the managerial ideology is universally legitimised to the extent that contra-cultural behaviour is non-existent, would be misplaced. If this was the case, the organization would be experiencing the fusion of official and unofficial dimensions associated with the type of organizational culture described as 'consensus'. However, this is not the case. Rather, the cultural and micropolitical processes operating in the Unit are nearer to those which underlie 'imperialism'. That is, the official arrangements are interacting with unofficial arrangements

which are contra-cultural. However, these contra-cultural processes operating within the Unit, taken as a collective force upon managerial effectiveness, are not of sufficient strength to undermine the official arrangements. If they were, the organization would be experiencing micropolitical processes associated with the 'informal empire' or 'balkans'.

Evidence of official arrangements not being perceived as legitimate comes from some members of the medical and nursing professions. Members of these two professions have indicated a personal conflict between professional interests and values and those required of them as managers. A typical example of this is provided by a member of the medical profession who refused to accept formal managerial responsibility for a department because it was perceived that managerial requirements would compromise clinical interests. The Consultant recalled that:

> The whole idea of managing is a concept in itself, and people being forced to do every single aspect of the job is being asked here. Now, asking people whose main job is something separate to take on a fairly large load of managerial tasks in order to save money further back, worries me. When I was considering whether to be the manager of my department I was told "you are responsible for the day to day running and use of resources,

> including the health and safety, the secretaries and the cleaners". As a clinical member of staff, I wonder where it all ends. As a clinician, I am trained to deliver a service to patients. Now in a very arrogant way and going back 50 years, I could actually say the hospital facilities should be there to enable me to do this. Having said that, I am asking for an organization that is perfectly run. Now the reverse of that and I see evidence of it occurring here, is that the chap delivering health care is also responsible for the environment and facilities he delivers in. It is asking too much. I reasonably expect as a professional for these to be provided for me.

The above comment is particularly interesting because it indicates the difficulty of attempting to give clinical professionals managerial responsibilities. This is not an untypical response, as in other Units, there is evidence of managerial responsibility not being accepted because many medical staff feel that it is another person's responsibility and not theirs.

Related to the same general conflict between professional and managerial interests, is the issue of the compatibility of economic concerns with the professional belief in individual patient care. One Ward Manager voiced the cultural assumption of the NHS being a unique

organization, providing a unique service, in order to de-legitimise the economic values at the heart of the structural arrangements which have devolved budgetary responsibility to "level three" of the organization. The Ward Manager perceived that senior management have opposite interests to clinical professionals. This was indicated by the following remark:

> Basically, they are looking at resources and I actually think they are trying to just streamline the service. They want to save money. That's a good philosophy, but we are cut to the bone already. From a nursing point of view, we are not dealing with a commodity. We are dealing with a human being. I mean to say, if you have so many people off sick and you are up to your budget, they still need looking after and you must have the manpower to do it. So, regardless of what your budget tells you, you have to pay overtime or take in agency nurses to give the care they are entitled too. So the budget is a nonsense quite frankly. You cannot have both things, you cannot have a high quality of care and a good quality of service and remain within that budget.

This comment is particularly interesting because the Ward Manager continued to indicate that these feelings are transmitted into daily

behaviour. The manager continued, to say that:

> They want to change our outlook on the way we use resources, regardless of whether we think it is right or wrong. From my point of view, if I decide that a person has three bandages on his leg and they cost ten pounds a time, then so be it.

Through this example, the same manager provided a perfect indication of how official arrangements are being manipulated and used to serve contra-cultural unofficial professional interests at the expense of the new official interests. The manager remarked that:

> ..information is still poor and while I do not have the information I will carry on spending as I feel appropriate. While there is no information I cannot function as a manager... It is playing the system but that is what I do.

Another example of professionals using inadequacies in the official budgetary and information procedures was provided by a Doctor who remarked that:

> If you are overspent by January and there will be no money until April, all that can be done is Whoops. What Whoops means is that persons who are

> managers will be censured, and ultimately the criticism would be on the UGM, not the doctors. Closing down wards gets sympathy from other doctors, that is why people write to "The Times".

However, such thoughts appear to be personal as opposed to being widely shared and acted upon by groups. Consequently, contra-cultural arrangements in relation to official arrangements are weak. This cultural weakness stems from the fact that doctors and nurses are not indulging collectively in contra-cultural activity. As such, there is no major resistance to the managerial ideology being transmitted as the dominant and naturalised ideology of the organization. The reasons for this are two-fold. First, as the earlier analysis indicated, the managerial ideology is legitimised in the minds of many, and is perceived as accommodating professional interests and managerial interests successfully. Second, some members of the nursing staff in particular do not feel that they possess the valuable symbolic and material resources to defend what many of them perceive as a conscious attack on their professional culture and strength. For example, recalling the introduction of ward management, which is the crux structural and cultural change below senior management level, one Ward Manager remarked that:

> We did not resist because we were totally sold on what the UGM was doing because we were not. Rather, we were feeling insecure because we may

> find an administrator running the ward. It's only now that we sit back and reflect that we should have rocked the boat a bit more. Its a clever way to bring in change - frighten people.

Another remarked that:

> As individuals we felt unsafe and a bit worried and as a profession we felt vulnerable. Our big panic was that we would not be Ward Sisters anymore. The suggestion was that Ward Managers need not be Sisters and we had visions of administrators coming in and running our wards and we would be glorified staff nurses.

Indeed, several Ward Managers perceive that the weakening of the nursing ideology and their cultural unity is a conscious policy in the Unit and one that is succeeding in the interests of senior management. One Ward Manager claimed that:

> ..the Nursing profession has been divided here. I do not think half of them realise what is happening... we are left with a lot of people accepting it. We have a lot of young nurses as ward managers. Had we had old nurses, there may have been problems.

Another manager indicated a similar feeling on the same issue when claiming that:

> They are making each ward an island. They want the manager to fend for themselves on each ward. There will not be an interchange of ideas. That's what is trying to be created.. managers are now saying things like "Ah that's not my problem, that's not my ward, that's not my area". So it is much more parochial orientated.

The reason believed by some nurses for this alleged official policy was indicated by a Ward Manager who remarked that the single managerial structure will in the long-term promote a managerial outlook as opposed to a nursing outlook. The manager remarked that:

> The whole career structure for nurses has been threatened. It's different at the Royal Infirmary or the Municipal, but if you want to stay here once you get to Ward Manager you are finished till you are 65. They say there is other things which we can do but there is not. There's no middle management left to manage. They say move into general management jobs but that means leaving nursing and we come into nursing to nurse.

One Nurse summed up what she thought was the general response and weakness of the Nurses in the Unit as a cultural group when she claimed that:

> Most people are going along, moaning and groaning about it, but it is a directive and unless you have got enough of you to turn around and say "no", it will just go along.

Another remarked that:

> The reality is that the job has to go on and if some decision has been made which I do not agree with, I'll voice my opinion. However, the style of management we have got at this level is, if it is to be it's to be, and it is no good digging your heels in and saying "I'm not doing it" because at the end of the day they will find somebodyelse. That's the reality.

Seemingly, the only individuals who have felt that they hold sufficient valuable material and symbolic resources to openly resist particular changes are the doctors. Two examples of this have been provided earlier in the analysis. However, one incident in particular sums up the difficulty of managing the medical profession in the Health Service. A medical consultant, who is a key actor in

the incident detailed the conflict between the managerial interests and professional interests.

> There's an interesting decision yet to be taken. It has been going on for 18 months. Management want to re-locate a department here. We are a specialist department, not a general one and so here is not the place. Now the management decision is to be Draconian and say you will accommodate this service and the staff. We've stood out against this and it has not happened. This Unit and the Community Unit have stood together on this one, but it has not happened by virtue of us saying no and I do not think it will happen. I must admit however that the UGM did say to me that "if you were in my position what would you have done" and I had to admit that I'd do the same as he'd done and try to place them here. It was a good neat managerial solution, if you disregard the subtleties and difficulties.

This is a fascinating example of a conflict of interests. It also indicates the confidence and ability of medical staff to protect their own positions against a managerial decision. It is the type of incident a Ward Manager had in mind when concluding that:

> ...the UGM runs the show except when the doctors make a fuss. If the doctors do not want to go along with what the UGM wants, it does not happen. But nurses do not have that sort of power. It's only happened two or three times, but it is evident that when they say "no", they mean "no".

In an acute hospital this incident is perhaps more likely be a common feature of the interaction between medical staff and management. However, in Kingstown hospital it is not common and it is one of the few examples of contra-cultural pressure being effective against the wishes of senior management.

In concluding, the general feeling about the implementation of general management in this Unit has been summed up by a member of the nursing profession when she remarked in referring to the UGM that:

> the UGM is very clever, he has succeeded, he came in to do exactly what he has done. I think the doctors are a bit switched off to it and the only time they think of the UGM is when a problem comes up. You see most of them are elsewhere anyway.

Others have also acknowledged the personal influence and effectiveness of the UGM and senior management whilst adding a sceptical twist to their comments. For example, one senior manager in

another Unit remarked that:

> the UGM would get a lot more opposition in another place,

and similarly, a senior Consultant with many years committee experience within the District and clinical responsibilities in all three Units being analysed in this investigation commented in a critical way that:

> This Unit is small, it does not have a lot of people to object and there is the feeling that "we've only got to bear it for a few years". I don't like the style of management here. I do not think there are terribly major problems to get to grips with and therefore, the UGM's succeeded in doing minor things. I'm perhaps being terribly unfair but I could not see the UGM surviving at the Infirmary or the Municipal.

Such comments are only hypothetical and speculative but they have value because they indicate that the other Units have vastly different cultural and micropolitical status quo's. One major factor in this difference is the influence of the medical profession. In the following two Units which are described, that medical influence is seemingly much greater both officially and unofficially. It is so to

the extent that the clinical professional ideology has greatly shaped the implementation of general management and the conditions in which managerial effectiveness is being strived for. This will be clearly shown by the events in the Kingstown Royal Infirmary and it is to this Unit that the analysis now progresses.

CHAPTER SEVEN

KINGSTOWN ROYAL INFIRMARY

In terms of the conceptual framework described in chapter four and the discussion in chapter five of the Griffiths Report, two significant statements can be made by the researcher about the introduction of general management into this Unit.

First, the official arrangements are a compromise between some professional assumptions and beliefs and some of the assumptions and beliefs which the researcher identified in chapter five as underpinning the Griffiths recommendations. The micropolitical and cultural features in the organization indicate that since the publication of the Griffiths Report there has been an 'official' desire to preserve the medical ideology as dominant within the Unit, whilst responding to pressure from the District Health Authority to establish service priorities in the face of budgetary constraints.

At the time of this research, the Unit is being managed by its second UGM. The change of UGM is a significant factor to note because the researcher believes that it has coincided with a shift in the official culture of the Unit. Previously, the official arrangements developed during the time of the first UGM, reflected the desire of the Unit Management Team (UMT) to preserve the professional medical ideology as the dominant ideology within the Unit and resist Griffiths inspired

changes which were perceived as threatening the medical ideology. During the time of the first UGM to be appointed, structural change occurred seemingly embodying Griffiths style assumptions. However, further analysis indicates that there was an official rejection of particular assumptions contained within the Griffiths Report in favour of preserving as dominant some traditional assumptions associated with the professional/functional approach to management. The outcome of this was an official philosophy of no change and hence an official culture which was dominated by clinical professional beliefs, assumptions and interests.

More recently however, during the regime of the second UGM, though the dominance of medical opinion has continued to be officially preserved, there is evidence which indicates that the official arrangements are being increasingly informed by some of the beliefs and assumptions which have informed the Griffiths recommendations. Currently, the official arrangements contain both beliefs in the Griffiths values of individual managerial responsibility and cost-effectiveness and professional values of clinical autonomy and professional accountability.

Second, evidence indicates that in the last two decades the Unit has experienced cultural and micropolitical conditions akin to the 'consensus' type of organizational culture. During these times, the universal pervasiveness of the organizational culture has resulted from the institutionalisation of the medical ideology - that is the

right, ability and freedom of practitioners to exercise their professional judgments. This observation bears out the argument of Harrison that:

> ..conflict [between managers and professionals] will only occur when and if the two groups are pursuing different objectives. Professionals maybe perceived as technical experts and managers maybe content to assume that professional decisions are the best available (Harrison 1988b:2).

During the time of the first UGM, the introduction of general management was perceived within the Unit as threatening this status quo. Hence, initially there was little evidence of a desire amongst the UMT to introduce the cultural assumptions of the Griffiths Report as the basis for the official arrangements of the Unit. Rather, there was the preference to introduce a general management structure without changing the official culture. This was so because it did not challenge the dominance of the medical ideology in the managerial processes of the Unit.

However, more recently and coinciding with the appointment of a different UGM, there is evidence of a recognition amongst senior management of a need for change in the official culture of the Unit. Furthermore, these changes seemingly reflect more of the Griffiths

assumptions. At the time of this research, these changes are in their infancy, but particular incidents indicate that the cultural and micropolitical status quo of the Unit increasingly resembles that which is akin to the dualism type of organizational culture.

In order to fully appreciate the content of the official culture and structure, the context of its development and the interaction with unofficial dimensions, it is important to elaborate on observations which have led to the above conclusions about the implementation of general management in Kingstown Royal Infirmary. The forthcoming analysis is a description of identified cultural patterns and behaviour at official and unofficial levels of the organization.

The Royal Infirmary has a long history dating back to the nineteenth century. During its lifetime, it has functioned as a workhouse, small voluntary hospital and now as a large acute general hospital. As of May 1986, the Unit had approximately 1400 beds, a budget of £32 million and housed clinical specialties and regional specialty services.

The history of the hospital is a vital factor to consider in attempting to understand the cultural and micropolitical forces which are playing a vital role in the process of organizational change and managerial effectiveness.

In pre-NHS times, the hospital survived through contributions from

caring charities and the work of 'caring professionals'. It is assumed (at least amongst current staff at the Royal) that the emphasis has always been on the care of the individual patient. Whether such claims are justified or not is somewhat irrelevant for the purpose of this analysis. What is important is that staff refer to the Unit's past to justify the pre-eminence of nursing and medical values. For many of the staff, the architecture and setting of the hospital symbolise the caring ethos within the hospital. One senior member of the nursing staff remarked that:

> ..it's comfortable here, the patients will tell you..A funny story happened not so long ago when a patient was transferred from the other end of town (The Municipal). As soon as she came here she said "Oh it is nice to be back here - it is comfortable" and I'm sure it is. I mean, if you try to ask them, it isn't the nursing care, it isn't the medical care, it isn't anything on that side, it is just the fact that the building is comfortable.

The architecture and geographical setting are perceived as symbolising different values from the Kingstown Municipal Hospital, a recently built, large, acute teaching hospital and medical centre. The Royal Infirmary is set in amongst tranquil 'green' grounds and its appearance is in stark contrast to the appearance of the Municipal

Hospital. The latter, with its complex multi-story design is seen to reflect the increasing financial considerations facing NHS management and the economic and political pressure for the maximum utilisation of space, centralisation of services and public access. Royal Infirmary staff perceive this as a cold, unwelcoming and confusing institution for the patient to be faced with when going there for treatment. Much of this feeling is due to the design of the Municipal hospital, which is seen to reflect not only the interests of the medical profession (through the medical school) but also those of administrators and local politicians, who all exercised influence in the commissioning of the hospital and whose concerns are perceived by some clinical professionals as not being entirely compatible with those of the medical and nursing professions.

Also, the history of the Royal is marked by under-funding and the Unit has been described as the 'poor relation' of the District in terms of public attention and publicity. Traditionally, the health provision in the locality has been dominated by the Kingstown Hospital which has a grand two hundred year history and a reputation for medical excellence. This hospital has now been replaced as the District's main hospital by the Municipal. Subsequently, much of the attention is now given to Kingstown Municipal Hospital.

However, the humble beginnings of the Royal Infirmary have seemingly helped to foster a spirit of togetherness and loyalty amongst staff that is still evident in current times. The caring ethos and spirit

of togetherness have been very important factors in the survival of the hospital and they are now major characteristics of the organizational culture of the hospital. Symbolic of this spirit are the entrepreneurial activities which staff undertake to help the hospital. These are widely noted and one member of senior management in another Unit puzzled:

> I would say and I do not quite understand why that they do appear to be socially a lot more friendly at the Royal. There appears to be more of a feeling for the building. I don't know if it just because it is older and it has got a history. It shows in the way they raise a lot of money for the hospital... they are always doing things.

This spirit was confirmed by the remark of a consultant with duties in all three units of the DHA. The consultant noted that:

> ..the Royal Infirmary has the enormous loyalty of 99% of the medical staff. They love it and they have open days and raise lots of money for it.

This collective spirit and loyalty to the hospital appears to characterise relationships between the various groups of clinical professionals. It is also evident in the interaction between clinical and non clinical administrative personnel. So much so, that traditionally, significant conflict between administrative and

professional clinical staff appears to have been minimal. One manager with many years experience in the Unit confirmed this when remarking that:

> The Royal is perhaps a little different from other organizations in that poor professional inter-relationships are not a feature of this Unit.

A current member of the UMT recalled the development of this relationship and the role of a former Unit Administrator, Mr Tom Bailey, in this, by the following remark:

> ..there has always been a very good spirit here at the Royal Infirmary. It's a phenomenal place to work. There has always been a good relationship between medical staff and administration. Mr Tom Bailey developed this and it has just grown and blossomed and there isn't any great sort of friction between one group of staff and another.

Indeed, during the recent times, the cultural and micropolitical processes operating within the Unit have resembled those associated with the 'consensus' type of culture. In the time of Mr Bailey, this seems to have particularly been so. The Unit appeared to function through the fusion of two cultures - the administrative and the

professional. Evidence indicates that these worked together in harmony, with medical opinion leading the Unit and administration being content to perform a facilitating role. As such, the organization was a professional bureaucracy in which professional and administrative objectives were not in conflict. The Unit Administrator was apparently content to operate on the basis that decisions based on professional, technical advice were the best available and the role of the Unit Administrator was to facilitate the work of the clinical professionals. This harmonious relationship was not achieved as a result of compromise. Rather, administrative staff were successfully incorporated into the medical culture. This incorporation occurred through both formal and informal channels. Formally, this was done by incorporating administrative and nursing staff into the medical decision-making forums. As one former Chairman of the Medical Executive Committee (MEC) proudly recalled:

> ..here at the Royal, we were one of the first hospitals to formally invite the Administrator and representative of the nurses as equals on to the Medical Executive Committee.

This formal incorporation was supplemented through the informal channels of frequent social gatherings of clinical professionals with the Administrator: across the dinner table, in the bar and outside of work.

Neither was this approach a cynical attempt to incorporate administration and render it ineffective. Rather, it was merely a means of acting in order to prevent the development of communication barriers between clinical professionals and administrative staff. However, one unintended consequence of this frequent formal and informal interaction has been that administrative staff have come to interpret the needs of the hospital through medical eyes. Over time the medical ideology - that is the right, ability and freedom of practitioners to exercise their professional judgement - has become institutionalised as a taken for granted dominant cultural assumption throughout the hospital. The consequence of this has been that a cultural bond has developed which has united individuals throughout the hospital. As a senior manager of the nursing profession remarked:

> The philosophy of the Royal is that it is a centre where people care for patients and everybody works together in order to maintain that. That is the important thing and everybody works at that.

A further consequence of this incorporation is that medical staff have maintained their control over scarce material and symbolic resources. A current manager recalled:

> ..the management here has always been that the clinicians must get the first share of resources - the lions share...The approach has always been,

> "I need an extra technician, or more nurses or whatever. I need them because of the workload which I can't cope with at the moment, and therefore, you must give them to me".

Out of the preceding discussion, it is possible to make two conclusions about the managerial process in the Royal Infirmary prior to the introduction of general management. First, medical opinion has played a dominant role in the managerial processes. This has been confirmed by several individuals. As a manager from another unit with lengthy experience in the DHA remarked:

> The Royal is and always has been clinician led. The nurses are very much supportive of the clinicians. They follow the clinicians and then the administrators run behind.

Another senior manager from the other general hospital in the DHA offered a similar view via the remark that:

> It is an interesting comparison between the Municipal and the Royal. The Municipal has always been administrator led. The Royal was and is the exact opposite. The former Chairman of the hospital MEC led the Unit team and from this the medical model of general management developed.

> But there has always been this difference between North and South of the district. When it was combined in 1982, we found that the North was medical led and the South administrator led.

Also, a current manager with an administrative background and many years managerial experience within the Unit re-iterated this point when claiming that:

> Certainly it has always been a Unit where the medical staff have had a great influence upon policy, and that is probably the case going back to the re-organization before 1982.

Second, in accordance with a 'consensus' type of organizational culture, the functioning of the Royal Infirmary has traditionally been characterised by unofficial arrangements which have been sub-cultural as opposed to contra-cultural. Because of this, the emphasis upon formal arrangements has been less in comparison to other units. Unofficial arrangements and informality has always been an accepted feature of the Unit's managerial process. Examples of the prominence of informality come from both administrative and professional staff. A Consultant remarked how a former Unit Administrator was:

> ..always negotiating at the lunch table with the doctors.

Similarly, a distinguishing feature of the official medical decision-making structure is the lack of a Cogwheel structure. This decision was made many years ago and still stands. The reason for the decision was recalled by a key actor from those days and indicates perfectly the style of management which has characterised the Unit. The Consultant involved in the decision many years ago remarked that:

> ..there is a feeling that when you do not have Cogwheel, some of the specialties are not always well represented. Having said that, it was rejected partly because our system seemed to work quite well, the people in the past have gone out of their way to consult with everybody. We felt that with our system you get a better overall spread of opinion. Here everybody is equal in voting power and you talk as an individual consultant not as a representative of a division...

Also, the successions to the post of Chairman of the MEC have had an informal style to them. One former MEC Chairman remarked that:

> We do not have elections, the names emerge, like puffs of white smoke at the Vatican.

Indeed, the style of management in the Royal Infirmary prior to the introduction of general management, was summed up by a current senior manager who recalled the comment of a medical colleague with experience of both the Royal Infirmary and the Municipal Hospital. The manager proudly recalled that the colleague described the difference as:

> ..the Royal Infirmary works like a large cottage hospital.

Significantly, the manager has interpreted this comment in a positive way and illustrated this by the following remark:

> ..he [the colleague] meant this not in a derogatory sense but in the sense that although it is a large hospital, the philosophy is one of a small group of people. There is a lot of people on this campus, but most know each other. It is a bit like a family, we are very protective of our spirit and proud of the hospital and what has been achieved in such a short space of time.

It is important to acknowledge this shared pride amongst people on the campus, because when the implementation of general management became imminent, there is little doubt that key actors felt defensive towards the Griffiths spirit and style of management. As one manager claimed

in the early days of implementing general management:

> Our traditions are our strength !

Undoubtedly, the belief in the traditions of the Unit was viewed to be in conflict with the spirit of change which the Griffiths Report contained. A current member of the UMT recalled that:

> I felt we were just getting it right in this Unit. The unit team was good, it was working well and making decisions and at the time we all said within the group "well we do not need a lot of change, because we feel we have just about got it right".

Indeed, amongst the medical fraternity in the Unit there was open scepticism to the Report and the recommendations. This was indicated by a consultant involved in the Medical Executive Committee:

> On this campus, it is fair to say that there is a considerable amount of esprit de corps. It is also fair to say that there was quite a feeling when Griffiths came out, that we did not need to change very much because things were already working here. So although we were not bitterly opposed to Griffiths, we viewed it with some suspicion.

Much of this scepticism appears to have been rooted in two inter-related factors. First, there was a desire to preserve the 'consensus' status quo which characterised the Unit. Second, there was a fear that Griffiths style management would undermine the dominance of the medical ideology within the Unit. The fear that medical interests could be ignored or subjugated in favour of managerial or political interests is a fundamental factor to consider in understanding the way general management was introduced during the time of Dr Shanks, the first UGM. The regime of Dr Shanks was marked by a very conservative philosophy towards implementing general management. It is reasonable to argue that in terms of the official culture it was a philosophy of no change.

The time of Dr Shanks is fascinating because it can be used to show how structure and culture can be used in a mutually supportive way as a defence against unwelcome change. For example, the recruitment process and the organizational chart are two structural phenomena which embodied the old official culture and provided a defence against change. It is necessary to explain this further.

First, the recruitment of key personnel in these general management times is significant. For example, the appointment of the two UGMs to date from the medical profession, (both had previously involved with the Medical Executive Committee), has served to ensure the preservation of the clinical voice as the dominant one in the

managerial process. Indeed, a rather cynical view of the process is that something resembling a 'Coup d'etat' process has occurred. That is, the dominant ideology at the care delivery level of the organization became officially dominant at strategic level through the appointment of an individual who represented the interests of the clinical professionals of the organization. This idea is interesting in this Unit because there was a fear amongst key actors within the medical committee machinery about the type of manager which Griffiths appeared to be encouraging. Certainly, several current managers in the Unit view a collective fear amongst the medical profession as a factor behind the willingness of the UGMs to date to accept the position of UGM. A current manager recalled a conversation with Dr Shanks and commented that:

> I know that Dr Shanks' reason for going for the job was to do with the change. He told me quite some time ago, that the reason he had taken it on was because he did not want to be a manager, he wanted to be a clinician. However, he felt that unless he took it on, dire consequences could follow and by that I imagine that he meant an administrator type who manages everything by statistics, workloads and projections. They did not want this. So to keep it within the Infirmary culture he took it on ...interestingly Dr Johnson evolved as UGM for much the same

reason. He was worked upon by his colleagues and was a reluctant applicant.

This latter view was not refuted by the current UGM, who when asked about a person with an administrative background being appointed to the post of UGM, remarked that:

> Our fear here was that when Dr Shanks left, we were left rather thin. A lot of our previous administrative people had left. So, I've stepped into the breach to see things through the next three years. If in that time somebody with an administrative background emerged whom we thought fitted, then I would be perfectly happy for that person to take the job, with one proviso. That is, that they were the sought of person prepared to listen to medical opinion.

The idea that a process akin to a coup d'etat had occurred was also put to one consultant by the present researcher. Although the consultant refuted that there was this "cynical philosophy" behind the appointments, the collective fear which key actors within the medical committee system of the Unit had at that time was confirmed. The consultant remarked that:

> I do not think it is a coup d'etat... I think we were very conscious as a profession, that if

> there was going to be a managerial revolution, how can we ensure that the health care of the patients comes first. How can we get that over?. And it seems sensible to have somebody medical. That is certainly part of the reason.

As well as being used to preserve the dominance of medical values, the recruitment process is interesting because it has been used to preserve the style of management of the Unit. An assumption dominant amongst the UMT appears to be that it is better to promote from within the Unit than from outside of the Unit. This cultural assumption can be traced to the desire to protect Unit spirit and traditions. Certainly, in the process of implementing general management there have been very few individuals recruited to senior managerial positions from outside of the Unit. Senior management positions are occupied by individuals who were already working in the Unit, or were at District Health Authority level.

Only one member of the UMT was not a senior manager prior to the introduction of general management. Interestingly, this individual has an administrative background and was functioning at middle management level. One of the significant things to note about this person is that rather than having a desire to introduce a new management style at this level, the individual acknowledges having a personal style and approach which 'fits-in' to the Unit's culture. The manager elaborated upon this by the remark that:

> The unit is very much doctor-led as opposed to administrative-led. I felt very vulnerable when I first came here. Administration lacked standing and I felt that I had to go out and prove myself quite strongly. It was very difficult but I did this by proving to clinicians that I had the ways and means of oiling the works to let them be free to get on with the job they were trained to do - that of treating patients.

This comment about the facilitator role is interesting because in these general management times it was anticipated that this role would be outdated. However, this is not so in the Royal Infirmary and it is further evidence that the official management style of the Unit remains largely unchanged and that the official culture is still incorporating non medical personnel into facilitating the work of medics.

Second, the structuring of relationships within the Unit at senior management level is also indicative of how structural features can be used to preserve a particular sectional interest, ideology and set of cultural assumptions as dominant in the managerial process of the organization. As one senior member of the UMT remarked:

> We've tried hard to preserve the strength of

> medical opinion through the Chairman of the MEC and I think we have achieved this.

Symbolic of this is the language used for the medical committee on the organizational chart. Appendix D shows the committee to be the Medical Executive Committee (MEC). From the organizational charts of the other units, it is important to note that the committee is labelled as the Medical Advisory Committee. From the analyses of the other units, it is evident that the difference in title is more than just semantics. Indeed, at senior management level, it is reasonable to conclude that during the reign of Dr Shanks, general management created little more than an illusion of change. Official job titles and personnel changed and the organizational chart was re-drawn. However, the official culture resembled that prior to the Griffiths report.

The significant structural change which did take place occurred at sub-UMT levels. This seemed to embody the Griffiths belief in managerial accountability and responsibility. For example, there were two major foci of structural change. First, identifiable managers were introduced into areas such as Pathology, Radiology and the Out-Patient Departments. These changes were a positive response to the Griffiths call for identifiable managers with managerial accountability and responsibility to the UGM. As one manager remarked:

> Radiology did not have a proper manager. They managed the place by an informal get together. No one person took responsibility. With a consultant as a manager it is now more cohesive.

In the case of the Out-Patient Department this was clearly a replacement of functional management. The manager of this section recalled the professional and functional plurality of this section via the remark that:

> ..Out-Patients sounds like a nice tidy section - it has got walls and has one specific function. When you look at it closely, you will see that the managerial infrastructure is quite complicated. It's medical records dominated but the nursing staff and medical staff play a major part. Ancillary support are also in my brief..so we are chopping across natural boundaries to make this work and there is accountability confusion at times.

As both of these departments have identifiable managers who have a medically oriented background, it appears also that these changes embodied the Griffiths call for involving clinical professionals in the managerial process.

The other major structural change which occurred was the amalgamation of nursing administration and general administration into the one general management structure. As a result, the hospital is now organized into areas of medical care. For example, the Acute Services, Health care of the Elderly, Paediatrics, Maternity and specialized sections of the hospital. Each area has an identifiable Divisional Manager who is managerially accountable to the Matron.

Such structural change seemingly indicates that particular assumptions of the Griffiths Report have been perceived as legitimate. Functional management has seemingly been replaced by general management, offering the possibility that multi-disciplinary management could become a feature of the Unit. Official advertisements for the Divisional posts are also said to have indicated this desire for culture change. As a senior manager remarked:

> We advertised the posts as either nurses or administrators, it was the person for the post really. A good professional is not always a good manager and vice versa.

However, further analysis indicates that whilst structures have changed, some traditional values have been maintained. The professional ethos has been maintained through the nursing backgrounds of all the individuals occupying these positions. Concerning the

appointees to managerial positions involving the nursing profession, it is possible to argue that the protection of professional interests have triumphed over the desire to really introduce change through multi-disciplinary management. Such cynicism is fuelled by the following remark of a senior manager involved in the recruitment of people to these posts:

> Fortunately, all the Divisional Managers were nurses....there were no administrators who came up to the nurses.

Further comments by the same manager shed some light onto why this may have been so. One remark was particularly indicative. The manager claimed that:

> There has to be, particularly in nursing, a professional role as well. So, if you had a manager, you would still need somebody who had a professional role as well because I think there is so much involved, that you have got to be a nurse to understand.

This situation regarding the nursing profession is significant from both the micropolitical and cultural perspectives. There is little doubt that the professional identity and self regulation has been maintained through the creation of the Divisional Manager structure.

It is difficult to generalise that this professional ethos is in conflict with a managerial ethos. However, evidence does indicate that some managers are more inclined to adopt a clinical perspective as opposed to a general management perspective, and as a result are not readily responding to initiatives such as budgetary devolution and increased formality in communications. Such evidence suggests that what is being witnessed is the preservation of functional management work behaviour as opposed to general management behaviour. Thus, concerning the nursing structure it is reasonable to perceive that structures have changed but the official culture has not and more significantly perhaps there was never the true intention to change the latter.

As was noted at the outset of this account the change of UGM has been a very significant event because there is now evidence from UMT level that the official culture is changing and genuinely embodying Griffiths assumptions. Shortly after taking up post, Dr Johnson the current UGM, indicated that the 'managerial' interests and objectives had given him a different perspective on the Griffiths Report, than he had held as a practicing doctor. This was indicated by the remark that:

> My views have changed somewhat on Griffiths. I can see that grafting Griffiths on to a hospital like this, can improve matters and the thing that improves matters is giving people responsibility

whereas they previously did not have it or had it without being seen.

Whilst still attempting to preserve the medical ideology as the dominant ideology of the official culture, the Griffiths values of cost-effectiveness and devolution of budgetary responsibility are increasingly becoming a fundamental part of the official culture.

Increasingly, the senior management are recognising that they are under resource pressures from the District Health Authority. Therefore, the UMT increasingly recognise that they must deal with what they see as a problem of clinical demands from professional groups on a total unit budget which is limited.

As a response, structural features of the organization are embodying the concern with the effective use of resources. Structural change is occurring which is somewhat different than that which occurred during the time of the first UGM. The emphasis is given to building on the changes in the organizational chart, by establishing systems and processes for improved information flow between the UMT and clinical staff and for budgetary responsibility to rest with clinical staff. For example, there is the intention to give to some doctors and nurses resource responsibility. This intention appears to be genuinely geared to achieving a change in the way professional staff use and think about the use of resources. As the UGM remarked:

I do not think Griffiths can or would work without

> having proper budgeting information and it is co-incidental that at the time general management is being produced, we are getting proper financial information. If that had not happened I cannot see how general management would have worked...so that has been a great benefit to general management - having that budgetary information. We have a lot of work to do on the financial side, but we are trying to devolve budgets further and further down the line, so that the people who use resources control them and pay for them. This means monitoring and making sure they are not wasted... I think people accept that the NHS has a finite amount of money, that it is going to be squeezed more, that we have to efficient.

The result of this realisation amongst the UMT is that several groupings of staff are being targeted for budgetary responsibility. First, the nursing staff are being prepared to manage budgets. For example, the Divisional Nurse Managers already have budgetary responsibilities and there are moves occurring to devolve responsibility to Sisters on the ward. As one senior manager remarked:

> the next step we are going along is to establish

> in a limited way ward budgets. So the sisters on each ward will be given budgets to manage the consumable items such as syringes, disposables, dressings etc.

Second, the intention is to formally involve medical consultants in the management process. One senior manager recognised the extent of the task here through the remark that:

> The next educative step is to make consultants aware of how much things cost. Before you can ask them to manage, you have to make them aware and at the moment most consultants do not have the faintest idea of how much things cost. One way we have started doing this is to give them information about the cost of drugs.

These moves are in their infancy and it would be misplaced to speculate upon their possible effectiveness. However, there is a very significant point to make regarding the awareness which the UMT now appear to have about the use of resources and professionals involvement in resource management. This is, that formal "physical" information systems such as budgetary statements, activity measures and the official emphasis on cost control are a new phenomena at the Royal Infirmary. These are initiatives which contain the spirit of Griffiths. As such, it is perhaps reasonable to conclude that the

official culture of the Royal Infirmary is beginning to change and resemble a compromise between the culture envisaged by Roy Griffiths and the medical culture which has been dominant for many years prior to the introduction of general management.

Having discussed the reaction of senior management to the Griffiths Report, it is necessary to direct the analysis to the second issue. The concern here is the effectiveness of management, and to consider whether the conditions necessary for achieving managerial effectiveness, as conceptualised in this investigation, exist in the Royal Infirmary. To gain an indication of this the discussion will be focused on the relationship between the official culture and structure and the unofficial culture and structure.

At the beginning of this description, it was noted that the cultural and micropolitical processes observed to be operating within the Unit in the past, were those akin to the 'consensus' type of organizational culture. It was also indicated that in an attempt to preserve this, the initial approach to introducing general management contained a resemblance to a 'coup d'etat' process. For the remainder of this chapter, the researcher offers a description of the current micropolitical and cultural conditions observed to be present within the Unit and a discussion of how they resemble the processes associated with 'dualism'. Through this, an insight into the effectiveness of management in terms "of pulling the organization together and along in a general direction" is provided.

Prior to the introduction of general management, two functionally distinct systems - the 'administrative' and the 'clinical' were operating in the Unit. As discussed earlier, these fused to the extent that they were not culturally distinct. Consequently, the Unit's micropolitical and cultural processes resembled those which underpin the 'consensus' type of culture.

In these general management times, "administration" has been replaced by "management". The preservation of particular professional values and ideologies as dominant within official arrangements has ensured that the 'managerial' culture and the 'clinical' culture are still fusing to the extent that the 'consensus' of the past is still evident to some degree.

Evidence indicates that members of the UMT and some clinical staff feel that each others interests are mutually compatible. For example, the UMT still view themselves as needing to perform a facilitating role for clinical staff. As such, management is not viewed as an end in itself but as a means to an end. This was indicated by the comment of a Unit Management Team member who remarked that:

> ..the managers are not the most important people in the Health Service....the most important person in the hospital is the Ward Sister because without the ward being run efficiently even the most

> competent medical person is going to be in difficulties. Most consultants would agree. But they need all the support of management and the department that they can get.

Additionally, a current Ward Sister remarked that:

> Management does have different interests. They say that they want patients first, but they don't. They have not got a clue about patients needs. But I think it is different here..I know that Matron will try and meet my needs and I am sure it is the same with the UGM because he is clinically still involved.

The mutual support which exists between management and staff is further indicated through the constant interaction between clinical professionals and non clinical professionals. It occurs both formally and informally. As a formal official arrangement, it is shown through the structural feature of "walk-abouts". A member of the UMT remarked about this arrangement and the belief underlying it. The manager noted that:

> We are not an isolated team, we make a conscious effort to be seen and this happened well before general management. It is a thing we have carried

> on. We walk about as a team once a week, nobody knows where we are going, we just appear. We drop in and say what is your problem...You see it is important, we have always had the open door approach and we also like to walk around and see what is happening.

Informally, it occurs between individuals at all levels of the organization. For example, a manager on the Unit Advisory Board (UAB) who is not from a clinical background remarked that:

> ..as a general style within this Unit, I think just about everybody would say that we don't mind getting our hands dirty and getting stuck in with the troops. There are not a lot of managers who sit behind desks here....it is one of the things that I love about this Unit. You can go out and get stuck in. I mean this afternoon, I have been in the mortuary with one of the professors and rather than summoning me to his office we went into the tea room at the back of the mortuary and sat down with the lads to discuss how we are going to organize things in the future. I like that, the lads like that and think that is why people think that they have got access to management.

This last extract is an example of how unofficial arrangements are strong in terms of their role in the functioning of the Unit and the way they re-inforce official arrangements. Indeed, sub-cultural activity is still a characteristic and institutionalised feature of the Unit. The current official arrangements have facilitated the preservation of sub-cultural values. For example, members of the nursing profession value being managed by nurses. The organizational structure has ensured that this is happening. Also, the department of Pathology, although seemingly having an identified manager accountable to the UGM, is functioning as a managerial unit in such a way that each discipline within Pathology is managed by a manager from that discipline and the 'Pathology Co-ordinator', in practice, apparently makes little attempt to manage each discipline individually. These structural arrangements satisfy the desires of particular groups to preserve values and beliefs which they see as legitimate and which are a fundamental part of their cultural existence.

However, that it is only a degree of fusion between management and staff is significant. Other evidence indicates that the interface between the official and unofficial is becoming increasingly abrasive because the latter contains contra-cultural phenomena. As was noted in chapter four, the 'dualism' type of culture contains the interaction of culturally distinctive groups of individuals. In the Royal Infirmary, this interaction contains both sub-cultural and contra-cultural elements. It does so because official structural and

cultural arrangements are being increasingly developed to include initiatives originating from outside of the Unit such as Clinical Budgeting and Korner Information Systems. These structural features embody and transmit beliefs of cost-effectiveness and efficiency in the use of resources. Some clinical individuals perceive these values to be in conflict with their clinical autonomy and their belief in the need to provide the best care available for each individual patient. Because of this the two cultures - the 'managerial' and the 'clinical' are showing evidence of becoming culturally distinct, thus defining, with increasing clarity, the distinction between official and unofficial dimensions of the organization. This is a major change within the micropolitical and cultural context of the organization and indicates a shift from 'consensus' to 'dualism'.

Contra-cultural activity is observable and conflict has become open and apparent between the two cultures. The basis of conflict is varied. One identifiable factor is the clash of managerial and clinical values. A consultant involved in the MEC noted that although this conflict is not a constant feature of the Unit, there is increasingly conflict between clinical values and managerial values. The consultant remarked that:

> ..there is conflict between managerial and professional values.

Much of this would appear to stem from the resource pressures which

are placed on the UMT from other levels of management, for example, the District Health Authority level. Increasingly, the UMT appear to recognise that the economic pressures placed upon them from DHA is providing them with the problem of trying to satisfy the demands of clinicians who wish to provide services, whilst keeping the Unit within cash boundaries. The result of this is that the UMT have had to identify service priorities. In turn, this has led to the UGM making decisions which the particular clinicians involved have perceived as undermining their clinical interests. The above mentioned consultant elaborated on the above comment by recalling the following incident which highlights the conflict:

> A particularly difficult one is going on at the moment. It is a local problem concerned with providing more accommodation in Out-Patients. The only way it seems we could do this without spending towards one third of a million pounds - we have a limit of £100,000 help from the District - was to move a Paediatric unit out of Out-Patients, where it has been for many years. The specific details are not important really except to say that there has had to be a managerial decision made to push the unit out of Out-Patients, against the will of the Consultants who work there, who have produced quite a lot of evidence and support from their staff and their

> colleagues in Physiotherapy and Occupational Therapy to resist this. In the end the UGM decided this was the only option. As Chairman of the Executive Committee, I had to explain to the group of consultants that this was a decision which the Unit Manager had taken and we ought to support it, not because people did not have reservations about this sort of decision being made, it could have happened to one of us, but it seemed to be the only option.....It was particularly difficult for the Unit General Manager, however, in another way it was easier because he was medical. Had he not been, I suspect a lot more people would have taken the view that this has been imposed on us by administration and why should they make these sorts of decisions. I have a feeling that it would have been more acrimonious. So ..there are problems and a clash of interests, but on the whole there are no major problems.

A senior manager on the UAB with an administrative background also recalled this decision and perceives it as a watershed of managerial effectiveness in these general management times. The manager argued that:

> the move was top management's idea and to their credit they have stuck out against all opposition and the move is going to happen. I think that it is seen by everybody as the first example of general management sticking to its guns and making something happen for the benefit of everybody....there are all sorts of theories of what would have happened under the old regime. I have a feeling that the medics would have stuck together and said "well, even if some of us are going to benefit you cannot push consultants around like this" and the idea would have fizzled out.

Managers from other professional groups have also indicated that there is conflict between management interests and professional interests. One Ward Sister remarked about experiencing a conflict in her value system due to being a clinical professional and now a manager with budgetary responsibilities. She indicated this by the comment that:

> As a manager you are cutting costs, budgeting, filling in establishments etc but as a Sister you want to give the best care possible...as a manager you have to cut corners all the time, we have no alternative.

Also a member of a profession allied to medicine who is a manager remarked that:

> The UGM has not actually come out and said we have to do X Y and Z but we have asked to do things and he has said "no" because it means spending money.

Another source of conflict arising out of the clinical and management cultures clashing is to do with the official structuring of relationships. There are pockets of discontent and contra-cultural activity which undermine official arrangements. One manager confirmed this when noting that:

> In the laboratories management is contested. Is it the technicians who are in charge or is it the consultants? The official answer is that it is the consultants but I know in most cases that they are actually run by technicians.

If the official arrangements are being ignored for whatever reason, this is likely to significantly impact upon the future effectiveness of budgetary and information systems and accountability processes. This will only serve to undermine the formal control element which is a fundamental part of the line management process encouraged by Griffiths.

An indication that the 'consensus' conditions are under threat is provided by former administrative staff who feel that the introduction of general management has undermined their particular interests and voice in the management process. One manager noted that:

> I suppose one policy was get rid of adminstration...there was a whole chunk of work ignored when Dr Shanks got his structure together...it was not recognised that administrators had a part to play. Parts of administration have now gone and people may say to you that they don't know how to get things done anymore.

The same manager seen this as a consequence of professional influence in the managerial process of the Unit. The manager noted in a critical manner that:

> ..the situation is not good for the support services, by that I mean diagnostic support as well as hotel-type support. Because things are seen in terms of doctors and nurses some of the operational problems of the support services can get neglected.

The practical consequences of this weakness in the managerial process

could seriously undermine the credibility of the UMT. Already there is an example of communication and co-ordination difficulties resulting out of this. This was provided by a manager who recalled the transfer of a clinical service unit from the Municipal hospital to the Royal Infirmary. The manager detailed that:

> Take the transfer of services from the Municipal to here. A ward at the Municipal is going to close and move here. Now the Municipal have a pile of paper about costings, projected workloads, and all this sort of thing...they are trying to approach it in an effective way. The way the transfer is being managed here is there is a load of good chaps on the medical committee who sit around and say "well we will not open a new type of ward, we'll scatter the patients around the general surgery ward, there jolly good chaps the surgeons, giving us a bed here and there you know, so it'll be alright". Management has allowed that to happen. No way would Municipal management have allowed that.

Another manager remarked in a similar vein about the transfer when noting that:

> Most of the people working on the transfer feel

> that we have not had enough time to work on it, we feel that we have not thought it through properly, that we have not allowed long enough to let it happen.

These comments indicate that although the informality within the management process is a valued part of the management culture amongst key actors at senior management level, there are increasingly dissenting voices from all backgrounds. Some individuals feel that the UMT does not have enough of a managerial outlook. One manager with an administrative background commented critically that:

> ..strategies, policies and direction are missing to a significant degree here.

Another noted that a physical basis for decision-making is not part of the culture. The manager remarked that:

> We have not been used to making decisions on the basis of facts and data. I think the light is dawning with Korner Information becoming available and so on, but at the other end of town they have really picked that up and made a lot of it. Here decisions are still very intuitive.

Significantly, these complaints are not confined to administration.

There are a group of younger medical staff who feel that a good administrative input to the Unit is needed. One Consultant commented that:

> Even though we are one district, there's a difference in the quality of management between the two units. The difference is nothing to do with the appointed UGM's but to do with the infra-structure beneath them. For example, the capability of administrators. The quality of accounting is far superior in the Municipal to here, and this existed long before Griffiths. I received a monthly statement at the Municipal to see where I was. I asked for one here and they did not know what I was talking about. Now I've only had three in 18 months at irregular periods. On a day to day basis, far too little is made of the management common sense of the consultant.

Another consultant rejected the value of friendliness and informality associated with the pride in cottage style with the remark that:

> Cottage-style, personally I am not very impressed by that. I do not think we have cottage-style management, we suffer from a lack of management.

Such clinicians share a belief in the need for the Unit to modernise its approach to management. They feel the need for clearer policy from above, and increased formality. Indeed several of them feel that the medical decision making structure epitomises all of the Unit's problems. One consultant argued that:

> ..there is a feeling amongst some of my colleagues that the present medical committee system does not produce the goods. Many people would like to see a Cogwheel structure...we do not have a structure that says "right, we are discussing the development of a new ward or block" and everyone argues about the pro's and con's and then we come out and say "look, this is what we have decided, this is the voice of the Clinicians". You will get people who will then go around the back and lobby the Unit manager. In other words, it is sort of consensus and the executive decision-making process is a bit more diffuse. Now some people may say it allows for a more democratic approach, it allows minor disciplines who don't have a lot of people to actually have their lobby. But on the other hand, I think it is a recipe for inactivity.

This complaint has actually been heard through official committee machinery. One key actor within this process acknowledged that a discussion had occurred about this issue. The individual noted that:

> ..there was a group of Physicians who thought the committee structure should be changed. It was debated and very well attended, because it was advertised a month in advance that it was a meeting pre-dominantly to discuss the structure. It was a very lively debate. In fact, there was a very large majority to continue the system. It was an open forum and good discussion.

However, such contra-cultural activity has not gone away. This was confirmed by the views of one consultant who criticised the whole management process within the Unit. This particular person argued that:

> It's an idiosyncracy of this Unit and the people now making the decisions are putting the Unit at risk. It has stuck to its old Surgeon and Physician approach. It is a professionally dominated Unit, but professionally dominated by antiquated thinking. The medical committee system is a self-perpetuating one...here we have a self-elected people really, we need an

> infrastructure informed by Cogwheel, then I'd know if we were being treated fairly. Many consultants are not involved in committee work. They are kept in the dark like a mushroom, getting shit shovelled on them. We need an effective management structure in this Unit. Currently, it is a self-perpetuating oligarchy.

Another consultant indicated that this feeling of dissent was quite widespread when noting that:

> Within any hospital there are power groups and individuals. We saw this prior to Cogwheel, and it was designed to prevent it. Cogwheel is an anti-dote to it. In this unit there are three groups. Those like recently appointed Clinicians who see it as an inefficient set-up, the apathy group who are happy with what they have got and who do not contribute and the bunch of committee men who by tradition come from
> particular groups .... they have got word of rumbles amongst physicians but although they feel uncomfortable, I doubt things will change, because they are in a position of authority.

Hence, from the preceding discussion there are two specific

observations which are very significant for the purposes of this investigation. First, evidence indicates that contra-cultural activity exists and this shows that the cultural and micropolitical status quo in the Unit has changed. Certainly, the 'consensus' conditions which the Unit has experienced in the past are showing signs of disappearing whilst the conflict between senior management and the clinical staff indicates that the Unit is experiencing those conditions associated with 'dualism'. If this is so then it is reasonable to conclude that the necessary conditions for achieving managerial effectiveness, as conceptualised in this investigation do not exist in the Royal Infirmary.

Second, in the Royal Infirmary, a clinical interpretation has greatly steered the approach of UMT to introducing general management. There is evidence that the official structure and culture have been used to initially act as a barrier to change and only more recently to facilitate change. As the analysis in the preceding chapter indicated, this initial approach is in stark contrast to that adopted by senior management in the Kingstown Hospital, in which the influence of the medical profession in the official culture has not been nearly as influential. In Kingstown Hospital senior management's approach to introducing general management has been significantly different, as the structure and culture have been used to facilitate change and develop a different official culture and structure.

However, it would be premature to use these two cases to present the

argument that should there be a large number of the medical profession within a unit then it necessarily ensures that an official culture with the medical ideology as dominant is inevitable. This is shown in the next chapter when a third unit which is also a large acute general hospital with a large number of medical staff is described. From the description, it is evident that a further different approach has been adopted by senior management to implementing general management. As in the case of the Kingstown Hospital, the official culture and structure greatly reflect the assumptions contained within the Griffiths Report. However, unlike in Kingstown Hospital the conditions associated with imperialism do not exist. Rather, the micropolitical and cultural forces present within the Unit indicate that a 'dualism' type of culture exists. However, unlike in the Royal Infirmary, this dualism has developed out of very different conditions to those associated with 'consensus'. This indicates that as far as achieving managerial effectiveness and introducing organizational change, each unit is a distinctive cultural and micropolitical context. More specifically, it shows that when general management was first implemented, each unit had a differing starting point in terms of the cultural status quo. These comments will be elaborated on as the analysis is developed in chapter eight to cover the Kingstown Municipal Hospital.

CHAPTER EIGHT

KINGSTOWN MUNICIPAL HOSPITAL

The first major statement to be made concerning the introduction of general management in this hospital is that the official culture and structure indicate that the senior management group within the hospital, labelled the "Policy Advisory Group" (PAG)), (see appendix B), led by the UGM, share a belief in the legitimacy of many of the assumptions of the Griffiths Report. As one senior manager recently concluded:

> We have taken on board the Griffiths recommendations to a large degree.

Major structural change has occurred and this is intended to facilitate the development of a new official culture throughout the hospital. The official structural arrangements and the values, ideology and beliefs underpinning the official culture are evidence of the PAG's desire to introduce the Griffiths model of management into the hospital.

The second major statement is that evidence shows that through these official arrangements, the influence of the PAG throughout the hospital appears to be increasing. Whilst the cultural and micropolitical processes present within the hospital indicate that

conditions associated with 'dualism' are evident in the hospital, it appears that the strength of official arrangements is developing, in some cases at the expense of the strength of unofficial arrangements. A managerial ideology is developing at the strategic level of the hospital and the influence of the PAG is seemingly much greater than that of the previous administration. However, this influence is not of sufficient strength to conclude that the hospital is an 'imperialism' type of organization.

The forthcoming analysis locates some key features of the official culture and structure of the Municipal Hospital and some of the major cultural and micropolitical processes occurring within the hospital which have led the researcher to these conclusions.

The Municipal Hospital is viewed as the 'jewel in the crown' of the District. Its prime status is a result of it replacing Kingstown Hospital as the main acute hospital within the District. Only recently fully operational, the hospital accommodates the full range of medical specialties as well as a busy Accident and Emergency Department. As a managerial entity, it is a complex institution. Its physical size, the magnitude of its resource utilisation (approximately £37 million per annum) and the inevitable micropolitical pressures associated with an institution containing many prominent clinical professions, all contribute to the complexity of the managerial task facing the PAG.

The introduction of general management co-incided with the hospital becoming fully opened. The timings of these two happenings led one manager to remark that:

> ..the organization has entered a new era of management.

Initially, this seemed a strange remark to make in view of the hospital's young age. However, it is important to recognise that the hospital is not without a history. As a senior manager in another unit remarked:

> I doubt that it is a hospital without a history. They did not start off with an empty building and a recruitment plan. They started off with an empty building but the staff and practices of the Kingstown hospital.

The managerial style of the Municipal Hospital can be traced back to the era when Kingstown Hospital held prime status within the locality. A current senior manager at the Municipal Hospital, who was an administrator at Kingstown Hospital indicated that the development of the administrator/doctor relationship was created at Kingstown Hospital and subsequently carried over to the Municipal. The manager recalled that:

> At Kingstown we approached the medical staff about attending their specialty committees and they said "no". But, gradually with the help of the Hospital Secretary, we broke that down and started to attend their divisions. So, we established a closer working relationship with them. We built on that really when we were commissioning the Municipal Hospital, because you cannot open clinical services and not talk to doctors and through the commissioning team and commissioning activities particulary, we established a closer-working relationship with them and they had to come to us to get things done. This has led us into a position here, were they trust us and rely on us and we have even gained their respect.

This working relationship is re-inforcing a trend which had developed within the district over many years. This trend is that hospitals, for example Kingstown Hospital and the Municipal Hospital on the south side of the city, have traditionally been viewed as administrator led, whilst those on the north side, for example, the Royal Infirmary, have been viewed as clinician led. In other words, non-clinical personnel have seemingly had a major influence in the strategic direction and daily affairs of the hospitals on the south side of town. This pattern is reflected in the managerial styles of each unit. Whereas informality and a strong corporate feeling amongst

staff are key characteristics of the Royal Infirmary, the Municipal Hospital is acknowledged as having a more formalised and bureaucratic style of management. A manager at the Royal Infirmary claimed that:

> We have always regarded the Municipal as being more structured and formalized in its communication. Perhaps, it is due to its early days when structures were being devised and the medical input was not as great as it could have been.

Another manager remarked in a similar vein and cited the commissioning of the hospital, as setting the trend for the managerial style of the hospital. The manager claimed that:

> The chap who helped to commission the hospital became Unit Administrator. He adopted the project management style and they have been much more comfortable with a more analytical style of management.

The administrative influence is an important cultural feature to note, especially in terms of the objectives of this investigation. The Unit Administrator's ability to develop formal systems and procedures seemingly strengthened the administrative voice within the unit management team and gave the impression that the administrator led the

hospital effectively. As such, many of the demands and interests of clinical groups were channelled by the Unit Administrator through official structural arrangements within the hospital. A senior manager with a clinical background who experienced the unit administration days at the hospital indicated so when recalling that:

> I did not see it as one group necessary dominating the hospital, although medical staff were the most influential. In any large acute hospital because the consultants dictate the pattern of work, their influence is going to be more pronounced. However, they were not a rule unto themselves but that was largely due to the persistance of the Unit Team to actually make sure that systems were set-up and that medical staff adhered to those systems to channel plans and developments through the correct channels. But, it did take a lot of time and effort. The Unit Team did its utmost and reasonably successfully so, to harness that influence. There was a good relationship with the medical member of the team and the Cogwheel system was clearly developed so that things were largely done through recognised machinery.

Such evidence indicates that those 'officially' controlling the hospital - the Unit Team - were strong in terms of their influence

upon the strategic direction and overall functioning of the hospital. As such, a major understanding of the functioning and interpersonal dynamics of the hospital can seemingly be gained by reference to official arrangements.

However, further evidence indicates the widespread operation of unofficial arrangements within the hospital. Sub-cultural activity occurred as expected because of the multi-professional basis of the work-force and the uniqueness of each department and ward. The structuring of relationships within the NHS has traditionally facilitated this. These were (and still are) are a normal part of hospital life and were officially accommodated in the consensus decision-making processes. For example, functional management and the facilitating role of the hospital's administrative function satisfied professionals' demands for accountability to one's professional peers, as opposed to managerially accountability to people not from the same professional background.

However, in addition to sub-cultural activity there was contra-cultural activity in a parts of the hospital. These greatly undermined the legitimacy of official arrangements and the authority and influence of the Unit Team. The presence of 'restrictive practices' amongst important ancillary groups impacted upon the smooth running of the hospital and led one manager to remark that:

The hospital had been held to ransom at times.

Another manager noted the ability of prominent Medical School individuals to:

> ...bend the ear of the Regional Medical Officer and ignore unit management.

Also, the ability of some departmental budget holders to ignore budgetary thresholds were all indications of contra-cultural behaviour undermining the official arrangements and authority.

These unofficial processes prevailed as a result of factors such as the size of the hospital, the functional/professional basis of relationships, and the power of the individual clinicians and the Medical School. Indeed, these cultural and micropolitical factors indicate that during pre-general management times, the hospital experienced conditions associated with the 'dualism' type of organization identified in chapter four. The official arrangements reflected the influence of both an administrative culture and clinical professional culture working together at senior management level, shaping the strategic direction and functioning of the hospital. The unofficial arrangements reflected both the influence of small groups, functionally and departmentally gathered, as well as individuals who had developed unofficial arrangements in order to pursue their own interests, often under the banner of 'clinical autonomy' and at the expense of the wishes of the Unit Team.

Both official and unofficial arrangements contained evidence of strength and both were culturally distinct. For example, the role of the Unit Team in influencing the strategic direction of the hospital, the operation of the Cogwheel structure and the Unit Administrator's 'good' relationship with the Chairman of the MEC (in pre-general management times it was called the Medical Executive Committee) and the nursing profession helped to ensure that much behaviour occurred through official channels.

However, at the point of care delivery clinical groups and individuals exercised their 'clinical autonomy' and influence through clinical practice. Their ability to use both official channels and unofficial channels to pursue their interests at all levels of the hospital undermined the ability of unit management to effectively manage the hospital at all levels. There appears not to have been a shared administrative or managerial ideology bonding individuals throughout the organization. The managerial process at the point of care delivery was not developed sufficiently and this encouraged informality and clinical autonomy.

Consequently, the culture of the Municipal Hospital was such that the unit management team were often performing the compliant and facilitating role to sub-cultural and even contra-cultural activity. The UGM, a member of the medical profession, indicated this on recalling the dealings of senior administrative personnel with members of the medical profession in pre general management times. The UGM

remarked that:

> ..administration were complying to medical requests which were individual or departmental requests. These were not necessarily directed towards the benefit of the whole and they were built more upon personal ambitions and issues.

The official and unofficial dimensions of the hospital were influential upon each other, to the extent that the hospital as a total entity, could not be described as resembling a professional hegemony or 'informal empire'. However, neither was it resembling the 'imperialism' type identified in chapter four. Micropolitical processes indicated that at sub-Unit Team level, official arrangements were weak in relation to unofficial arrangements. Indeed, many parts of the hospital experienced conditions similar to those associated with the 'informal empire' or the 'balkans' types of organization. One manager candidly remarked that:

> ..the hospital setting breeds informality and we could not honestly say that we knew what went on in every part of the hospital...as a result, things happened incrementally, they just kept growing and you would come across big areas of expenditure.

Therefore, despite the official arrangements much activity was taking place outside of these. Broadly, the hospital functioned on the basis of two culturally distinct sets of arrangements - the administrative and the medical. These activities developed, because beyond Unit Team level official arrangements were weak. Consequently, this situation led to the Unit Administrator using official arrangements to perform a facilitating and co-ordinating role in order to try and manage clinical demands. In turn, this seemingly weakened the Unit Administrator's ability to direct and manage the hospital in a clear strategic direction. The current UGM believes this to be so and indicated this by the following remark:

> Having been involved in the commissioning of the hospital, I felt that the way it was being run was not satisfactory. It was not being managed, it was being run by an administration that was responding to demands; that was likely to say "yes" to get peace and quiet. Overall, it was a compliant form of administration; it was directionless and people were not being motivated in the right direction.

Similarly, a current member of the PAG who was on the Unit Team in pre-Griffiths times, recently remarked in the light of experience of the general management regime that:

> There was a lack of overall management, but I did not think at the time that management was a problem here. The Unit Team seemed to work quite well. There were instances in the past when I thought things were okay here but I now realise that everything was done to find money for the medical staff to do things..There are things we call "insidious developments". These are little services which start off in a corner through the interest of a particular Consultant and they just spread and take up resources. Now these are being questioned and it is being asked "is this a priority area"?. To judge things like this, we are getting a base line to judge priorities.

These latter remarks and criticisms indicate that at PAG level, the introduction of general management has prompted a critical evaluation of past managerial effectiveness within the hospital. As one PAG member remarked:

> ...even before Griffiths we were talking of the need to take stock. That time has now come and we have said "let us stop now and look at the whole thing and decide whether we have got it right" and we will do that by actually reviewing what we are doing in each department.

In contrast to the Royal Infirmary, arising out of this evaluation has been a realisation of the necessity for change in the managerial process of the hospital. The changes in the official arrangements indicate that the UGM and the PAG have perceived that many of the Griffiths criticisms applied to the hospital and that they perceive the Griffiths 'prescription' to be legitimate. This is a significantly different reaction to the Griffiths recommendations in comparison to the initial reaction of senior management in the Royal Infirmary.

Briefly, it is worth noting that the professional/functional backgrounds of senior management members may be an important factor in this different approach. For example, the PAG comprises, a former administrator, an Accountant and a Personnel Officer. These professional backgrounds are important to note because whilst both the Royal Infirmary and Municipal have UGMs who have medical backgrounds, the team dynamics, attitude towards implementing the Griffiths Report and the subsequent managerial styles and philosophies are very different. Seemingly, the shared acceptance of values such as setting acceptance of the need to set priorities, control expenditure and view service provision in population and group terms as opposed to individual patient terms, may have been easier to establish amongst senior management in the Municipal Hospital than it has been in the Royal Infirmary. In the Infirmary, the professional backgrounds of key management personnel have contributed to personal conflicts for senior managers about the relationship between economic concerns and

the professional belief in satisfying the needs of the individual patient. Indeed, the fundamental difference in style and philosophy between the two management teams is that at the Municipal Hospital, senior management (including the UGM) see a 'fit' between managerial values and professional values, whereas at the Royal Infirmary there appears scepticism as to whether the two can work together in practice without compromising clinical values and interests.

The combination of professional and managerial concerns is shown by the managerial philosophy within the hospital. A member of the PAG indicated this with the following remark:

> Regarding the management philosophy, the General Manager has a stock phrase which is "we are all here to treat the patient and we must not lose sight of that". The philosophy of the unit is too provide the best possible care to the patient within the resources we have got. We all accept we are here to treat the patient. The UGM always says that no matter if you are Personnel or Domestic, everybody has a role to play in ensuring that the patients get the service they want. The second part of the philosophy is, that people are clear about what their role is and are left to perform their role without too much interference, and will take responsibility in performing their

role.

Hence, the structural changes which have occurred within the hospital do embody many Griffiths-style values and cultural assumptions. The effectiveness of the managerial process in these general management times revolves around a acceptance throughout the hospital of a number of changes of structural and cultural significance.

First, the style of management at the top of the organization is geared to establishing leadership, direction and management of the daily functioning of the hospital as well as the strategic direction. Amongst the PAG and other senior managers, there is a commitment to developing a managerial ideology as the dominant ideology throughout the hospital. The thrust of this committment rests in a shared belief in the concepts of managerial accountability and individual responsibility as the basis of structuring relationships throughout the organization. The introduction of budgetary systems to encourage cost-effectiveness, the improvement of information systems to infuse decision-making with physical criteria and the need for professional clinical staff to participate in the managerial process as "managers" are an indication of the new official culture which the PAG are trying to develop. A further indication was provided by a senior manager who claimed that:

> The central management philosophy and culture is one which is trying to manage. It is trying to be

> pro-active rather than just responding to situations. You see, it is impossible to just sit on a hospital like this and expect to control it. You cannot just assume a neutral stance. You have to get hold of the organization and lead it through. Because of prominent specialties and we have got many, a Medical School and a university department, clearly you have people who are trying to push back the barriers of their specialties, often being the international leaders in their field, and they are going to draw the demand in for their services. To actually prevent that, you have to find out what is happening; the patterning and direction of what is going on in parts of the organization and control it. This means that you cannot allow growth in all areas of the hospital. You will say that we will allow growth to a particular degree in that area at the expense of another area. The other areas will see it negatively but at least you are controlling it as an organization.

The above extract is interesting in terms of the language used. References to control, directing, prevention and pro-activity are indicative of a much bolder and confident stance by senior management. It represents a commitment to the leadership style of management which

Griffiths encouraged. This in turn requires a different structure and culture at sub-PAG levels. This was indicated by a PAG member who remarked that:

> I hate jargon, but we wanted to be a pro-active management, rather than a re-active management and that was the main philosophy. We thought we could do this centrally by delegating an awful lot of work to the Departmental Managers. The co-ordinating role of the Administrator was the theme of the "Grey Book" and we said "why do we need to co-ordinate"?. If these people are managers in their own right, they can talk to each other, and they need not come and talk to us unless there is a problem.

Indeed, the extent to which a managerial ideology develops as the dominant ideology depends a great deal upon the relationship between senior management and departmental managers. For this relationship to achieve the change required, both groups of individuals need to change their own managerial styles and their perceptions of each other. As one senior manager remarked:

> We have to let responsibility go, they have to accept.

Another manager remarked that:

> ...the general thrust is that there should be maximum delegation down to individual managers, who are set clear objectives and accountable for the failure to meet those objectives. So, it is really personal responsibility and a move away from the traditional everything must be referred upwards idea.

For the official culture to be strong, it is below the PAG level of management where the managerial ideology needs to be internalized by staff. Senior management appreciate this and there are three key structural and cultural changes being introduced which are directed at groups of individuals from differing functional and professional backgrounds. Through these changes there is an attempt to infuse the professional culture with the managerial culture envisaged by Griffiths. This is clearly an attempt at achieving the type of organizational culture which resembles that of the 'consensus' organization.

The first major change is the identification of accountable managers for all departments and services within the hospital. The managerial changes at departmental level revolve around each department having an accountable manager who is managerially responsible to the UGM for the functioning of that department in all its aspects. A list of

management responsibilities has been issued to these managers and a PAG member remarked that:

> It was made clear to them that if they accepted the job then that was where the buck stopped.

This is a change of major structural and cultural significance. Structurally, central administration, which was a fundamental feature of the pre-Griffiths NHS, has been dismantled. As one PAG member remarked:

> ..central administration was the middleman that oiled the wheels. Now maximum devolution is encouraged through identified accountable managers.

These managers represent the new middle management of the organization. Culturally, the major change is that it is following the line management ideas used throughout the private sector and following the Griffiths assumption that managers should have responsibility for service levels, quality standards and budgets.

The basis of the link between the senior management and departments throughout the hospital is managerial accountability. Consequently, the demands on them and the staff below them are expected to be very different. Managers are now expected to be much more self-sufficient

with greater responsibility and accountability. The increased emphasis on cost-effectiveness is shown by much greater financial responsibilities and implications of inefficient use of resources. Indeed, the crux of the accountable manager system is the devolution of budgetary responsibility. Departments have held budgets before general management but as a PAG member remarked:

> The real change will come if they do not live by their budgets because we are tightening up on how managers live by budgets. We have had departmental budgets for years, the only difference is the tightening up on the accountability for actually making sure people live within the budget. Previously, we talked to managers, for example, the Paramedical Services managers' and we encouraged them to try and remain within their budgets, but at the end of the year if they did not, we bailed them out. But now,it was said in our first round of budget talks with them, that they are personally responsible for making sure that their department operates within the budget and that their continuation as a manager depends on that. They accepted it, and so if they are running into difficulties now they come and tell us instead of waiting for us to see the figures two months later.

The devolution of budgetary responsibility and accountability is part of the managerial strategy to avoid a major problem, as perceived by the UGM, of the managerial process of the NHS in pre-Griffiths times. The UGM remarked that:

> The great problem of the Health Service in the past has been that there were to many people with influence and power but no responsibility. When people come to me now and say "do this, do that", I want to know what their budget is. There are to many people who can tell you what to do and they have no budget. Just as management can get confused about their responsibilities, medical people and other professions can often get confused about theirs. I am not trying to clip wings, I am trying to make the best use of information and advice. One needs to be in a position to ignore advice they should not give. It applies not just to medical staff but across the board.

As well as each manager being accountable, there is also a "departmental review" process. The process is symbolic of senior management's emphasis on gaining a greater awareness of what is happening at departmental level. The philosophy of greater managerial control was highlighted by the remark of a PAG member:

This control has largely come through a system of departmental reviews and the objective of these is for senior management to gain a greater awareness of what is occurring in departments. We have come clean with our managers and said "we are in this as well, help us", and what we have done is to arrange to have information from them, on where they are in their departments, how many staff they have got, what their budgets are, where their money goes, what their emphasis is on spending, which patients do they treat, does it all come to them or do they go out and find it, what sort of problems we have got. We have now got basic information just as a base line and we have sat with each one of them to talk about their department, the managerial arrangements within it, their relationship with us and their view for management in the future. It was very basic stuff, but it is an indictment on the NHS that for most of them it was the first time that they have ever sat on their own with an Administrator, Personnel Officer, Planner and Accountant. In fact, one bit of feed back was that it is tremendous because "it is the first time we have had access to you all at once". So this is how we are working and it reflects our basic philosophy

> of maximum delegation, and keeping ahead of things rather than being seen as puppies running after developments.

Perhaps more importantly in terms of the cultural and micropolitical processes of the hospital, this infusion of a managerial ideology into professionally dominated areas and areas previously bound by ancillary restrictive practices, threatens to reduce the scope for the continuation of the 'informal empire' and 'balkans' type conditions in particular areas of the hospital. By senior management gaining greater control and awareness over behaviour and practices throughout the hospital, the effectiveness of management acting through official arrangements, is potentially increased. Therefore, management will function to have more control over the functioning of the hospital both strategically and operationally. With reference to the past administrative set-up, the notions of awareness and control could not be overtly built into the philosophy. As a PAG member remarked:

> We have confirmed one clearly accountable manager for each area, then delegated a lot of the work that was traditionally ours to them and then built up our own workload around control of developments and building in what we wanted to do with the District's strategic plan.

Symbolically, the system of departmental managers is important. The

importance is that it indicates a system in which professionals from a range of backgrounds are seemingly becoming more directly involved in the managerial process. Their participation in the managerial process was a major message of the Griffiths Report. These are signs that this may be occurring as several are accountable managers and others are Clinical Directors. Departments such as Pathology and Cardiology have managers from clinical backgrounds whilst the X-ray Department has a Radiologist as the clinical adviser. However, there are areas in which Doctors have refused to be managers. For example, Theatres. Indeed, in some areas, medical staff have wanted to become the manager but have not been appointed.

The significance of such structural changes, from a cultural perspective, is that it is a first step towards dialogue between managers and clinical professionals. As such, the distinct cultural differences between individuals which is the basis of a 'dualism' type of organization is potentially being reduced.

The medical staff provide the second major target of cultural and structural change. The attitude of the UGM and PAG to the medical profession is in stark contrast to the attitude adopted by senior management in the Royal Infirmary. This is interesting considering the medical background of the UGMs in both hospitals. The attitude at the Municipal was well summed up by a senior manager who recalled his experience of medical colleagues and what he perceived as the abuse of their clinical autonomy and influence upon the past direction of the

hospital. The manager indicated how this informs his approach to managing the medical profession. He clearly stated the aim of being perceived as head of the hospital by the comment that:

> In this unit, the power of the medical profession has to be channelled to the benefit of the unit. Medical staff are the prime people in looking after and having responsibility for patients and of course you have to listen to them. But they cannot be allowed to influence things which are not directly their concern. I am trying to make the best use of information and advice they can and should give and one needs to be in a position to ignore advice they should not give. This applies not just to medical staff but across the board.

This philosophy is supported structurally by the functioning of the Medical Executive Committee. That they are regarded as an advisory committee by the UGM, has been indicated by the following comment:

> I regard the MEC as an advisory body. They can offer advice through the Chairman but they are not a committee of tremendous power as far as I am concerned. They offer advice and I please myself whether I take it or not. It is in my interests

> to take it if it is reasonable advice but I am not told what to do by medical staff anymore than by Physios or Porters.

This is an example of how the UGM is using the official structure to adopt the leadership style envisaged by Griffiths.

At an individual level, the medical profession have traditionally not been involved formally in the managerial process. Unless a doctor is a departmental manager this is still the case. As a senior manager claimed:

> Medical staff have always seen themselves as autonomous and to a large degree they remain so.

As such, the medical profession still practice as individuals, largely outside of the accountability processes of official arrangements. This is a significant cultural feature of the hospital in view of their influence on the use of resources. However, it is on this issue that there is evidence of the PAG adopting a very pro-active and political approach to medical staff. As one PAG manager confirmed:

> They are becoming more accountable but we are having to do it very sensitively.

An example of this sensitive approach is the "clinical review"

process. This is another example of senior management using the official structure to try and affect cultural change. The "clinical review" is a forum at which developments in relation to clinical specialties are discussed with clinicians. The PAG's intention is to get the clinicians to think more as a team of managers rather than as individuals, and to think collectively on how to improve the service. One senior manager described the "clinical review" processes as all about:

> ..getting them involved in management. It is very easy for each doctor in his own specialty to claim "my specialty is deprived" and all the rest of it and "we have not get enough resources and what a despicable bunch the managers are because they are closing beds down or whatever". They still do this and will continue to. That is their prerogative as people who treat individual patients. You know they can say that "I have so many patients who are going to die because we have not got the resources to treat them". You cannot really argue against that fact, they face this daily. However, rather than them shouting from the touchline, we are trying to get them participating within the system, because we are always going to have to make those decisions whilst there are scarce resources. We are going

to have to make those decisions and the less arbitrary they are, the better the service will be. We will actually be making judgments based not on whims or prejudices but on established criteria.

Another senior manager remarked that:

Through the clinical and departmental reviews we are trying to establish a base line which is built up in conjunction with managers and consultants. We sit with them and we say "well exactly what do you do?, what are your priorities for the next year?, what trends affect you?, what is the likelihood of increased expenditure due to these trends? and what is the pattern of your demand?". Through this we can build up a baseline not in terms of "we want to take money away from you" but "we want an understanding of what is happening and plan for your development". It's getting the clinicians involved in management and participating in the managerial process. So it's bringing in the clinicians without telling them you are managing them. You see, the long-term consequences are that once you get that established, you can effectively start to compare

one specialty to another.

Here again is evidence of management attempting to introduce the Griffiths-style management based on managerial accountability, individual responsibility and physical criteria as the basis of decision-making. Hence, it is another example of the legitimacy of the Griffiths assumptions in the minds of the PAG.

It is also significant that senior management recognise (albeit privately) the political motives of such structural phenomena. One manager remarked that:

> The "clinical reviews" are forums in which we discuss developments with them. They know it as "clinical profile", that is what they call it, but on the corridor we know it as "clinical review".

In concluding this discussion of the PAG's approach to the medical staff, it is essential to make two major points. First, there is still no formal managerial role for most medical staff - their only formal accountability is professional as opposed to managerial. Their only formal involvement in the managerial process as a group is through the Chairman of the Medical Executive Committee (MEC). Second, despite the lack of availability of formal initiatives to ensure their involvement in the managerial process as individuals, the

structural initiatives described and attitude of the PAG indicates that an increasingly pro-active approach is being used in attempting to use get the medical staff involved in management. This is potentially a significant change in the managerial process within the NHS.

The third major area of change is directed at the nursing profession. A senior manager with a nursing background remarked that:

> ..the structure of nursing in this unit has not altered that much, but the philosophy has.

The philosophy change is clearly intended to embody many of the assumptions of Griffiths. Interestingly, it is being led by a manager who personally claims to embody the Griffiths philosophy of having the outlook of a general manager as opposed to a professional functional manager. This was indicated by the following comment of the manager:

> I am very much a manager and I see my involvement as not only managing the nursing service but having a contribution to make regarding the overall management of the hospital...I am a manager first and a nurse second.

The manager is leading the moves to legitimise the Griffiths beliefs in cost-effectiveness, greater individual accountability and

responsibility amongst nurses throughout the hospital. For example, these assumptions are at the heart of imminent changes in the role of the Ward Sister. As one manager with a nursing background remarked:

> What general management has done is to re-emphasise the role of the Ward Sister. They hold the clinical supplies budget but over the next few years they will hold the staffing budget. Currently, we are moving towards getting more information, so that we can break down expenditure at ward level and then we will allocate the budget to go along with this.....It will take time and we acknowledge that we are expecting an awful lot from Ward Sisters. So we will watch the effect on them and give them support.

Similarly, at middle management level, we see evidence of attempts to introduce multi-disciplinary management to replace functional management. Symbolic of this change in philosophy is the change in title of the Divisional Manager posts on the organizational chart. This was indicated by one of the PAG who remarked that:

> We have got Divisional Nurse Managers for the specialties and one fairly recent agreement which I thought was a major achievement was, that we got

> the "Nurse" taken out of the title. They are now regarded as the Divisional Manager for Surgery and Divisional Manager for Medicine and we are beginning to talk to them about what that actually means in terms of who they manage on the wards. Do they just manage the nurses or do they also have, which I understand they have but do not use at the moment, a responsibility for non-clinical support services to those areas?. So we are just beginning to look at this.

Currently, the nursing structure is interesting because it embodies Griffiths assumptions. However, there is still a hint of functional professional management traditions prevailing which preserve the nursing sub-culture. This is provided by the backgrounds of the Divisional Managers and the comment of a senior manager with a nursing background. The manager remarked that:

> Faced with the choice of a Divisional Manager being a nurse or a non-nurse, it would be better if that manager was a nurse and a good manager. Nurse managers have been blinkered in the past but the strengths of them are very much on their actual first-hand knowledge of coming up through the ranks.

Therefore, as with the Royal Infirmary, the key issue to observe here in the future is whether these managers act as general managers or as professional functional managers. However, to speculate on this here is inappropriate. It is only reasonable to note that as far as the PAG are concerned, the official culture is one of general management as opposed to functional management. Having discussed features of the official culture and structure in detail, it is appropriate to now develop the analysis by discussing whether the conditions for achieving managerial effectiveness, as conceptualised in this investigation, exist within the hospital.

At the outset of this description, it was noted that the cultural and micropolitical processes observed to be operating within the hospital prior to general management, resembled those of the 'dualism' type of organization. Currently, the political and cultural conditions observed to be operating indicate that the hospital is still a 'dualism' type of organization, but one in which the official arrangements appear to be gaining strength often at the expense of unofficial arrangements.

Before discussing this statement further, it is useful to consider briefly the expectations of senior management about the amount of change which they perceive can be achieved. Indications of their expectations were provided by a couple of managers who are part of the PAG. One manager remarked that:

> We are sowing the seeds of change but the fruits will follow much later. Many people do not realize this.

Another remarked that:

> In a place like this, the culture change comes very slowly. I would say that there has been a change but not to the extent that it has achieved all the objectives of general management yet. But that change will go on and on...

The preceding discussion has indicated that both structural and cultural change is being introduced by senior management and there are indications that the strength and influence of official arrangements is increasing vis-a-vis unofficial arrangements. To discuss the basis of this claim, it is necessary to note the reactions and feelings of key actors to some of the structural and cultural initiatives which have occurred.

There is clear evidence which indicates that the managerial ideology which underpins the official culture is becoming increasingly legitimised and naturalised amongst individuals with key roles in the hospital - the departmental managers, the consultant body of staff and the nursing profession. This is important to note because it is amongst these people practicing at the bedside and at operational

level of the hospital, that the official arrangements need to accepted. As one manager said:

> The inner sanctum control the purse strings but they rely on accountable managers to run the hospital.

Indeed, if these people do not perceive the official arrangements as legitimate, sections of the hospital will continue to be beset by 'balkans' and 'informal empire' processes. In turn, these will undermine attempts to achieve managerial effectiveness.

It does appear that official arrangements are penetrating the practices and informing the behaviour of some clinical professionals in these areas. The official arrangements are increasingly being perceived as legitimate, as the concerns of senior management are seen as reasonable. One Departmental Manager who has a background in a profession allied to medicine indicated this by the following remark:

> I think that our unit management team are keen to see the service provided in an effective way and I also think that they are accepting what I say is effective and so there is an element of trust there and I think that they are helping us towards it.

Significantly, the Chairman of Medical staff indicated that a more sympathetic view of management and its concerns may be being taken amongst some medical staff, by the remark that:

> I feel that management has improved in there being clearer lines of decision-making and as long as there is a good team guiding the general manager and the manager has the right motivation which is not necessarily just financial, then I think it can work well. It does not suit all clinicians by any means but I think the more sensible ones are coming to terms with it. They are coming to terms with the fact that costs have to be contained within different services, with non-clinical people being managers of clinically important departments, and the fact that clinical profiles and some review procedures are being introduced.

Similarly, a consultant remarked in a similar vein that

> Management has to demonstrate that it has the skill and enthusiasm to make the hospital a success, not just in terms of balancing the books. Through that, they will gain the respect of clinicians. That is happening here and overall we

> are very fortunate in having a Policy Advisory Group which has largely gained the respect of consultants.

Also, amongst the nursing profession there is perceived to have been benefits for the profession with the change. A senior nurse manager remarked that:

> In the context of the District, the Municipal has come out of it best of all, because we have a clearly defined nursing management set-up, where to a great extent nurses are being managed by nurses... Although I accept that those jobs could be done by non-nurses, they would be done much better by a nurse because the credibility thing is absolutely vital.

Similarly, a Divisional Manager also remarked approvingly that:

> Professional people are not accountable to non-professionals, it is not happening here and that is why it is working here. General management is working here, we have professionals responsible for professionals in management.

An acceptance and contentment with the changing role of Ward Sisters has also been indicated. A Divisional Manager commented that:

> They are economic managers and we have already got down to ward based budgets. They are already responsible for the clinical supplies budget. There is more control this way, they are happier, they get a clinical supplies print-out, it is beginning to come through fairly regularly, so they know if they are overspent. I've certainly felt the difference and like it and the Ward Sisters have because they have budgets and make decisions across a wider spectrum.

Such comments could be open to the cynical remark that contentment over change amongst professionals may indicate that no real change has occurred at all ! However, there is evidence of culture change and it is worth discussing this in greater detail.

First, the departmental manager system is showing evidence of strengthening official arrangements. Significantly, from both a cultural and micropolitical perspective, several managers at departmental level have noted that improved communication is a feature of the hospital's managerial process. One departmental manager commented that:

> Our UGM has instituted the 'management forum', which is a selection of managers who meet on an ad hoc basis with the unit executive, to review policies and give us a chance to comment on implications of change...There are various gripes, with good reason, but through this management forum, we have been given the opportunity to have our say. This is one of the things which has helped people. They say "now look, this is what is planned, what do you think about it?". On the whole that freedom of expression is there, and I feel that at this level they are being quite constructive in what they are doing.

The effectiveness of this structural initiative is significant for two reasons. First, the discourse between senior management and the care delivery level of the hospital is greatly increased. As one accountable manager remarked:

> I feel that we have much closer links with the unit management team than ever before. I do not think the passage of information is good management - it is part of good management - I always got the impression, that in the past in order to placate us, they gave us lots of information but what you could do about it if you

> did not like it was another matter. One gets the impression that they are now actually trying to involve us in the decision-making process....In terms of my services, the "them" and "us" situation has been broken down a bit.

Second, through this official channel, grievances are openly discussed. Such a channel affords the possibility of preventing contra-cultural behaviour by managing it officially. Through an open discussion of problems, sub-cultural interests can be discussed and accommodated, as opposed to them possibly becoming covert and contra-cultural. This is significant because it is an example of official arrangements being used to manage and possibly penetrate areas where official arrangements have traditionally had only a minor influence.

Also, there is clear evidence that rather than being perceived as challenging clinical control and interests the responsibilities of being a Departmental Manager are perceived as fusing with clinical interests. This was indicated by the comment of one departmental manager who remarked that:

> I've been given a budget, made a manager and so in some ways we have our strengthened role, so that is a plus.

Another manager remarked favorably about the extra responsibility when noting that:

> I think a lot of people are aware of what management is, even the doctors now. The UGM has been very supportive and he actually lets us manage. He does not just send us directives which I interpret and pass on, he really lets us manage. We have made some advancement from in the past, when we were just well paid clerks half of the time.

There is also evidence that perceptions of professional clinical staff are accommodating a more sympathetic view of the managerial function. This was indicated by the following remark:

> One of the problems is that you see a desperate clinical need but somebody else says "no". That can be difficult to accept. Having said that, what one has to do and what I hope I am trying to understand is, that there maybe very good reasons as to why that cannot happen. Either because of the knock-on effects on other professions or the financial/manpower consequences. So on balance, someone has to take an overview. How people accept that depends on how they have been managed

as far as relationships are concerned.

Complementing this more sympathetic view is a feeling that the PAG have genuinely gained greater authority and influence, which makes avoidance of their wishes more difficult than in the past. This was indicated by one accountable manager who remarked that:

> The "departmental reviews" are for the inner sanctum (the PAG) to become more aware of what we are doing, and they are more aware now than ever before. Eventually, they will be reviewing how we use our budget, and the way we control the establishment.

Perhaps most significantly, some departmental and accountable managers have admitted a change in their behaviour which is in keeping with the official view of managerial behaviour. For example, one manager noted that:

> General management has changed my behaviour and my colleagues, but for staff it has been work as normal. You see one of the things that has come out of all this is that when you are challenged on a budgetary basis, which we fully realise is there, you have to look at practice very hard and Korner will make us do this even more I suspect,

> because if used properly we will have to have a good hard look at what we are doing.

In other areas, management have much more knowledge and control of what is happening. For example, a much harder line is now being taken towards ancillary services. In this area, it is essential to acknowledge that initiatives such as the privatisation of ancillary services are a major factor in the change here. However, the summation of these initiatives plus general management is that the PAG are seemingly managing these services more effectively than ever before. As one senior manager remarked:

> We are making changes in portering, in domestic, in catering, in terms of looking for greater efficiency, in terms of cutting out a lot of the consultation, the wasteful consultation that has always taken place in the past. There is a more direct approach. It's a harder approach and we are now saying "no" in a number of areas. But linked in with the management style within the hospital there is very clear backing to do that.

Hence, there is evidence of official arrangements gaining strength in particular areas of the hospital. However, it is regarding the impact upon medical staff that the acid test for the general management regime is provided. It is widely acknowledged that the medical staff

have been the least affected to date. A member of the medical profession who is formally involved in the managerial process noted this by the comment:

> ..the evolution of management has been such that it has been the non-clinical areas taking it on board. Eventually, the clinical areas will become more involved in direct management ... administration, records and nursing have been the areas most affected.

However, there is evidence that the structural initiatives aimed at consultants on a group level and at an individual level are promoting change. For example, the UGM has begun to show that it is not a false promise by him that he would:

> ..not be told what to do by medical staff, any more than Physios or Porters.

A couple of recent incidents illustrate this perfectly. First, the PAG decision to refurbish the foyer of the hospital met with medical staff resistance. Echoing the Griffiths concern with the "customer", the decision is part of the official policy to welcome people to the hospital, rather than as one manager remarked:

> ..perpetuate the attitude of you get what we give

you.

The UGM acknowledges that:

> ..it's a change of policy and medical staff do not like it and say the money should be spent elsewhere. But they cannot show me a pressing need for equipment of an urgent nature. ... I think you should look to spend money more wisely across the board and this is an example of the new philosophy. I shall go ahead and do it and previously this would not have happened.

Additionally, a consultant with many years committee experience recalled a second incident which has recently showed the authority of the UGM over medical staff in particular issues. The consultant detailed that:

> It was decided that a group of records staff should have uniforms. The medical division of Cogwheel heard about this and wrote to the UGM saying, "it is ridiculous to spend money on this". That is the classical medical reaction to any change they perceive as wasteful. The UGM wrote back saying "You must remember that in these days of general management, there are many decisions

> taken without reference to the medical staff and which are not their business. We have decided on these uniforms and you must remember that the image of the hospital is not entirely dependent on what doctors do to patients".

The Consultant who recalled this second incident commented that:

> This is classic example of medical reaction and the new regime. No administrator could have written this to the medical committee.

Similarly, a Divisional Manager remarked that:

> Here we do have a UGM who makes decisions, unpleasant as they may be, and at the end of the day you need strength at the top. He gets away with it because he is a doctor. If he were an administrator or a nurse, he would not get away with it...he is certainly no puppet to his colleagues. He has the right qualities and credibility because he was Commissioning Officer and knows every room in the place.

The treatment of the MEC as an advisory body and "not as a committee of tremendous power" has also had an impact that led the MEC chairman

to remark that:

> The power has shifted away from the MEC. In the old days, they used to be the power that few administrators dared to contradict. Now, there are a few situations in which the UGM does not necessarily follow the wishes of the MEC. Of course, it would be unwise to contradict it too frequently but there are instances.

In terms of managerial effectiveness these incidents and perceptions are significant for several reasons. First, the senior managers in the hospital appear to have greater confidence in their own authority and power base. The UGM is both a symbolic and real power resource. As one PAG member remarked:

> MEC is important but doctors do not run the unit.

At an individual level, the structural initiative of, clinical profile, has significantly raised senior management's confidence in their dealings with clinicians. For example, one PAG member remarked that:

> We have a lot more influence over what the medics do. We now dare to say and do things regarding what they do and the way they use resources that

> we would not have dared to do in the past. The "clinical review" process for example. If we would have asked for this in the past, nothing would have happened. Now, if the medical staff do not respond they could find themselves out in the cold. Clinicians have to co-operate to get their say in the resources battle. If they do not they will be ignored.

Indeed, the "clinical review" process is an example of how structural initiatives are seemingly increasing the influence of official arrangements at the expense of unofficial arrangements and developing a managerial culture throughout the hospital. As one senior manager noted:

> There is a "departmental review" process underway and a "clinical review" process, whereby we are trying to establish the basis upon which we can start to look, in detail, at individual departments. We are now trying to establish a baseline which is built up in conjunction with the departmental managers and consultants.

That official arrangements are penetrating areas of the hospital which where previously operated by unknown and perhaps unofficial arrangements is shown by the fact that for the first time, as one

manager noted:

> ...most departments are formally or informally preparing profiles of what their activities are. Some have been prepared to call it a profile, some have resented that expression. They tend to be fragmenting down into sub-units who are preparing their own profile. For example, the Physicians have split up and individuals departments like Cardiology and Diabetes are preparing their own.

Hence, official arrangements appear to be increasingly strong vis-a-vis unofficial arrangements. Clearly, such claims have to be tempered with realism. For example, as one senior manager noted:

> Politically there is no doubt that the main force in any Health Service set-up is the medical staff. That is true here as anywhere else. However, the balance to that now, is the General Manager. The Medics are not united on any one front. That allows a manager to come in and as long as that manager is sensitive of the politics and is sensitive of the power bases and who is doing what and who influences who; who for example has the ear of the Regional Medical Officer and by-passes District all together; who is most influential

> within the Medical School. As long as you are conversant with the politics, as a manager, you can work it. For example, the direction is being set for this hospital from within the General Managers Department. It is the UGM who is taking the lead but to say that he is actually the political leader is variable here.

In conclusion, the official arrangements seem to be increasingly gaining strength as the official culture is increasingly perceived as legitimate and senior management perceived as possessing genuine authority. As one PAG manager noted:

> I think that the PAG is beginning to have central management. It is beginning to control things that go on, partly due to its "departmental review" process, partly through a thing called "clinical process"... we are beginning to control things in that way. They are big things, if you like, how you spend money, which direction we are going in, what developments will and will not take place. In terms of the patients actually getting the service at the sharp end, I do not really think we control that at all.

Another senior manager remarked realistically that :

> We are managing the unit, management does not control the unit today. Today is the first steps to control, central control, and we know what we are trying to do, but we are not there yet. However, I am confident we will get there.

This comment is supported by a member of the medical profession who is formally involved in the managerial process of the hospital. The consultant remarked that:

> I do not think even from within, it is strikingly different yet. Probably, there is much more formal interplay between different levels in the hospital and certainly a clearer vision of where we are going in the future, with clearer defined strategies..the day to day existence is not different, but the longer term views are far different. There is stronger control of developments now, the debate on clinical developments is more formal and that is the start of a better informed allocation of resources.

So, the conditions underpinning the 'dualism' type of organization exist because unofficial arrangements are also very strong still. Much of the official culture has still not truly reached many parts of

the organization, despite the organizational chart indicating that this is happening. As one Divisional Manager noted in a realistic manner:

> It is going to take a very long time to change because it is a professional service, ruled by professionals, and bound up by professionals. You can have as many structures and philosophies as you like, but if professionals do not change nothing else will.

There is clearly evidence that unofficial forces are strong. However, it is important to distinguish between those forces which are contra-cultural and those which are sub-cultural.

There is evidence of contra-cultural forces operating within the hospital. The basis for this varies amongst individuals and groups. For example, one group of staff who function as a separate discipline within nursing are particularly offended that they are now a unit-managed service as opposed to a district-managed service. As a result, within the hospital, they are ultimately managerially accountable to a manager not from their own particular nursing discipline. This has greatly offended their professional status and pride, as previously the service was professionally managed by a member of that particular discipline of nursing. As a consequence, the current official arrangements within the hospital have no

legitimacy in the minds of these nurses or their most senior representative. This is indicated by the views of a senior member of the profession, who happens to occupy an important managerial role in the new official structure. There are two particular beliefs perceived as being at the heart of the new official culture, which offend the professional outlook of the manager. First, the manager believes that the current official arrangements are not in the interests of the individual patient. As has been remarked throughout this study, this is the fundamental professional belief and the manager noted that:

> The bit that offends me is that the profession has been ignored throughout the district. We are managed in each unit and the laughing stock of the country. What matters to them (management) is not the service but that somebody is seen to be controlling all of the beds, all of the patients and all of the staff. They do not see it from the point of view of care given to the patient.

The second official belief which has offended the value system of the clinical professional is the new managerial basis for structuring official relationships. The lack of legitimacy was indicated by the following remark of the same manager:

> How on earth can you split managerial and professional

matters. It is a non-starter. I am managerially responsible to the DNS. I do not think I need to be under this person, I do not need the support, I know what I am doing.

Another indication of a contra-cultural outlook is provided by one current manager who acknowledged that some people do not accept the need to change. The manager candidly remarked that:

> ..the biggest thing is this reluctance to accept that we are working within limited resources. Cost-improvement targets are a fact of life now. However, many medical staff have constantly to be reminded of this. They still seem to think that there is a bottomless pit of money and that they only have to approve it through the medical machinery and it will happen. There are an enlightened group who do influence their colleagues, but the majority of them still think that it is a bottomless pit. That's the most obvious way in which one can see resistance.

Another manager remarked in a similar vein that:

> Until we can get the consultants tuned into the realities of general management and to accept that

> things are not like they used to be, then we are not ever going to achieve the concept of general management. It seems at the moment that they still feel that the problem is somebodyelse's. I think that we have very much got to work further towards getting consultants to own some of the problems that they identify as other peoples' because to a great extent they are their problems that only they can influence.

These comments are significant because they indicate that the desired widening of perception which Griffiths wants from the NHS manager and professional is still not happening for some individuals. The economic concerns and values expressed in the Report are either being rejected or ignored by some clinical professionals. Additionally, individual responsibility and accountability for their actions is also not being taken.

A significant question which follows these observations is that of why is the change not happening?. From the two comments above, this is not totally explained by a desire on the part of some people to avoid the current economic constraints of the NHS. Rather, it appears to be partly due to a lack of awareness due to a clinical education process and traditional culture of hospital life which has ensured that economics are somebodyelses's concern. However, there does also appear to be an element of resistance to the official

arrangements because of a perceived clash between beliefs central to the medical culture and those central to the managerial culture. As one clinical manager commented:

> You cannot have budgetary control and increase the throughput of patients at the same time. The two do not go together. They do where you have gross inefficiencies, but where you do not, they don't.

Similarly, a divisional manager noted a conflict in the values associated with being a manager and those associated with being a clinical practitioner. The manager remarked that:

> There can be a conflict between what is professional and what is managerial. I've got to admit it and say that at times we run at dangerous staffing levels and as a professional I should stand up and say "this is dangerous we must close beds" because if an accident happened, I am responsible to the UKCC professionally and could lose my license to practice. But like all managers, you adjust and provide the best with what you have got. But professionally, I should be saying "no"....This must also be happening for physios and pharmacists.

Another feature of the medical culture provides medics with a rationale for rejecting the new official culture. This is, that traditionally Consultants have not been formally located on the organizational chart in terms of accountability. This is a major cultural feature and part of the medical upbringing. This taken for granted assumption is difficult for senior management to change. A senior figure within the medical committee machinery indicated this and noted how the lack of formality in communication, which medical colleagues take for granted, makes the role of representative of the medical profession a very difficult one. The consultant remarked that:

> I'm in an orthodox position, but there are plenty of influential voices who will go straight to the UGM. They will often tell me that they are doing this, but sometimes not and I am not going to put myself in the position of stopping them.

Another consultant remarked that:

> If you look around at the consultant body of people who have strived to that position within a teaching hospital. They are not going to be subservient. They tend to be independent and narrow minded. Indeed, Kingstown has a reputation for people who are less than orthodox and able to

> promote their own case very volubly. There is a new Medical School and it is going to attract that kind of thrusting individual and people who will want to build up their own departments. So, you have many people who have fought tooth and nail for particular departments and they are going to be suspicious of people coming out of the blue and analysing the situation in such a way that they are going to be given directions. Because of this, a lot of it [management] is perceived in a negative terms such as "it does restrict our budget, we do not get the staff that we need".

The avoidance of official structural arrangements is an example of contra-cultural behaviour because by doctors being able to further their interests in this way, it is ensured that the official management channels of communication are ignored. Such actions are in keeping with the clinical expectations of the NHS. Traditionally, consultants have been able to disregard formal channels in order to voice grievances and pursue their interests. To achieve a change in this pattern of communication requires a major shift in attitudes amongst medical staff as well as official structural arrangements which ensure that some formality is achieved.

An additional example of contra-cultural behaviour also involves official arrangements which are being used to perpetuate behaviour

which is associated with the old administrative culture. For example, there is evidence that there is an accountable manager for a department within the hospital who is acting with professional values rather than managerial values upper-most in mind. This is indicated by the desire of the manager to actually manage the a range of separate clinical disciplines within the department. Rather, the manager has indicated that the title and role of "manager" was accepted because it prevented a "person from outside of the department" being appointed. Hence, it appears that the Manager is preventing the change which Griffiths desired for reasons associated with preserving the professional clinical culture. Further, the manager perceives that other managers are adopting a similar approach. This is shown by the following comment of the manager concerned:

> I do not feel that anything different is required of me. It has made no difference to the way I do my job. I do not see others changing either. They should be but they still have the attitudes of overspend and we will be OK. If we overspend, they can't cut us anymore.

Therefore, there are contra-cultural forces which are operating within the hospital and undermining management. Other examples of unofficial activity are of a sub-cultural nature. These do not necessarily undermine the official arrangements. However, they do indicate how some groups are preserving their culture. For example,

the fear of the "outsider" is again a factor in one unofficial arrangement observed by the researcher. An individual involved in the unofficial arrangement divulged to the researcher that:

> Mr [X] is on the structure as the accountable manager for the [Y] Department. But I perform most of the managerial duties. Every thing has been delegated to me, but I am not accountable if I overspend. This is an arrangement to protect him in case I leave. In the meantime, he knows that the department is safe with me as manager and in return, I know I can use him because of his individual status.

This is a perfect example of a sub-cultural arrangement because the PAG are prepared to accept it. They do so because they still perceive that the area is managed and that the arrangement is not contra to official interests.

As well as contra-cultural factors which undermine the official arrangements, there is another problem which is clearly hindering the development and influence of the official arrangements. The problem is sub-cultural in that it is related to the clinical culture within which medical, nursing and other clinical staff have been brought up within. The problem being that of skill shortages. For example, regarding doctors becoming involved as 'natural managers', an

accountable manager candidly remarked that:

> ..the consultants do not understand what is going on. One consultant is managerially responsible for a unit and cannot get used to an administrator not being there to do things for him. I've told him that he must write the requisitions and budget things himself...so they [consultants] have not lost their power but they cannot quite fathom out how to use it....they still go in and badger and say "I want" and they more often than not get.

Similarly, senior management are aware of problems with developing general management skills amongst nurses. One senior manager noted that the professional learning experiences of the nursing profession is contributing to weaknesses in the official arrangements. The manager remarked that:

> Divisional Nurse Managers show a reluctance to do the paper work, they much prefer hands-on. They are a bit like the doctors in that they are trained in a practical function. To them, management is something that you pick-up along the way when you become a Sister or whatever.

Hence, the above discussion indicates that there is strength in both official and unofficial arrangements. The sheer clinical composition of the hospital work-force makes the strength of latter inevitable. Therefore, in terms of achieving managerial effectiveness, as conceptualised in this investigation, the Kingstown Municipal Hospital is not experiencing the necessary conditions. The evidence of conflict between cultures in all of the three units analysed suggests that the consensus type of organization is unattainable. This suggestion will be discussed further in the final chapter of this investigation. It is to this chapter that the discussion in now directed.

CHAPTER NINE

CONCLUSIONS

Within the context of Health Service organizations, the researcher has set out to investigate some key issues of managerial effectiveness and organizational change. The investigation of these issues has been steered by the following thesis - for managerial effectiveness, conceptualised as pulling the organization together and along in a general direction, the structure and culture of the organization in both the official and unofficial dimensions, need to be in a relationship of mutual support.

The implementation of the Griffiths Report in the Units of management of a DHA has provided the opportunity to examine the thesis. The examination has been conducted via two inter-related questions which also happen to be vital to our understanding of the organization and management processes of Health Service organizations. These questions are, first, to what extent are the cultural assumptions espoused in the Griffiths Report (discussed in chapter five) informing the official structure and culture of the Units? Second, are senior management in the Units of management effectively pulling the organization together and along in a general direction? To deal with this second question, it has been necessary to address in each Unit, senior management's handling of the structure and culture of the organization. By doing so, indications of some of the complexities of

achieving managerial effectiveness, as understood in this investigation, are provided.

Having reached the stage were the methodological issues have been discussed and empirical evidence presented, this concluding chapter represents a discussion of the issues of managerial effectiveness and organizational change. The discussion ends with a look at managerial effectiveness within Health Service organizations in particular.

The presentation of these issues is structured on the basis of three questions. First, what do the findings suggest about our approach to understanding organizational change? Second, what are the implications of these findings for our approach to understanding managerial effectiveness? Third, what are the implications of these findings for our understanding of managerial effectiveness in Health Service organizations?

These questions are addressed with reference to the empirical work undertaken by the researcher during this investigation and to recent work in the Health Service. The outcome of this discussion is a number of concluding statements. It is the expectation of the researcher that these statements are useful for informing future theorising of managerial effectiveness and organizational change in both Health Service and other contexts.

Before addressing these questions, it is worth returning briefly to the conceptual assumptions which have underpinned this investigation.

The need to do this arises because the theoretical assumptions have greatly informed the research method. Consequently, it is important to recognise that all findings and conclusions are influenced by the initial theoretical assumptions which the researcher has brought to the study. Such assumptions contain a bias which has shaped the research methods used and the interpretation of the results.

The main theoretical assumption is that social (human) activity is an outcome of the interplay between human's mental functioning and environmental circumstances. Consequently, individuals, acting both alone and in groups, exercise some choice in defining their own situations and creating their own meanings.

In using this assumption, it has been necessary for the researcher to draw upon different strands of organization and management theory. Most notably, the use of the cultural and micropolitical perspectives has infused the investigation with insights from the recent 'processual' approaches to understanding organizations (Watson, 1986). However, within the researcher's understanding of the cultural aspects of organizational life, the impact of contingent factors such as organizational size, technology and environmental circumstances has been recognised. In doing so, insights from the 'systems' strands of theory have also been used. This eclecticism reaches its full expression in the 'system-like' conceptual framework presented in chapter four. This framework accommodates both the subjectivity of individuals and the objective constraints on them. It

therefore affords the opportunity to consider the impact on organizational behaviour and form of contingencies and individual action.

The significance of drawing together insights from different strands of organization and management theory lies in the realisation that the valuable insights which infuse the strands need not be treated as mutually exclusive. Rather, they need to be analysed and when appropriate intertwined. This is what the researcher has tried to do in this investigation's conceptual scheme and the result of this eclectical approach is a valuable basis and conceptual model by which to approach organizational and management theorising in the future.

The contribution of this research as a empirical study, rests in the issues of organization, managerial effectiveness and organization change being intertwined within a methodological approach which has attempted to acknowledge the way in which diverse and often opposed meanings operate for individuals and groups within an organization. It is the view of the researcher that it offers an approach for the future which avoids some of the past inadequacies of organizational change and management theorising. It is to these issues that the discussion is now directed.

Organizational Change

Though this study is not one concerned with change processes per se and does not share the all-encompassing objectives of major change-

oriented projects (Pettigrew, Mckee and Ferlie, 1988), some valuable insights have emerged which can enhance our understanding of organization change. They have emerged out of an approach which has met the above theorists challenge of being comparative, contextual and pluralistic but could be criticised for being non-processual and pre-occupied with change as opposed to changing.

The main insight re-inforces the argument presented in chapter three, that attention to the context of change is vital to any understanding of the management of organization change (Pettigrew, 1985). Having analysed how general management has been introduced in three different organizational contexts, two conclusions are drawn by the researcher.

First, the change process is bound up within the subjective abilities of the individual and groups to interpret the content of change in terms of, its practicability and legitimacy, the symbolic and material resources which they possess and the particular contingencies impacting upon them. Interpretations of change reflect the motives and interests of individuals and groups. The significance of this for change theorising is that, as with the broader body of organization and management theory, change theorising must move beyond a purely rational model for understanding, to one that takes account of the human factor within organizations.

Second, because these interpretations reflect the motives, beliefs,

meanings and interests of individuals and groups, it is evident that the cultural aspects of the organization can act as either a facilitator or a barrier to change. All three case studies have shown senior management using the culture of the organization to some degree but also being at its mercy. The official and unofficial interplay within the organization is evidence that though senior management can use the cultural features of the organization, they cannot take the management and control of culture for granted. The presence of the unofficial culture and structure is evidence of this. Therefore, in terms of the management of organizational change, official power holders, change agents and theorists interested in change must recognise that culture can be a barrier to change (Deal 1985, Lorsch, 1985) as well as a facilitator (Schein, 1985; Silverzweig and Allen 1976).

Both of these conclusions will now be discussed in turn. The assumption of social activity heightened the importance of paying attention to the subjective element of organizational functioning. The model of structure and culture has been used to demonstrate the basis and expression of this subjectivity. The examination of it has been achieved by using the cultural and political perspectives. It is these perspectives which have indicated how a change initiative with particular standard set of recommendations is introduced at the local level in a distinctive fashion. This distinctiveness is in accordance with the meanings that the initiative has for key actors in the local context, the symbolic and material resources possessed by those actors

and the contingencies impacting upon the group and wider environment at the time.

This theoretical approach has led the researcher to avoid viewing change as something which takes place in a vacuum that excludes the distinctive historical, cultural and political factors of the context. Rather, by taking account of these phenomena the researcher has moved beyond the application of a purely rational decision-making approach to understanding the management of organizational change. The inadequacies of such an approach were outlined by Thomas (1988). One of the seven 'obstacles' to the rational model noted by the author is associated with human subjectivity:

> ..choices are inevitably value-laden. peoples' subjective values will largely determine their choices of objectives, and the various criteria (and their weighting) used in judging which means are to be adopted in trying to achieve the chosen objectives (Thomas 1988:29).

To demonstrate this point, it is worth referring to the three cases presented earlier. In all of the three cases, the structural features of the organization such as the official structuring of relationships (as indicated by the organizational chart, appendices B,C and D) show that general management has been implemented throughout the organizations. Aspects of the official structure such as the

organizational chart indicates the replacement of functional management by general management. It also shows the professional and functional membership of Unit management to be similar. However, to conclude about the extent and nature of change from purely structural evidence such as this would be superficial and dangerously misleading.

It would be so, because having delved into the cultural and political features of each Unit of management, it is evident that the senior management have interpreted the recommendations of the Report in different (and partly contrasting) ways. These differences will be discussed in greater detail later in the analysis when the issue of managerial effectiveness is addressed. At this point it is sufficient to note that these differences reflect the subjective preferences which senior management individuals have used to inform the official culture and structure of their organizations. Such preferences reflect the personal beliefs of senior managers, their ideological sympathies, interests and their judgement of the political and cultural features of their organizations as well as constraints acting on the. In turn, this has greatly shaped the content of the 'change message' which senior management have transmitted throughout the organization. Therefore, any attempt to understand the change which may have occurred must accommodate this distinctive initial interpretation of the change recommendations by Unit General Managers and senior management colleagues.

Such evidence re-enforces the view expressed by Pettigrew et al (1988)

in an article entitled 'Understanding change in the NHS' that:

> The neglect of context and of the role of powerful groups within them has produced a situation in which myths abound and are perpetuated about rational problem-solving processes of planning and then in a linear fashion implementing change.....in the present research change is seen as a consequence not just of problem-solving processes ...Rather changes are also a product of processes which recognise historical and continuing struggles for power and status as motive forces, and consider whether interest groups and individuals may gain or lose as proposed changes surface, receive attention, are consolidated and implemented, or fall from grace before they ever get off the ground (Pettigrew et al 1988:301).

The second insight is a logical progression from this recognition of subjectivity and re-inforces the point about the political element of the change process. This insight, although more appropriate for an analysis concerned with the process of change, is worth noting considering the central role of culture within the investigation.

The proposition is that culture can be both a facilitator or a barrier

to change. It is so, because culture is both a social product and process. The human element ensures that culture is impossible for any individual or group of individuals to manage and manipulate in its entirety. The support for this statement rests in the evidence in all of the three cases of the presence of contra-cultural, unofficial activity. Despite the official features of the organization embodying and transmitting ideological and culturally laden messages, such unofficial activity is evidence that the changing of structural features by management is possible but the changing of values, attitudes and the basic cultural assumptions of groups is an extremely difficult process. It effectively involves managing the meanings which provide people with their cognitive reference map and inform behaviour. Such meanings are deep-rooted and taken-for-granted and difficult to change. The strength of these meanings and the material and symbolic resources possessed by particular groups largely determine whether culture is a barrier or facilitator of change. The cases highlighted in this research indicate how it can be either of these things.

In the case of the Kingstown Hospital, described in chapter six, evidence indicates that prior to general management the Unit was experiencing conditions associated with 'anomie' and suffering from strategic aimlessness. Because of a lack of cultural strength at all levels of the hospital, the UGM viewed that key groups of staff in the Unit were open to cultural change. Cultural assumptions appeared not to be deeply held or widely shared and so the difficulty of trying

to change meanings was lessened. Faced with this cultural status quo and armed with the strength provided through the possession of the material and symbolic resource associated with being the official power holder, the UGM set about manipulating meanings for individuals and groups throughout the organization.

In an attempt to move the Unit from the re-active, 'anomie' administrative culture which prevailed prior to the introduction of general management, to the managerial culture envisaged by Griffiths, the UGM has used past glories associated with the history of the hospital and the reputation for quality of patient care to inspire and motivate people in their work. This has been perceived as legitimate by some clinical staff who perform their work on the wards as well as members of the senior management (Managerial Core Group). The UGM has espoused and publicised the professional belief in patient care and the preservation of this 200 year old value of the organization, in an attempt to bond individuals at varying levels of the organization and from distinct professional and occupational backgrounds. The UGM's degree of success in achieving unity is not the major issue here. Rather, it is the way in which the official leader of the organization has attempted to manage meanings and pull individuals together and along on the basis of shared meanings. As was argued in chapter six, the UGM has been attempting to develop the legitimacy of official arrangements throughout the organization by manipulating meanings and re-creating meanings for individuals which are to be perceived by them as in line with clinical beliefs and interests. The

challenge of managing professional staff has been approached by trying to re-inforce amongst staff, pride in the hospital as an institution of care, whilst trying to develop a loyalty and commitment to general management principles of organization. This process is an example of a manager beginning to create and manage meanings for people and beginning to impact upon the way that they think and act at the work-place. The shift of the organization from an 'anomie' type of culture to an 'imperialism' type of culture indicates that to some degree the culture has been effectively used to manage change.

In contrast, the Royal Infirmary indicates how culture can be used as a barrier to change. The account of the introduction of general management presented in chapter seven, indicates that the initial reaction of senior management was to perceive the Griffiths managerial ideology as a threat to the traditional and officially dominant professional ideology. The strength of the professional culture was immense. The resultant official response was one of "no change". This was inspired by the clinging to values associated with the professional ideology as opposed to the managerial ideology being espoused in the Griffiths recommendations. The deeply held belief that the medical voice should be dominant in the managerial process of the Unit was perceived to be under threat, as was the much valued informality of communication and relationships. Hence, the official response was to defend these beliefs. The outcome has been an initial implementation of general management in which the official culture and structure owed more to the traditions of the Unit than a desire to

change towards a Griffiths inspired official culture.

The evidence from these two cases begin to take us away from an artificial understanding of change and a misleading evaluation of change. It does so because, first, it emphasise that to fully understand and evaluate organizational change it is necessary to analyse the structural and cultural features of the organization simultaneously. An inadequate and misleading view of change will result if structure had been assessed without attention to culture or vice versa.

Second, it shows that it is essential to look beyond the official statements espousing change. Rather, it is necessary to look at the distinctive features of the context in which change is occurring. This means that attention needs to be paid to the unofficial arrangements and patterns of behaviour.

By using the cultural and political perspectives this is what has been done in this investigation and the outcome is a different picture of the implementation of general management than would have been achieved by concentrating on only the people leading the change, namely senior management and their official statements and formal organizational charts. The value of this for understanding managerial effectiveness in the NHS will be discussed later in this chapter. It is the value of it for our understanding of managerial effectiveness to which the discussion is now steered.

Managerial effectiveness

The main conclusion to be drawn from this investigation is that if managerial effectiveness is viewed as pulling the organization together and along in a general direction, the achievement of managerial effectiveness necessarily involves the official power holders, for example senior management, ensuring that the structure and culture of the organization, in both the official and unofficial dimensions, are mutually supportive.

As was shown in chapter three, this conceptualisation of managerial effectiveness, with attention to the official and unofficial dimensions of the organization, originates from a model developed by Watson (1986). Watson's model was discussed in chapter three and developed as the conceptual framework of this investigation (described in chapter four).

It is the researcher's view, that the conceptual framework of this investigation, with its emphasis on the cultural and political interplay in the organization, offers the opportunity to avoid some of the inadequacies of orthodox management theory which were identified in chapters three and four. It is a scheme to aid further investigation of the task and function of management within the organization whilst avoiding the inadequacies of "orthodox" management theorising. The latter include underplaying human subjectivity and

cultural plurality within the organization and of not paying attention to the ideological and political nature of managerial activity. Evidence from the cases presented also leads the researcher to the following propositions:

First, organizations are indeed cultural milieux (Louis,1983) comprised of individuals and groups with differing interests, beliefs and cultural assumptions which inform their behaviour and infuse their lives with meaning;

Second, these meanings provide the basis for co-operation and conflict amongst individuals and groups within the organization;

Third, management as an organizational function is very much informed by the interests, beliefs, ideology and assumptions of individuals who perform the managerial activity acting alone and as a group. The managerial function is not isolated from this cultural and political interplay and performed in some ideological or value free vacuum;

Fourth, because the management task is infused by values and meanings, it cannot be automatically assumed that the ideology, assumptions and beliefs are shared by individuals throughout the organization. To officially legitimise one ideology and mobilise structural and cultural features, is likely to de-legitimise and render unofficial the meanings, values,and beliefs of other individuals and groups.

It is necessary to elaborate in turn on each of these propositions. Louis presented a view of:

> .. organizations are cultural milieux, that is .. distinctive social units possessed of a set of common understandings for organizing action (e.g., what we're doing together in this particular group, appropriate ways of doing in and among members of the group) and languages and other symbolic vehicles for expressing common understandings (Louis 1983:39).

The evidence presented in this investigation supports the view that organizations are indeed cultural milieux comprised of individuals and groups with differing values, beliefs and cultural assumptions which inform their behaviour and infuse their lives with meaning. In a later article, Louis used the phrase 'intra-organizational loci of culture' to refer to the:

> Alternative sites of culture internal to an organizational setting.. (Louis 1985b:78)

A number of potential sites of culture existence within the organization have been identified by Louis. Considering the evidence from the different Units of management, some of the loci identified by Louis match the sites in the Units of management at which the

researcher has identified distinct cultures. For example, the senior management at the top of the organization have each developed their own official culture. The subtle language used in the Kingstown Municipal Hospital, described in chapter eight, by members of senior management, associated with the introduction of a system of clinical audit amongst the medical profession bears out the following argument of Louis:

> Culture may develop around the top of an organization. There maybe a "for our eyes-only" culture encompassing the secrets that have emerged among a ruling elite (Louis 1985b:79).

The statement of official values produced by the UGM of the Kingstown Hospital supports Louis' argument about the development of a:

> "for-public consumption" culture at the top, one deliberately designed by the ruling elite to be passed down through the organization (Louis 1985b:79).

Elsewhere within the Units of management cultures have been observed. Some departments within the hospitals, (which Louis would class as formal unit designations) exhibit culture 'foci'. For example, the belief of one group of medical staff within a clinical service department, in the need to preserve the autonomy of the different

disciplines within the particular clinical specialty area in the face of general management structures being introduced into the department, is the basis of cultural cohesion and the response to general management.

The wards of the hospital are also another 'loci' of culture. Through observation, the researcher noted the difference in style and atmosphere between the different wards. For example, the decision of a Consultant on a Paediatric ward not to wear the 'threatening white coat' because children need to 'feel at home' is a distinctive feature of the dress associated with a childrens's ward vis-a-vis other wards.

Further, the "horizontal" and "vertical" layers of the organization are also loci of culture. This is a particularly so in Health Service organizations. For example, descriptions by clinical staff of the ward areas as:

..the sharp end..

..where it all happens.

..the shop floor..

..the grass roots..

all demonstrate how clinical staff operating at one level (care delivery end) of the organization perceive their work and the value of it as different in relation to the work of individuals practicing at other levels.

The 'Cogwheel' (1967,72,74) medical structure has facilitated "vertical" levels of the organization being loci of culture. In the Kingstown Municipal Hospital, there is evidence that the different medical divisions contain distinct professional outlooks and interests. Indeed, the need to accommodate this distinctiveness within the formal management structure of the Royal Infirmary is behind the dissent of some doctors who believe that the lack of a Cogwheel structure is a major cause of inequality and ineffectiveness within the medical management structure of the Unit.

This evidence supports the argument presented in chapter three, that any organization is potentially a culturally pluralistic arena. It is so due to the range of diverse meanings, beliefs and assumptions held by individuals and groups within the organization.

The cultural plurality within the organization is significant because it forms the basis of conflict and co-operation between individuals and groups within the organization. Smircich noted that:

> ..organizations exist as shared meanings..the stability, or organization, of any group activity depends upon the existence of common modes of interpretation and shared understanding of experience. These shared understandings allow day to day activities to become routinised and taken

> for granted. Through the development of shared meanings for events, objects, words and people, organization members achieve a sense of commonality of experience which facilitates their co-ordinated action (Smircich 1983a:55).

It has been evident in the Units of management that such co-operation on the basis of shared meanings is present at strategic and operational levels of the organization. The senior management of each Unit are working as a team in order to transmit throughout the organization, clear values and assumptions which inform the official culture. The statement of 'corporate objectives' (appendix F) produced by the senior management group in the Kingstown Hospital, is indicative of the work being done by the UGM in order to develop shared values amongst senior management personnel.

In the other Units, such explicit documents have not been produced but there have been clear and shared statements made by senior management personnel to the researcher which outline what general management means within that particular Unit. Such statements are the basis of the official culture and structure and are serving to strengthen the image and identity of the managerial function within the Unit.

Shared meanings are powerful and necessary for a strong official culture. They are important in striving to achieve managerial effectiveness. For example, after analysis of the Royal Infirmary, it

is apparent that operational and strategic levels of the organization have traditionally been pulled together, as in a 'consensus' type organization, on the basis of the practitioner belief in individual patient care (Thompson 1986) and the shared perception amongst managers and staff of the hospital being a centre of care excellence.

Indeed though there is now evidence of 'dualism' in the Royal Infirmary there is still strong 'practitioner' beliefs bonding many individuals at strategic and operational level. The strong mutually supportive relationship between nursing and medical groups of staff at operational level is mirrored and re-inforced by the relationship between key medical and nursing personnel at senior management level.

Therefore, shared meanings are often the basis of co-operation between groups and individuals within the organization.

Conversely, they may well be the basis of conflict. The unofficial activity within each Unit is evidence that meanings and values which are not shared amongst individuals are the basis of group conflict and personal conflicts for individuals.

Group conflict is evident where the values and beliefs of a group are being penetrated by values and beliefs associated with another culture. In Kingstown Municipal Hospital, the nursing profession is split by the allegiance of some nurses to values and interests which other nursing colleagues see as originating from a group, senior management, who are more interested in economics and finances than

patient care.

Similarly in the Kingstown Municipal Hospital, members of senior management use subtle language to de-fuse the potential for conflict which surround the introduction of clinical review for medical staff. The conscious use of language and recognition of the politics associated with it indicates that they recognise the potential for group conflict over this issue.

For many individuals, there is a personal conflict as a result of taking on the managerial role and reconciling it with the traditional profession values, beliefs and interests. At least one senior manager in a Unit admitted to:

> struggling to accept the management of other professionals because as a nurse if it happened to me I would not like it.

Within the Units of management, individuals at the same hierarchical level of management have reacted differently to managerial responsibility. For example, in the Kingstown Municipal Hospital, the organizational chart indicates that departmental managers have been appointed. However, further analysis shows that departmental managers are reacting very differently to their new responsibilities. Some departmental managers perceive the incoming of general management as legitimate and relish the 'opportunity' which they now have, whilst

others view it oppositely and see the sham acceptance of this managerial responsibility as the best way to safeguard traditional work practices and the professional values of the department.

The fact that the examples above are either of support for the official culture or of conflict with it, indicates that Unit management are perceived as creating official cultures which are not perceived by individuals throughout the organization as value or ideologically free. This argument gains further credibility when the variations between the official culture and structure of the Units are noted.

The official culture and structure of the Kingstown Hospital and the Kingstown Municipal Hospital embody a managerial ideology that is distinctly different to the professional ideology initially at the heart of the official culture and structure of the Royal Infirmary. Management is not being undertaken in some ideological or value-free vacuum. Rather, it is very much underpinned by the values, beliefs, ideology and assumptions of individuals acting alone and as a group who perform the managerial activity. In being so, the official cultures and structures of the Units of management promote some values and assumptions to the official plane, whilst relegating others to the 'unofficial' plane. The outcome of this political behaviour by senior management is that in all the three cases analysed in this investigation general management has been implemented in three distinctive ways.

The resultant unofficial activity demonstrates that it cannot be automatically assumed that the official ideology, assumptions and beliefs are shared by individuals throughout the organization. This supports the argument made by several theorists, and noted by the researcher in chapter three, that it is inadequate to assume that there is a single culture which is universally shared throughout the organization (Van Maanen and Barley,1985).

The lack of a 'consensus' type of organizational culture demonstrates two things. First, the absence of a universal shared culture within the organization. Second, that though control over the official structure and culture of organizations is important in trying to achieve managerial effectiveness it can only be regarded as facilitating managerial effectiveness, rather than guaranteeing it. Despite control over official arrangements, the 'imperialistic' and 'dualistic' types of culture, show that managerial effectiveness as conceptualised in this investigation has not been achieved.

Hence, arising out of this discussion two further arguments of conceptual significance are offered. First, if 'organizational culture' is to be valuable as a concept then accommodation of the cultural plurality is essential. To continue to talk about it as an all- embracing feature of organizations is likely to be dangerously misleading. Second, managerial effectiveness can only be conceptualised by taking account of the status quo which exists within

the organization. This is indicated by the relationship between the structure and culture of the organization in both its official and unofficial dimensions.

Managerial effectiveness in Health Service organizations

The third and final question to be considered is - what are the implications of these findings for our understanding of managerial effectiveness in Health Service organizations?

Since the publication of the Griffiths Report, numerous investigations have been concerned with understanding and evaluating the impact of general management on the management function within Health Service organizations. Best (1987) examined the effect of general management in terms of the speed of decision-making and the development of an increased consumer orientation to service provision. Banyard (1988a,b,c) surveyed 'Units of Management' in two Regional Health Authorities, focusing on individuals' perceptions of changes in aspects of management such as the speed of decision-making, delegation and communication. Additionally, health organization and management theorists such as Harrison (1988b), Hunter (1988), Pollitt et al (1988a, 1988b) have worked both as individuals and as a team in order to investigate and evaluate the introduction of general management.

Within this discussion, evidence from these studies is considered

alongside evidence obtained during this investigation. It is used to consider some of the major issues arising out of the introduction of general management into Health Service organizations. It is anticipated that these issues can enhance our understanding of managerial effectiveness in the NHS.

Before doing this, it is important to acknowledge these investigations for two reasons. First, growth in the amount of empirical work on managerial activity in the NHS should be welcomed. As Hunter et al remarked:

> Management practices are generally neglected by researchers and there is very little in the way of a sound analysis of what managers actually do. In contrast, there is a great deal of analysis, primarily by health economists, on what managers and others could or ought to do but this only serves to highlight the absence of any significant input from other social sciences in contributing to a better understanding of the management of change (Hunter et al 1988:3).

Second, a brief scan of the theoretical approaches used, indicates that as with this investigation, other recent investigations have shared, to some degree, the need to focus beyond both the objective and what the present researcher labels as the 'official' features of

organization. Rather, researchers have felt the need to look at the softer and more 'subjective' aspects of Health Service organizations in order to understand and investigate both the introduction of general management and evaluate its impact. Strong and Robinson claim that their study of the philosophy, rationale and initial impact of general management on the NHS at DHA level is an 'ethnography' which gives a:

> ..a flesh and blood portrait of the behaviour and views of a wide range of those who work in NHS management (Strong and Robinson 1988:foreword).

Others have gone even further towards the subjective pole (of the subjective/objective continuum, Smircich (1983c) by using participant observation to study aspects of management in the NHS (Filby and Wilmott 1988; Munson and McNulty 1989).

These approaches are encouraging, in that they are incorporating some of the recent 'processual' trends (discussed in chapter three) within organization and management theory. Indeed a common feature in the theoretical approach to these investigations is that the human element of organizational life is increasingly central to attempts to understand and investigate the management function within the NHS. As such, they share a similar theoretical starting point as this investigation. This can only be welcomed if we are to avoid applying the inadequacies of organization, management and change theory (also

discussed in chapter three) to studies of the NHS organizations. The similarities of the approach between the work of Pollitt et al (1987) and this investigation are worth noting. Both studies use conceptual schemes to look beyond the 'public' versions of change. In this investigation the researcher has used the official and unofficial dichotomy. Whereas Pollitt et al use the formal and informal distinction to distinguish the 'form' of change from the 'substance' of change. The latter distinction has also been used by Harrison (1988b) and was explained fully in a memorandum to the Social Services Committee entitled "Evaluating the impact of National Health Service Management". In this paper the authors stated that:

> One underlying assumption which guides our own study and which, we would venture to suggest, ought to underlie any attempt to evaluate the Griffiths and related changes, is that it is both possible and desireable to distinguish between the <u>form</u> and the <u>substance</u> of management.....whilst the evaluation of Griffiths must take into account the formal changes, it must also go beyond them and consider their impact. Thus the extent to which GM posts have been filled and by whom, the extent to which new management structures have been introduced, and the extent to which systems such as management budgets or performance indicators have been adopted are all of interest

> in the evaluation of Griffiths, but only as a means of achieving the Griffiths objectives of improved performance, greater consumer orientation, and better implementation of plans. The achievement, or otherwise, of these objectives should be the central focus of investigation. As the Griffiths report itself noted, it is all too easy to create the illusion of change' (Pollitt et al 1987:1)

Recently, Pollitt et al (1988b) contributed an article entitled "The reluctant managers : clinicians and budgets in the NHS" which brought 'behavioral' concerns to the fore concerning the introduction and evaluation of management budgeting.

These approaches are evidence that in Health Services organization and management literature, theorists are beginning to look beyond the official version of events in their attempts to understand management and organizational change.

At the outset of this chapter, it was noted that some of the observations made by the researcher during this investigation have implications for our understanding of managerial effectiveness within Health Service organizations. For the remainder of the discussion, the intention is not to try to assess the amount of change which has taken place along the cultural dimensions discussed in chapter five.

Nor is it to evaluate the impact of general management per se or assess whether the introduction of general management is a success or failure per se. The work of Banyard (1988a,b,c), Parston (1988) and Strong and Robinson (1988) has gone some way towards doing this.

Rather, the intention of the researcher is to discuss two propositions which it is believed are of major significance in our attempts to understand managerial effectiveness at Unit management level.

To lead into the discussion of these propositions, it is useful to re-state the two questions which have steered the data collection in this investigation.

First, to what extent are the cultural assumptions espoused in the Griffiths Report (discussed in chapter five) informing the official structure and culture of the Units? Second, are senior management in the Units of management effectively pulling the organization together and along in a general direction? To deal with this second question, it has been necessary to address senior management's handling of the structure and culture of their organizations. By doing so, indications are provided of whether the necessary conditions exist for achieving managerial effectiveness, as understood in this investigation.

As a result of dealing empirically with these two questions and in

addition to the conclusions about organizational change and managerial effectiveness discussed earlier in the chapter, two major propositions concerned with the managerial process and managerial effectiveness in the NHS are offered by the researcher.

First, general management is affording senior management at Unit level greater freedom to try and shape organizational form and behaviour according to local circumstances. Evidence from the three Units indicates that senior management are taking this opportunity to such an extent that a major cultural change resulting from the introduction of general management concerns the increased willingness of senior managers to take responsibility for introducing and developing diverse official structures and cultures in their organizations.
The second proposition is more directly linked to managerial effectiveness. This is, that the necessary conditions for achieving managerial effectiveness, as conceptualised throughout this study, do not exist whilst cultural assumptions held by clinical professionals such as doctors, nurses and para-medical professionals are in conflict with some of the assumptions being espoused by senior management through official structural and cultural arrangements.

It is necessary that the basis of these propositions is explored further beginning with the first.

The cases described in chapters six, seven and eight have re-inforced the point made in chapter five, that the recommendations of the Report

have not been perceived as ideologically or value neutral by those in the NHS. Rather, the reactions at national level (described in chapter five) and those at local level (described in chapters six, seven and eight) indicate variation in the translation of the Griffiths recommendations at the local level.

The translation and transmission of the Griffiths Report has occurred through a process which is impacted upon by the local context. Within this local context, it has been demonstrated that there are a whole range of 'subjective' factors operating which have influenced the introduction of general management. These factors include, the traditionally dominant ethos and cultural assumptions within the organization, the influence of key personalities including the appointed UGM's, interests and beliefs of key groups of actors in the organization and the historical development of the organization. In addition, there is the impact of 'objective' factors such as contingencies of size, and technology. These factors play a part in explaining the variations of official culture and structure which have been observed in the Units of management of the DHA.

In all of the cases discussed, the official structure and culture within each Unit shows that senior management have varied in their acceptance of the assumptions contained in the recommendations of Griffiths. As a consequence, the official cultures and structures show that the introduction of general management has been diverse. The introduction of general management has afforded senior managers at

Unit management level sufficient scope to try and shape organizational form and behaviour according to local circumstances. More so than was possible in previous re-organizations which were taken as structural 'blueprints'.

Evidence indicates that three different models of general management are operating in the Units. These three different models are underpinned by distinctive official cultures and official structures. Therefore, it seems that UGMs have taken the opportunity discussed by P.J Humphris who as a UGM commented in 1986 that:

> The implementation of general management offers an unprecedented opportunity to abandon the NHS obsession with prescribed, mechanistic structures and to create imaginative, flexible and diverse management arrangements at sub-unit level (Humphris 1986:57).

The UGM's have innovated in their approach to formal roles and definitions of roles. Structural differences between these organizations embody differences in the official managerial style, philosophy and ideology. These styles, philosophies and culture show that the official culture recommended by Griffiths has been accepted to varying degrees by senior management within the Units.

To illustrate this point it is worth looking at a number of examples.

First, one of the major messages in the Griffiths Report was for the need to take the management process as near to the patient as possible. In practice, the official acceptance in the Units of the need to devolve managerial responsibility appears to have been varied. In Kingstown Municipal Hospital, general management has been devolved down to ward level in the form of a system of 'Ward managers' with budgetary responsibility resting with these managers at the ward level. By comparison, in the other two larger Units, this devolution has been much slower and restricted and functional management has not quite fully replaced with general management. Budgetary responsibilities appear to have been kept largely at a level of management which in hierarchical terms is one above the ward sister/manager.

Similarly, with regard to the involvement of the medical profession as a group in the management process, there are three differing official approaches being pursued. The comments of the UGM's and the organizational charts show this. In Kingstown Hospital and to some degree in the Kingstown Municipal Hospital, the medical committee is not viewed as an executive body, whereas in the Royal Infirmary it is an executive voice in Unit management. The actual inputs of the respective medical committee in terms of the executive decision-making process at Unit management level is not the issue here. Rather, it is the overt public statement concerning the power of the medical opinion on Unit management which is of interest. Certainly, the language distinction between the Medical Advisory Committee and the Medical

Executive Committee is perhaps symbolic of an ideological difference between Units.

Third, attention to the nurse management arrangements indicates that in all of the three Units the role of the most senior nurse varies. In the Kingstown Hospital, the official desire to erode functional management ensures that the chief nurse now has responsibilities for staff who are not from the nursing disciplines. Alternatively in the Kingstown Municipal Hospital, the chief nurse has performs a role which is similar to the former Director of Nursing Services (DNS) role in that it is purely nursing based, but which in practice is trying to officially remove functional management in favour of general management. Finally, in the Royal Infirmary the chief nurse is very much performing the old DNS role and there is little change in the philosophy towards the management of the nursing staff as compared with functional management times.

These examples are evidence that the officially dominant ideology between the Units varies and this is translated into the official culture and structure of the Units. In each Unit, management is shown as a function underpinned by meanings assumptions and ideologies. In the Royal Infirmary, general management has been introduced whilst protecting the dominance of medical and nursing values as well as the traditional style of interaction amongst staff and managers of the hospital. In contrast, in the other units there has been a greater attempt to challenge particular existing practices and interests and a

willingness to take on board assumptions contained within the Griffiths report. The official arrangements demonstrate an official desire to introduce change.

The issue of the desire to change is important. The cases described in chapters six, seven and eight, show that for some individuals the introduction of general management has been an opportunity for change, to be grasped, whilst to other individuals it has been perceived as a threat to the traditionally dominant culture and as such something to be tempered and treated with caution. This is no more clearly shown than in the differences in attitude between the general manager in the Kingstown Hospital and the first general manager in the Royal Infirmary.

The impact of the UGM in developing this diversity of official arrangements needs to be noted. Each Unit General Manager has greatly shaped the composition and philosophy of the Unit management team in their respective Units. In all of the cases, there have been differences in the structure and cultural orientation of the team. Differences in the professional and functional backgrounds of the members of the senior management teams between the Units is a significant factor to note. In the Royal Infirmary, there has been a clinical professional domination of the team as indicated by the backgrounds of key actors whilst in the Kingstown Hospital and the Municipal hospital there has been a more 'administrative' (non-clinical professional) composition of the team. Such differences

appear to be vital factors in the different style and philosophies of each Unit management team.

The importance of the professional/functional background and personalities of UGM's cannot be underplayed in attempting to understand this variability. The visibility and overt management style of the UGM in the Kingstown Hospital has been vital in introducing the general management culture and identity to the Unit. Similarly the UGM in the Kingstown Municipal hospital has made a conscious attempt to be visible and let people know who is in charge of the hospital.

Other theorists have noted that in these general management times the background and personalities of individuals performing general management roles is significant on the style of management which characterises the organization. It was reported by Davies that Hunter acknowledged that there has been:

> ..a very different interpretation of what general management is in different parts of the country, Davies 1988:791).

Davies continues that a factor in this is the background of the general manager. He notes that Hunter:

> distinguished between three different groupings of

> general manager : those 'relabelled' managers who had been administrators; those who had joined the NHS from outside - many of whom had left since and those who had been professionals elsewhere in the service. Each had different experiences and perceptions of what general management was (Davies 1988:791).

In concluding we can say that this evidence indicates that senior management locally are responding to the change. In all three cases general management is being implemented and the official arrangements are reflecting the Griffiths assumptions to varying degrees. As Parston observed:

> this sense of local control is one of the strongest features of the cultural evolution now occurring in the NHS. Its beginnings are rooted in the early debates that followed the Griffiths report and its most obvious ramification is the diversity of organizational structures which now exists in the NHS. More important to the potential long-term success of general management implementation, however, is the growing recognition that general managers have to commit time and thought diagnosing and developing managerial responses to local conditions, rather

than simply awaiting central imposition of standardized approaches (Parston 1988:24).

However, the response of senior management to change is only one side of the equation. The other side of the managerial effectiveness equation is concerned with the response of individuals throughout the Units to organizational change. It is to this issue that attention is now turned.

The second question which has structured the presentation of findings is, are senior management in the Units of management pulling the organization together and along in a general direction? To deal with this question, it has been necessary to look at the relationship between the official and unofficial arrangements in the Units. Through this relationship, some indications are provided of whether the necessary conditions exist for achieving managerial effectiveness.

Having done this, the second proposition offered by the researcher is that, managerial effectiveness, as conceptualised throughout this study, cannot be achieved whilst cultural assumptions held by clinical professionals such as doctors, nurses and para-medical staff are in conflict with some of the assumptions being espoused by senior management through official structural and cultural arrangements.

The conceptual framework offered the 'consensus' organization as the type of organizational culture which is best suited for achieving

managerial effectiveness. Within the Units of management observed, the cultural and micropolitical processes are not those which are associated with the 'consensus' type of organizational culture. Rather, they are those which indicate either the 'dualism' or 'imperialism' types of organizational culture. Both of these descriptions describe situations of conflict between cultures.

A common feature of the Units described in this study, is that the 'consensus' description does apply. It does not because within each Unit, the official culture has not been universally accepted by groups and individuals. Much of the conflict can be understood as having a basis in the clash between medical and managerial cultural assumptions.

The notion of clinical autonomy is a cornerstone of the work practices and social reality of individuals who deliver health care to the patient, in particular, the Doctors. The cases described in chapters six, seven and eight indicate that some assumptions which make up the official culture are perceived to challenge this clinical autonomy. Using the definitions of Tolliday (1978), Harrison (1988b) discussed the notion of clinical autonomy and the various 'claims to autonomy' which inform our understanding of the notion.

Using this discussion as a basis, it is possible give examples, from the cases covered in this investigation, of conflict between the medical culture and the general management culture.

One claim to autonomy identified by Tolliday is that of 'the right to practice free from hierarchical management'. In all of the cases described in this investigation, there is evidence of unofficial activity which is a direct response by a member of the medical profession to what they perceive as a challenge to this right.

For example, in the Kingstown Municipal Hospital an 'accountable manager' (with a medical background) and medical colleagues perceive this right as being threatened by the introduction of the general management principle into the department. The response to what they perceive as an 'illegitimate challenge' has been for the 'accountable manager' to accept managerial responsibility solely to preserve the autonomy and self-regulation of medical colleagues within the department.

The idea of an 'outsider' coming in as a 'manager' has been perceived as a threat to the traditional work practices and basis of relationships within that department. The accountable manager informed the researcher that the response is a defence mechanism against managerial accountability being introduced into the department over and above professional autonomy. As such it subverts official arrangements.

Similarly, in another clinical department there is evidence of a senior member of the medical profession officially accepting the

managerial role required by senior management but devolving the responsibility to another person (a non clinical person). The arrangement whilst being officialised because the department now has an 'accountable manager' is in reality 'unofficial' because it is a defence mechanism against management interference. As the non-clinical person involved admitted:

> we don't want interference by people from outside of the department..the way it works is that I can use the Prof as a source of power in dealings with other clinicians and with management, in return for freeing the Prof from the daily routines of management.

This is another example of the protection of a cultural assumption which has traditionally been taken for granted but which is now perceived as being challenged. It is indicative of the professional belief in the right to practice free from hierarchical management.
These examples are at the individual level. However, an example of a group of individuals responding is this manner is provided by the Doctors in the Kingstown Hospital. Their collective fear about hierarchical control led to an official protest. The outcome has been that they are not formally accountable to any manager other than the UGM.

Beliefs about the 'acceptance of patients' and 'control over

diagnosis and treatment' (Schulz and Harrison, 1986) are a further source of conflict between the medical and managerial cultures. In all three cases, there is evidence of doctors and nurses questioning the compatibility between the professional beliefs about treatment of the individual patient and a managerial ideology which they perceive as financially driven in spirit. To these individuals who value the total control over the clinical decision and the right to control diagnosis and practice (Schulz and Harrison 1986) therein lies conflict between cultures.

These examples of doctors and nurses defending their beliefs can be demonstrated both at an individual and group level. For example, the initial official culture of the Royal Infirmary was largely a response to fears (held by senior management individuals and prominent medical staff) that the clinical 'right to practice' maybe challenged by the introduction of general management (McNulty and Filby, 1988).

A further source of conflict identified by the researcher which has not been mentioned in the Tolliday or Schulz and Harrison analyses is an expectation on the part of some medical staff that their practice should be facilitated by non-clinical staff. The case (discussed earlier) of the senior doctor in the Kingstown Municipal Hospital who passed over the daily running of the department to another person is perhaps an indication of such a perception. A further example of this perception has been provided by a senior consultant in the Kingstown Hospital who refused to accept managerial responsibility for the

department because 'it was asking too much'.

That such perceptions are held is not surprising bearing in mind that the official structure within the Health Service has traditionally placed non-clinical personnel in a 'facilitating' role for the medical profession. General management, in encouraging the Doctors to act as managers, is challenging this. As one manager in the Kingstown hospital noted:

> Some of them can't get to grips with the idea that they now have to do a lot more for themselves than in the past. The filling in of requisition orders for equipment is an example.

The researcher is not alone in drawing attention to the increasing conflict between the manager and in particular the Doctor. Ham (1988) commented in an article entitled 'The challenge is to reform the NHS without losing the Doctors' that:

> ..it should be emphasised that doctors face an ethical dilemma in deciding whether to assume responsibility for budgets and participate in the management of services. The concern of doctors to do what is best for the individual patient may conflict with the need to set priorities between services, to keep expenditure within agreed limits

> and to maximise the benefit of services to the population. Any attempt to integrate doctors into management must acknowledge this conflict and recognise the significant personal commitment of most doctors to provide a high-quality service often beyond their contractual obligations (Ham 1988:24).

Similarly Harrison's thesis is that recent changes (including general management):

> .. represent the first serious attempt, in the lifetime of the NHS, to shift the 'frontier of control' between, on the one hand, doctors (physicians), and, on the other, the government (Harrison 1988b:1)

As managers are now 'agents of government' the potential for conflict is heightened if not inevitable.

Whereas arguments, such as that of Harrison and the case of the Kingstown Royal Infirmary, lead the researcher to suggest that a 'consensus' organization was achievable in pre-general management times, evidence in these general management times from the Units analysed by the researcher, suggests that the present level of conflict and the basis of it, render the 'consensus' type of

organization unattainable.

Hence, the proposition that managerial effectiveness, as conceptualised throughout this study, cannot be achieved whilst cultural assumptions held by clinical professionals such as doctors, nurses and para-medical professionals are in conflict with assumptions being espoused by senior management through official structural and cultural arrangements.

Rather, managerial effectiveness in the Units of management is more easily understood and explained by reference to one of the other types of organizational culture outlined by the researcher in chapter four.

The type which is most appropriate depends on the cultural and political processes operating in that particular context. For example, in the case of Kingstown Municipal Hospital it would seem that managerial control has increased in general management times. As such, the 'imperialism' type is useful in describing this organization because change has been introduced and is having an impact either because some staff perceive it as legitimate or because others such as nurses and para-medics do not perceive themselves to possess sufficient material and symbolic resources to resist.
Alternatively, in contexts such as the large acute general hospital (Kingstown Municipal Hospital and Kingstown Royal Infirmary) the researcher suggests that the 'dualism' type of culture is most valuable in understanding and explaining the political and cultural

processes which are operating. This is so because within both Units of management there are two cultures, the managerial and the medical, operating alongside each other. The scenario is one of a power struggle between on one side, senior management (managerial culture) striving to 'manage' the hospital and increase their influence over medical practice through official arrangements such as, clinical audit and departmental review, and on the other side, powerful group of medical staff (medical culture) possessing sufficient material and symbolic resources to preserve their clinical autonomy and self regulation.

Its value to our understanding of managerial effectiveness in the NHS is further strengthened by the observation that the broader Health Service arrangements appear to foster the existence and respective strengths of the two cultures. This is so because they allow the demonstration of the strengths of the respective cultures to occur at different levels of the organization.

For example, as the cases have shown, general management appears to have facilitated the development of a managerial culture at the top of the organization. As Banyard noted in his discussion of evidence collected by the Commons Social Services Committee in 1987:

> One common view is that general management had tended to improve the image of units - if only because a more senior member of staff was now

> able to champion the cause of each Unit. Several submissions reported favorably on a strong sense of identity and purpose at Unit level, as well as a greater sense of cohesion and direction (Banyard 1988c:883).

Whilst at the care delivery levels of the organization and in terms of the management of the medical profession in particular, the managerial culture, as yet, cannot be said to have had a major impact. As Harrison noted:

> ..the Doctors' structural monopoly remains unchanged. It is still general practitioners who provide the selection of cases for consultants to work upon. It is still consultants who decide which, and how many, patients to see, how to diagnose and treat them, when to admit and when to discharge them. It is still not possible for health authority managers to ensure that they recruit consultants whose clinical interests match local priorities, and most consultants are employed by Regional Health Authorities in whose premises and upon whose residents they practice. The prime determinant of the pattern of health services is still, just as before Griffiths, what doctors choose to do (Harrison 1988b:123).

Therefore in concluding this investigation it is reasonable to suggest that the official cultural assumptions contained within the Griffiths Report are perceived by many as being in conflict with beliefs of staff who deliver care, especially the medical profession. As a result, in contexts where the delivery of care is controlled by the Doctors in particular, the strength of the material and symbolic resources are such that managerial effectiveness, as conceptualised in this investigation cannot be achieved.

Further, even in contexts where the medical power is not present or not such a strong factor, management control is more likely to derive from the power of management over staff (because of management's material and symbolic resources) as opposed to the universal legitimacy of the managerial culture. This is 'imperialism', and it does not fit with the conception used in this investigation of managerial effectiveness.

Currently, it appears that the managerial process of the NHS is based on a relationship between different cultures within the NHS. It remains to be seen whether conflict between the cultures continues to make it an uneasy relationship which breeds the type of organization explained by reference to either the 'dualism', 'informal empire', balkans' or 'imperialism' types of organization culture or whether the conflict is resolved and the organization develops into one which resembles that described as 'consensus'.

Bibliography

This bibliography gives full references for all works cited within this thesis. It also contains books and articles not cited in the text but which the researcher has consulted and believes may be of interest and use to other researchers in similar fields.

ABRAVENAL, H. (1983), 'Mediatory Myths in the Service of an Organizational Ideology' in Pondy, L. R., Frost, P.J., Morgan, G. and Dandridge, T.C. (eds), Organizational Symbolism, Greenwich, Conn.:JAI.

ALBROW, M. (1970), Bureaucracy London:Macmillan.

ALDRICH, H.E. (1979), Organizations and Environment, Englewood Cliffs, N.J.: Prentice-Hall.

ALDRICH, H.E. & PFEFFER, J. (1976), 'Environments and Organizations', Annual Review of Sociology, Vol 2.

ALLAIRE, J & FIRSIROTU, M.E. (1984), 'Theories of Organizational Culture', Organization Studies, Vol 5, No 3.

ANONYMOUS. (1984), 'Administrator Dominated or Management Efficient NHS, British Medical Journal, 289, 17th Nov, pp 1331-1332.

ANONYMOUS. (1985), 'Persuading Doctors to Enter Management', British Medical Journal, Vol 290, June 8, p 1761.

ARGYRIS, C. (1964), Integrating the Individual and the Organization, New York:Wiley.

ARGYRIS, C. (1972), The Applicability of Organizational Sociology, Cambridge University Press.

ARNOLD, D. (1987), 'Is Management a Common Culture', The Health Service Journal, March 19, pp 332-333.

ARNOLD, D.O. (1970a), (ed) The Sociology of Subcultures. Berkeley, CA:Glendessary.

ARNOLD, D.O. (1970b), 'A Process Model of Subcultures', in ARNOLD, D.O. (ed.)

ARNOLD, D.O. (1970c), 'Subculture Marginality', in ARNOLD, D.O. (ed.)

ATKINSON, P.A (1976), The Clinical Experience:An Ethnography of Medical Education, Unpublished PhD Thesis, Reported in Research Methods in Education and the Social Sciences, Open University, Block 4 Part 3, Milton Keynes:The Open University Press.

ATKINSON, P.A (1979), 'Research Design in Ethnography', in The Open University, Research Methods in Education and the Social Sciences, Block 4, Part 3, Milton Keynes:The Open University Press.

BAILEY, F.G. (1970), Stratagems and Spoils:A Social Anthropology of Politics, Blackwell:Oxford.

BAILEY, K. (1982), Methods of Social Research, New York:Free Press.

BANYARD, R. (1988a), 'How Do UGMs Perform?', The Health Service Journal, (21 July), pp. 824-825.

BANYARD, R. (1988b), 'Watching the Revolution', The Health Service Journal,(11th August), pp. 916-917.

BANYARD, R. (1988c), 'More Power to the Units', The Health Service Journal,(4th August), pp. 882-883.

BARLEY, S.R. (1983), 'Semiotics and the Study of Occupational and Organizational Cultures', Administrative Science Quarterly, 28, pp 393-413.

BARNARD, C.I. (1938), The Functions of the Executive, Cambridge, Mass:Harvard University Press.

BARNARD, K and LEE, K. eds. (1977), Conflict in the National Health Service, Croom Helm:London.

BARNARD, K., LEE, K., MILLS, A. and REYNOLDS, J. (1980), 'NHS Planning:An Assessment', Hospital and Health Services Review, Vol. 76. nos. 8 and 9, pp 262-265, 301-304.

BATE, P. (1984), 'The Impact of Organizational Culture on Approaches to Organizational Problem-Solving', Organization Studies, 5/1 pp 43-66.

BECKER, H.S. (1958), Problems of Inference and Proof in Participant Observation, American Sociological Review, Vol 23. No.6 pp 652-660.

BECKER, H.S. et al (1961), Boys in White, University of Chicago Press.

BECKER, H.S. (1971), 'The Nature of a Profession', in Sociological Work:Method and Substance, London:Allen Lane.

BECKER, H.S. and GEER, B. (1957), 'Participant Observation and Interviewing', Human Organization, 16, pp 28-32.

BECKER, H.S. and GEER, B. (1982), Participant Observation:The Analysis of Qualitative Field Data, in BURGESS, R.G. (ed.).

BENSON, J.K. (1977), 'Organizations:A Dialectical View', Administrative Science Quarterly, 22:1-21.

BERGER, P. L. and Luckmann, T. (1971), The Social Construction of Reality, Harmondsworth:Penguin.

BEST, G. (1987), The Future of NHS General Management: Where Next?, Kings Fund Project Paper No 75, Kings Fund College:London.

BITTNER, E. (1973), 'The Police on Skid-row', in Salaman, G. and Thompson, K., (eds), People and Organizations, London:Longman.

BITTNER, E. (1974), 'The Concept of Organization', in Turner, R., (ed), Ethnomethodology, Harmondsworth:Penguin.

BLAU, P.M. (1963), The Dynamics of Bureaucracy, University of Chicago Press.

BLAU, P.M. (1974), On the Nature of Organizations, New York:Wiley.

BLAU, P.M. and SCHOENHERR, R.A. (1971), The Structure of Organizations, New York:Basic Books.

BOEKE, J.M. (1952), Economics and Economic Policy of Dual Societies, Haarlem.

BOGDAN, R. and TAYLOR, S.J. (1975), Introduction to Qualitative Research Methods, New York:Wiley.

BOLAND, R.J. and HOFFMAN, R. (1983), 'Humour in a Machine Shop:An Interpretation of Symbolic Action', in Pondy et al. (eds).

BOURN A. (1987), 'Fighting Truth Decay in the NHS', Accountancy,(September), pp. 120-121.

BOURN, A. and BOURN, M. (1988), Teaching Management to Medics, Health Service Journal, (May 19th), p 567.

BOURN, M. and EZZAMEL, M. (1986), 'Organizational Culture in Hospitals in the National Health Service', Financial Accountability & Management, 2(3), Autumn.

BRAHMA, R.K. (1984), 'Contribution to ARM Conference', Reported in the British Medical Journal, Vol. 289 (21st July, 1984), pp 201-2.

BRINDLE, D. (1988), 'NHS Management is Declared Fighting Fit', Financial Times, January 29.

BROMS, H. and GAHMBERG, H. (1982), Mythology in Management Culture, Helsinki School of Economics

BROWN, R.G.S. (1979), Reorganizing the National Health Service:A Case Study of Administrative Change, Blackwell/Robertson:Oxford.

BRYMAN, A. (ed.), (1988), Doing Research In Organizations, London:Routledge

BRYMAN, A. (1989), Research Methods and Organization Studies, Unwin Hyman:London.

BUCHANAN, D.A. and Huczynski, A.A. (1985), Organizational Behaviour: an Introductory Text, Englewood Cliffs, N.J.:Prentice-Hall.

BUCHANAN, D., BODDY, D., and McCALMAN, J. (1988), 'Getting In, Getting On, Getting Out and Getting Back', in BRYMAN, A. (ed.).

BULMER, M. (ed.) (1977), Sociological Research Methods, London:Macmillan Press

BURAWOY, M. (1979), Manufacturing Consent, Chicago:University of Chicago Press.

BURGELMAN, R.A. (1985), 'Managing the New Venture Division:Research Findings and Implications for Strategic Management', Strategic Management Journal, Vol.6, No. 1, pp 39-54.

BURGESS, R.G. (ed.) (1982a), Field Research:a Sourcebook and Field Manual, London: Allen & Unwin

BURGESS, R.G. (1982b), 'Approaches to Field Research', in BURGESS, R.G. (ed.).

BURGESS, R.G. (1982c), 'Styles of Data Analysis:Approaches and Implications', in BURGESS, R.G. (ed.).

BURGESS, R.G. (1982d), 'Keeping Field Notes', in BURGESS, R.G. (ed.).

BURGESS, R.G. (1982e), 'The Role of Theory in Field Research', in BURGESS, R.G. (ed.).

BURGESS, R.G. (1982f), 'Elements of Sampling in Field Research', in BURGESS, R.G. (ed.).

BURGESS, R.G. (1982g), 'Some Role Problems in Field Research', in BURGESS, R.G. (ed.).

BURGESS, R.G. (1982h), 'Multiple Strategies in Field Research', in BURGESS, R.G. (ed.).

BURGESS, R.G. (1982i), 'The Unstructured Interview as a Conversation', in BURGESS, R.G. (ed.).

BURNS, T. (1961), 'Micropolitics', Administrative Science Quarterly, 6.

BURNS, T. (1977), The BBC:Public Institution and Private World, London: Macmillan.

BURNS, T. and STALKER, G.M. (1961), The Management of Innovation, London:Pergamon.

BURRELL, G. and MORGAN, G. (1979), Sociological Paradigms and Organizational Analysis, London:Heinemann.

CHAMPAGNE, F., CONTANDRIOPOULOS, A.P., LAROUCHE, D., CLEMENHAGEN, C., and BARBIR, C. (1987), Long Range Planning, Vol. 20, No 3. pp 77-83.

CHAWNER, J. (1983), 'The Consultant's Role in NHS Management', British Medical Journal, Vol. 287 (10th December), pp 1916-8.

CHILD, J. (1972), 'Organization Structure, Environment and Performance', Sociology, 6:2-22.

CHILD, J. (1984a), 'Culture, Contingency and Capitalism in the Cross National Study of Organizations', in Staw and Cummings.

CHILD, J. (1984b), Organization (2nd edition), London:Harper and Row.

CLEGG, S and DUNKERLEY, D. (1980), Organization, Class and Control, London:Routledge and Kegan Paul.

COGWHEEL REPORTS, Reports of the Joint Working Party on the Organization of Medical Work in Hospitals: 1st Report (1967); 2nd Report (1972); 3rd Report (1974).

COHEN, A.K. (1970), 'A General Theory of Subcultures', in ARNOLD, D.O. (ed.)

COHEN, M.D., MARCH, J.G. and OLSEN, J.P. (1972) 'A Garbage Can Model of Organizational Choice', Administrative Science Quarterly, 17:1, pp 1-25.

COLES, J. (1988), 'Clinical Budgeting as a Management Tool' in R.J.Maxwell (ed.), Reshaping the National Health Service, pp. 126-137, Hermitage, Berks:Policy Journals.

COOK, T. (1988), 'Why the Best Option May Yet Lie Within', Financial Times, March 16.

COOMBS, R.W. (1987), 'Accounting For the Control of Doctors:Management Information Systems In Hospitals', Accounting, Organizations and Society, Vol. 12, No.4, pp 389-404.

CROMPTON, R., and JONES, G. (1988), 'Researching White Collar Organizations: Why Sociologists Should Not Stop Doing Case Studies', in BRYMAN, A. (ed.).

CUMMINGS, L.L. and STAW, B.M. (1981), Research in Organizational Behaviour, VOL.3, Greenwich, Conn.:JAI Press.

CYERT, R.M. and MARCH, J.G. (1963), A Behavioral Theory of the Firm, Englewood Cliffs N.J.: Prentice-Hall.

DASGUPTA, A.K. (1974), Economic Theory and the Developing Countries, Macmillan:London.

DAVEY, W.J. (1985), 'Unit Management and the Role of Doctors in Local Decision Making', British Medical Journal VOL 291, 28 September, pp 911-913.

DAVIES, C. (1972), 'Professionals in Organizations:Some Preliminary Observations on Hospital Consultants', Sociological Review, 20.

DAVIES, P. (1988), 'More Than Just Window Dressing', Health Service Journal, 14 July, pp 790-791.

DAVIS, S.M. (1982), Managing Corporate Culture, Cambridge, MASS.:Ballinger.

DAY, P. and KLEIN, R.E. (1983), 'The Mobilisation of Consent Versus the Management of Conflict:Decoding the Griffiths Report', British Medical Journal, Vol. 287, (10 December), pp 1813-1816.

DEAL, T.E. (1985), Cultural Change:Opportunity, Silent Killer, or Metamorphis?, in KILMANN, R.H. et al (eds.).

DEAL, T. E. and KENNEDY, A. (1982), Corporate Cultures, Reading, MA:Addison- Wesley.

DHSS. (1972), Management Arrangements for the Re-organised National health Service (Grey Book); London, HMSO.

DHSS. (1979), Patients First:Consultative Paper on the Structure and Management of the National Health Service in England and Wales, London:HMSO.

DHSS. (1983b), Health Care and its Costs: The Development of the National Health Service in England, London, HMSO.

DHSS. (1984a), 'Griffiths Report - Health Authorities to Identify General Mangers',Press Release No. 84/173.

DHSS. (1984b), 'Improving NHS Performance': Clarke, K. Press Release. 84/276, 23rd August.

DHSS. (1985a), 'Performance Indicators for the NHS', Letter No. DA (85) 19, 19 July.

DHSS. (1985b), Health Services Management:Management Budgeting, Circular HN(85)3.

DHSS. (1985c), Health Services Management:Consultants and General Practitioners in General Management:Unit Medical Representatives with General Management Duties, Circular HC (85) 9.

DHSS. (1985d), Health Services Management: Management Budgeting, Circular HN(85)3. London: DHSS

DHSS. (1986a), General Managers: Arrangements for the Introduction of Performance Related Pay, Circular No. PM (86) 11.

DHSS. (1986b), Health Services Management:Resource Management (Management Budgeting) in Health Authorities, Circular HN (86) 34.

DHSS. (1986c), Health Services Management: Resource Management in Health Authorities, Circular HN(86)34. London: DHSS

DHSS. (1986d),'Don't be nervous of change - Ray Whitney tells NHS managers', Press Release 86/124, 11th April

DHSS. (1986e),'National Strategy Document for Health Services Information Management Published', Press Release 86/308, 9th October

DHSS. (1986f), 'New Resource Management Initiative in NHS', Press Release 86/338, 4th November

DIMMOCK, S. (1985a), 'The Attributes of Excellence', Nursing Times, January 23.

DIMMOCK, S. (1985b), 'Big Business and the NHS', Nursing Times, January 30.

DIMMOCK, S. (1985c), 'The Role of the General Manager', Nursing Times, February 6.

DIMMOCK, S. (1985d), 'Managing the Business', Nursing Times, February 13.

DIMMOCK, S. (1985e), 'What Role for Nurses', Nursing Times, January 20.

DONALDSON, L. (1985), In Defence of Organization Theory, Cambridge University Press.

DRUCKER, P. (1979), Management, London:Pan Books.

DUNWOODY, J. (1984), Contribution to CIPFA/AHST Conference on the Griffiths Report, Reported in Public Finance and Accountancy, (January) p.30.

ECKSTEIN, H. (1958), The English Health Service, Cambridge, Mass., Harvard University Press.

ELLIOT, P. (1972), The Sociology of the Professions, London:Macmillan.

ELLIOT, P. (1973), 'Professional Ideology and Social Situation', Sociological Review, 21.

ESLAND, G., SALAMAN, G. and SPEAKMAN, M. (eds.) (1975), People and Work, Edinburgh: Holmes McDougall

EVAN, W.M. (1975), 'Measuring the Impact of Culture on Organizations', International Studies on Management and Organization, pp 91-113.

EVANS, T. (1983), Griffiths - The Right Prescription?, CIPFA/AHST:LONDON.

FARQUHARSON-LANG REPORT. (1966), The Administrative Practice of Hospital Boards in Scotland, HMSO:Edinburgh.

FEINMANN, J. (1985), 'Doctors on the Move as Managers', Health and Social Service Journal, (September 12th), pp. 1126-1127.

FILBY, I and WILLMOTT, H. (1986), Ideology, Myth and Humour:An Ethnography of a Public Relations Department in a State Bureaucracy, Working Paper No 107, Doctoral Working Paper Series:Aston University.

FILBY, I and WILMOTT, H. (1988), Ideologies and Contradictions in a Public Service Department: The Seduction and Impotence of Living Myth, Organization Studies, 9, 3. pp 335-349.

FINANCIAL TIMES. (1988), 'Healthcare':Financial Times Survey, January 15.

FINE, G.A. (1970), Small Groups and Culture Creation:The Idioculture of Little League Baseball Teams', American Sociological Review, Vol. 44. pp 733-745.

FINE, G. (1984), 'Negotiated Orders and Organizational Cultures', Annual Review of Sociology, 10, pp 239-262.

FISHER, C.M. (1970), Indigo Plantations and Agrarian Society in North Bihar in the Nineteenth and Early Twentieth Centuries, PhD Thesis:University of Cambridge.

FISHER, C.M. and MCNULTY, T.H. (1988), Management Development and the Concept of Culture - Is there a Future?. Unpublished Paper: Nottingham Polytechnic.

FROST, P.J., MOORE, L.F., LOUIS, M.R., LUNDBERG, C.G. AND MARTIN, J. (eds.) (1985), Organizational Culture, London: Sage

GALLAGHER, J. and ROBINSON, R. (1953), 'The Imperalism of Free Trade', The Economic History Review, Second Series, Vol. VI, No. 1.

GARFINKEL, H. (1967), Studies in Ethnomethodology, Englewood Cliffs, N.J.: Prentice Hall.

GEERTZ, C. (1973), The Interpretation of Cultures, New York:Basic Books.

GIDDENS, A. (1979), Central Problems in Social Theory: Action Structure and Contradiction in Social Analysis, London:Macmillan.

GIDDENS, A. (1982), Sociology: A Brief But Critical Introduction, London: Macmillan

GLASER, B.G. and STRAUSS, A. (1967), The Discovery of Grounded Theory, Chicago:Aldine

GOFFMAN, E. (1959), The Presentation of Self in Everyday Life, New York: Double Day.

GOFFMAN, E. (1968), Asylums, Harmondsworth: Penguin

GORDON, M.M. (1970), 'The Concept of the Subculture and its Application', in ARNOLD, D.O. (ed.)

GOULDNER, A.W. (1964), Patterns of Industrial Bureaucracy, New York:Free Press.

GREEN, S. (1974), The Hospital: An Organizational Analysis, Blackie:Glasgow.

GREGORY, K.L. (1983), 'Native-view Paradigms:Multiple Cultures and Culture Conflicts in Organizations', Administrative Science Quarterly, 28: pp 359-376.

GRIFFITHS, R. (1983), NHS Management Inquiry (Griffiths Report), London:DHSS.

GRIMES, D.S. and ALLEN, D. (1985), 'Griffiths and Professionalism', British Medical Journal, Vol. 290, 4th May, pp 1367-1368.

HALFPENNY, P. (1979), 'The Analysis of Qualitative Data', Sociological Review vol. 27, no. 4, pp 799-825.

HAM, C.J (1981), Policy Making in the National Health Service, London:Macmillan.

HAM, C.J. (1985), Health Policy in Britain, London:Macmillan, 2nd Edition.

HAM, C. (1988), 'The Challenge is to Reform the NHS Without Losing the Doctors', The Independent, Sept 15.

HAMMERSLEY, M. (1979), 'Data Collection in Ethnographic Data' in The Open University. Research Methods in Education and the Social Sciences, Milton Keynes: The Open University Press

HAMMERSLEY, M. (1979), 'Analyzing Ethnographic Data' in The Open University Research Methods in Education and the Social Sciences, Milton Keynes: The Open University Press

HAMPTON, J.R. (1983), 'The End of Clinical Freedom', British Medical Journal, Vol. 287, No 6401, pp 1237-1238.

HANDY, C (1985) (Third Edition), Understanding Organizations, Penguin:London.

HANNAN, M.T. and FREEMAN, J.H. (1977), 'The Populations Ecology of Organizations', American Journal of Sociology, 82, pp929-64.

HARRISON, R. (1972), 'Understanding Your Organization's Character', Harvard Business Review, 3, pp 119-128.

HARRISON, S. (1982), 'Consensus Decision Making in the National Health Service: A Review', Journal of Management Studies, Vol. 19, No. 4, pp 377-394.

HARRISON, S. (1986), 'Management Culture and Management Budgets', Hospital and Health Services Review, Vol. 82, No. 1.

HARRISON, S. (1988a), 'The Workforce and the New Managerialism' in R.J.Maxwell (ed.), Reshaping the National Health Service, pp. 141-152, Hermitage, Berks, Policy Journals.

HARRISON, S. (1988b), Managing the National Health Service:Shifting the Frontier?, Chapman and Hall:London.

HARRISON, S., HAYWOOD, S. and FUSSELL, C. (1984), 'Problems and Solutions: the Perceptions of NHS managers', Hospital and Health Services Review, Vol 80, No 4.

HAYWOOD, S.C. (1979), 'Team Management in the NHS:What Is It All About?', Health and Social Service Journal, Centre 8 Paper, 5 October.

HAYWOOD, S.C. and ALASZEWSKI, A. (1980), Crisis in the Health Service:the Politics of Management, London:Croom Helm.

HEALTH SERVICE JOURNAL. (1988), The NHS - 40 Years Serving the Public, Supplement to the Health Service Journal, 30 June.

HEFFER, S. (1986), 'Time for the Sick Man of the Welfare State to take Stiff Medicine', Daily Telegraph, June 5.

HELLER, T. (1979), Restructuring the Health Service, London, Croom Hall

HERZBERG, F. (1976), The Managerial Choice: The Managerial Choice: to be Effective and to be Human, Homewood, Ill.:Dow-Jones-Irwin.

HICKSON, D.J. et al. (1971), 'A Strategic Contingencies Theory of Intra Organizational Power', Administrative Science Quarterly, 16. 2. pp 216-229.

HOFFMAN, J.E. (1980), 'Problems of Access in the Study of Social Elites and Boards of Directors', in W.B. Shaffir, R.A. Stebbins and A. Turowetz (eds), Fieldwork Experiences:Qualitative Approaches to Social Research, New York:St Martin's Press.

HONIGMANN, J.J. (1982), Sampling in Ethnographic Fieldwork, in BURGESS, R.G. (ed.).

HOPKINS, R. (1987), 'Doctors as General Managers: To Be Or Not To Be, British Medical Journal, Vol. 295, (21st November), pp 1360-1361.

HORNER, S. (1984), Contribution to Annual Conference of CCCMCH 23, (June 1984), reported in British Medical Journal, VOL. 289, (July 28th), pp. 262-263.

HOWARD, K. and SHARP, J.A. (1983), The Management of a Student Research Project, Gower:Aldershot.

HUMPHRIS P.J. (1986), 'Developing a Sub-Unit Structure', Hospital and Health Services Review, March, pp 57-59.

HUNTER, D.J. (1980), Coping with Uncertainty, Letchworth: Research Studies Press.

HUNTER. D.J., HARRISON S., MARNOCH., and POLLITT, C. (1988), For Better or For Worse?:Assessing the Impact of General Management, paper presented at ESRC 'Decisions in Health' Conference, Royal Aeronautical Society, London.

INSTITUTE OF HEALTH SERVICES MANAGEMENT. (1987), Memorandum to the Social Services Select Committee Inquiry into NHS Management, London, Mimeo.

IRWIN, J. (1970), 'Notes on the Present Status of the Concept of Subculture', in ARNOLD. D.O. (ed.).

JACQUES, E. (1951), The Changing Culture of a Factory, London:Tavistock.

JACQUES.E (ed.), (1978), Health Services:Their Nature and Organization and the Role of Patients, Doctors, and the Health Professions, London:Heinemann.

JELINEK, M., SMIRCICH, L., and HIRSCH, P. (1983), 'A Code of Many Colors', Administrative Science Quarterly, 28. pp 331-338.

JICK, T.D. (1983), Mixing Qualitative and Quantitative Methods:Triangulation in Action, in Van Maanen, J. (ed.).

JOHNSON, T. (1972), Professions and Power, London:Macmillan.

KAKABADSE, A. (1982), Culture of the Social Services, Gower:Aldershot

KANTER, R.M. (1983), The Change Masters, London: Allen & Unwin.

KELEHER, R. and COLE, C. (1988), A Model For Change in the NHS, Health Services Management, December, pp 167-169.

KENN, C. (1986), 'Management Training of Clinicians in the NHS', British Medical Journal, Vol. 293, (13th September), pp 706-707.

KILMANN, R.H., SAXTON, M.J., SERPA, R. and associates (eds.). (1985), Gaining Control of the Corporate Culture, Jossey Bass:London.

KINSTON, W. and ROWBOTTOM, R. (1983), The New NHS Districts and their Units:A Working Paper, Brunel Institute of Organization and Social Studies.

KLEIN, R.E. (1983), The Politics of the National Health Service, London:Longman

KLEIN, R.E. (1984), 'Who Makes Decisions in the NHS?', British Medical

Journal, Vol. 228, No. 2.

KLEIN, R.E. (1985), 'Who Makes the Decisions in the NHS?, in NHS Management Perspectives for Doctors, King Edwards Hospital Fund: London.

KLUCKHOHN, F.R. and STRODTBECK, F.L. (1961), Variations in Value Orientations, Westport, Conn:Greenwood.

KOGAN, M., GOODWIN, B., HENKEL, M. KORMAN, M., PACKWOOD, T., BUSH, A., HOYES, V., ASH, L. and TESTER, J. (1978), The Working of the National Health Service, Royal Commission on the National Health Service, Research Paper no.1, London:HMSO.

KORNER, E. (1982-1984), Steering Group on Health Service Information. Reports 1-6, London: HMSO

KOTTER, J.P. (1982), The General Managers, New York:Free Press

LAWRENCE, P. R. and LORSCH, J.W. (1967), Organization and Environment, Harvard University Press.

LEVITT, R. and WALL, A. (1984), The Reorganized National Health Service (Third Edition). London:Croom Helm

LINSTEAD, D. (1984), 'The Realities of Human Resourcing:A Case Study Which Questions the Utility of Rational Manpower Planning Models in Health Care', Health Services Manpower Review, Vol.10, no 3. pp 9-11.

LIPSET, S.M., TROW, M. and COLEMAN, J. (1956), Union Democracy, Chicago:Free Press.

LITTLER, C.R. and SALAMAN, G. (1984), Class at Work, London:Batsford.

LORSCH, J.W. (1985), 'Strategic Myopia:Culture as an Invisible Barrier to Change', in KILMANN et al (eds.).

LOUIS, M.R. (1983), 'Organizations As Cultural-Bearing Milieux', in Pondy, et al (eds.).

LOUIS, M.R. (1985a), 'Sourcing Workplace Cultures:Why, When and How', in KILMANN et al (eds.).

LOUIS, M.R. (1985b), 'An Investigator's Guide to Workplace Culture', in FROST, P.J., et al (eds.).

LUDBROOKE, A. and MOONEY, G.H. (1984), 'Clinical Freedom, Efficiency and the Griffiths Report', British Medical Journal, Vol.288,pp. 420-421.

McGREGOR, D.C. (1960), The Human Side of Enterprise, New York:McGraw-Hill.

MCKINNON, J. (1988), 'Reliability and Validity in Field Research', Accounting, Auditing and Accountability, vol. 1, no. 1, pp 34-55.

MCNULTY, T.H. and FILBY, I. (1988), Gatekeepers and Grocers in the NHS:The Cultural Re-ordering of a Management Initiative, Unpublished Paper:Nottingham Polytechnic.

MANGHAM, I.L. (1979), The Politics of Organizational Change, London: Associated Business Press

MANGHAM, I.L. (1986), Power and Performance in Organizations, Oxford:Blackwell

MANNING, P.K. (1977), Police Work: The Social Organization of Policing, MIT Press.

MARCOVITCH, H. (1986), 'Can the Managerial Revolution Work?', BMA News Review, October.

MARS, G. (1973), 'Chance, Punters and the Fiddle' in Warner, M. (ed).

MARSHALL, J. and McLEAN, A. (1985), Exploring Organizational Culture as a Route to Organizational Change, in Hammond, V. (ed). Current Research in Management, Pinter:London.

MARTIN, J., FELDMAN, M.S., HATCH, M.J., and SITKIN, S.B. (1983a), The Uniqueness Paradox in Organizational Stories, Administrative Science Quarterly, 28. pp 438-453.

MARTIN, J. and SIEHL, C. (1983b), 'Organizational Culture and Counter Culture': An Uneasy Symbiosis, Organizational Dynamics, Autumn pp 52-64.

MARTIN, P.Y. and TURNER, B.A. (1986), 'Grounded Theory and Organizational Research', The Journal of Applied Behavioral Science, Vol. 22, No. 2, pp 141-157.

MASLOW, A. (1954), Motivation and Personality, New York: Harper & Row

MAXWELL, R. (ed.) (1988), Reshaping the National Health Service, Oxford: Policy Journals.

MAYO, E. (1949), The Social Problems of an Industrial Civilization, London:Routledge and Kegan Paul.

MEYER, M.W. (1978), Environments and Organizations, San Francisco:Jossey Bass.

MILES, M.B. (1979), 'Qualitative Data as an Attractive Nuisance: The Problem of Analysis', Administrative Science Quarterly, vol. 24, no. 4, pp 590-601.

MILES, R.H. (1980), Macro Organizational Behaviour, Santa Monica, Cal.:Goodyear.

MINTZBERG, H. (1973), The Nature of Managerial Work, New York:Harper and Row

MINTZBERG, H. (1983), 'An Emerging Strategy of "Direct" Research', in Van Maanen, J. (ed.)

MINTZBERG, H. (1985), 'The Organization as a Political Arena', Journal of Management Studies, 22. 2. pp 133-154.

MITCHELL, J.C. (1983) 'Case and Situational Analysis', Sociological Review, vol. 31, no. 2, pp 186-211.

MORGAN, G. (1986), Images of Organization, London:Sage.

MORGAN, G. and SMIRCICH, L. (1980), The Case for Qualitative Research, Academy of Management Review, Vol. 5, No. 4, pp 491-500.

MOSER, C. and KALTON, G. (1971), Survey Methods in Social Investigation, 2nd edn, London:Heinemann.

MUNSON, P. and MCNULTY, T.H. (1989), 'Housekeeping in the NHS', A paper prepared for the BAA Conference, University of Bath, March 1989, Trent Business School, Discussion Paper Series.

NATIONAL ASSOCIATION OF HEALTH AUTHORITIES IN ENGLAND AND WALES. (1984), 'Reactions to the Griffiths Inquiry', in Health and Hospital Service Review, (March), pp 94-97.

NATIONAL HEALTH SERVICE TRAINING AUTHORITY (1986a), Developing the Role of Doctors in the Management of the National Health Service:A Discussion Document, Bristol.

NATIONAL HEALTH SERVICE TRAINING AUTHORITY (1986b), Better Management, Better Health, Bristol.

OPPENHEIM, A.N. (1966), Questionnaire Design and Attitude Measurement, London:Heinemann.

OUCHI, W.G. (1981), Theory Z. Reading, Mass.:Addison-Wesley.

PAGE, G. 1983 C3 'Are doctors managing?' Health and Social Service Journal, (January 27th), pp. 109-110

PAIGE, V. (1985), 'General Management in the NHS', Hospital and Health Services Review, September. pp 205-213.

PALMER, V.M. (1928), Field Studies in Sociology: A Student's Manual, University of Chicago Press: Chicago.

PARSTON, G. (1988), 'Evolution - General Management' in R.J.Maxwell (ed.), Reshaping the National Health Service, pp. 17-33, Hermitage, Berks, Policy Journals.

PEARCE, F. (1989), The Radical Durkheim, Unwin:Allen

PERROW, C. (1970), Organizational Analysis, London: Tavistock.

PETCHEY, R. (1986), 'The Griffiths Reorganization of the National Health Service:Fowlerism by Stealth?', Critical Social Policy, Vol.6, No. 2, pp. 87-101.

PETERS, T.J. (1978), 'Symbols, Patterns and Settings', Organizational Dynamics, Autumn, pp. 3-23.

PETERS, T.J. and WATERMAN, R.H. Jnr. (1982), In Search of Excellence, New York: Harper & Row.

PETTIGREW, A.M. (1972), 'Information Control as a Power Resource' Sociology, (May). pp. 187-204.

PETTIGREW, A.M. (1973), The Politics of Organizational Decision-making, London: Tavistock.

PETTIGREW, A.M. (1977), 'Strategy Fomulation As A Political Process', International Studies of Management and Organization, Vol. 7.

PETTIGREW, A.M. (1979), 'On Studying Organizational Cultures', Administrative Science Quarterly, Vol. 24:570-581.

PETTIGREW, A.M. (1985), The Awakening Giant: Creativity and Change in I.C.I., Oxford: Blackwell.

PETTIGREW, A., MCKEE, L. and FERLIE, E. (1988), 'Understanding Change in the NHS', Public Administration, Vol. 66 Autumn pp. 297-317.

PFEFFER, J. (1978), 'The Micropolitics of Organization' in Meyer, M.W. Environments and Organization, San Francisco: Jossey Bass.

PFEFFER, J. (1981), Power in Organizations, Boston: Pitman.

PFEFFER, J. and SALANCIK, G.R. (1978), The External Control of Organizations: a Resource Dependence Approach, New York:Harper and Row.

POLLITT, C., HARRISON, S., HUNTER, D., and MARNOCH, G. (1987), Evaluating the Impact of General Management: A Memorandum to the Social Services Committee.

POLLITT, C.J., HARRISON, S., HUNTER, D.J. and MARNOCH,G. (1988a), 'No Hiding Place: On the Discomforts of Researching the Contempory Policy Process', Paper presented to a CRSP Seminar, May.

POLLITT, C.J., HARRISON, S., HUNTER, D.J. and MARNOCH,G. (1988b), 'The Reluctant Managers:Clinicians and Budgets in the NHS', Financial Accountability and Management, Vol, 4, No. 3.

PONDY, L.R., FROST, P.J., MORGAN, G. & DANDRIDGE, T.C. (eds.) (1983), Organizational Symbolism, Greenwich, Conn.: JAI Press.

PONDY, L.R. (1983), 'The Role of Metaphors and Myths in Organization and in the Facilitation of Change', in Pondy, et al. (eds.).

RATHWELL, T.A. (1987), Strategic Planning in the Health Sector, London:Croom Helm.

REED, M. (1985), Redirections in Organizational Analysis, London:Tavistock

REES, M. (1985), The Costs of Cardiotheracic and Neurological Units in Southampton General Hospital (University of Southampton, 1985) Referred to by Bourn and Ezzamel (1986).

RICHMAN, J. (1983), Traffic Wardens: an Ethnography of Street Administration, Manchester University Press.

ROYAL COLLEGE OF NURSING. (1984), 'Reactions to the Griffiths Inquiry', in Health and Hospital Service Review, (March), pp 94-97.

ROYAL COLLEGE OF NURSING. (1986a), 'Feeling Better:Getting Better', RCN:LONDON.

ROYAL COLLEGE OF NURSING. (1986b), 'Dear General Manager', RCN:LONDON.

ROYAL COMMISSION ON THE NATIONAL HEALTH SERVICE. (1979), Report , Cmnd 7615, London, HMSO.

SALAMAN, G. (1979), Work Organizations, Longman:London

SALAMAN, G. and THOMPSON, K. (eds.) (1973), People and Organizations, London: Longman

SALMON. (1966), Report of the Committee on Senior Nursing Staff, Ministry of Health, HMSO:London.

SCHATZMAN, L. and STRAUSS, A.L. (1973), Field Research: Strategies for a Natural Sociology, Englewood Cliffs, NJ:Prentice:Hall).

SCHEIN, E.H. (1983), 'The Role of the Founder in Creating Organizational Culture', Organizational Dynamics, Summer.

SCHEIN, E.H. (1984) 'Coming to a new Awareness of Organizational Culture', Sloan Management Review, 25, pp 3-16.

SCHEIN, E.H. (1985), Organizational Culture and Leadership, San Francisco: Jossey Bass.

SCHULZ, R.I. and HARRISON, S. (1986), 'Physician Autonomy in the Federal Republic of Germany, Great Britain and the United States, International Journal of Health Planning and Management, Vol.1, no.5,

pp. 335-355.

SCHWARTZ, H., and DAVIS, S.M. (1981), 'Matching Corporate Culture and Business Strategy', Organizational Dynamics, Summer, pp 30-48.

SCRIVENS, E. (1988), 'The Management of Clinicians in the National Health Service', Social Policy and Administration, Vol. 22, pp. 22-34.

SCRIVENS, E. (1988), 'Doctors and Managers:Never the Twain Shall Meet?', British Medical Journal, Vol. 296, pp 1754-1755.

SIEBER, S.D, (1976), 'A Synopsis and Critique of Guidelines for Qualitative Analysis Contained in Selected textbooks', Project on Social Architecture in Education, New York:Centre for Policy Research, Reported in Miles, M.B. (1979).

SIKULA, A.F. (1973), 'The Values and Value Systems of Industrial Personnel Managers', Public Personnel Management, July - August.

SILVERMAN, D. (1970), The Theory of Organizations, London:Heinemann

SILVERMAN, D. and JONES, J. (1976), Organizational Work, London:Collier MacMillan.

SILVERZWEIG, S. and ALLEN, R.F. (1976), 'Changing the Corporate Culture', Sloan Management Review, 17, pp 33-49.

SMIRCICH, L. (1983a), 'Organizations as Shared Meanings', in Pondy et al (eds.).

SMIRCICH, L. (1983b), 'Studying Organizations as Cultures' in Morgan, G. (ed.).

SMIRCICH, L. (1983c) 'Concepts of Culture and Organizational Analysis', Administrative Science Quarterly, (28). pp 339-358.

SMIRCICH, L. (1985), 'Is the Concept of Culture a Paradigm for Understanding Organizations and Ourselves',in FROST, P. et al (eds.).

SMITH, A. (1987), 'Clinical Freedom', British Medical Journal, Vol. 295, p.1583.

SOCIAL SERVICES COMMITTEE. (1984), First Report, Session 1983-84: Griffiths NHS Management Inquiry Report, HC209, London, House of Commons/HMSO.

STAW, B. M. and CUMMINGS, L.L. (eds) (1981), Research in Organizational Behaviour, Vol.3, Greenwich, Conn.:JAI.

STEERING GROUP ON HEALTH SERVICES INFORMATION. (1982), (Chairman, Mrs E Korner) First Report to the Secretary of State, London:HMSO.
STEWART, J. (1979), The Reality of Management, London:Pan Books.

STEWART, V. (1983), Change:The Challenge for Management, McGraw-Hill:London.

STEWART, R., SMITH, P., BLAKE. J, and WINGATE, P. (1980), The District Administrator in the National Health Service, London:Kings Fund

STOCKING, B. (1985), Initiative and Inertia:Case Studies in the NHS, London:Nuffield Provincial Hospitals Trust.

STRAUSS, A. (1987), Qualitative Analysis for Social Scientists, Cambridge: Cambridge University Press.

STRONG, P. and ROBINSON, J. (1988), New Model Management:Griffiths and the NHS, Nursing Policy Studies Centre:University of Warwick.

SUDMAN, S. and BRADBURN, N.M. (1982), Asking Questions:A Practical guide to Questionnaire Design, San Francisco:Jossey Bass.

THOMAS, M. (1985), 'In Search of Culture:Holy Grail or Gravy Train?', Personnel Management, September.

THOMAS, P. (1988), 'Decision-Making and the Management of Change in the NHS', Health Services Management, June.

THOMPSON, D. (1967), Europe Since Napoleon, Harmondsworth:Penguin.

THOMPSON, D. (1983), 'Perception, Power and Responsibility in Management Development: A Study of the Implications for Change in the National Health Service', Management Education and Development, Vol 14, Pt.3, 1983, pp 212-232.

THOMPSON, D. (1985), 'District General Managers:The Fourth Coalition?', Hospital and Health Services Review, July pp158-164.

THOMPSON, D.J.C. (1986) Coalitions and Decision-Making within Health Districts, University of Birmingham, HSMC Research Report, 23.

THOMPSON, D. (1987), 'Coalitions and Conflict in the National Health Service', Sociology of Health and Illness, Vol 9, No 2, pp127-153.

TICHY, N. M. (1983), 'Managing Change Strategically:The Technical, Political and Cultural Keys', Organizational Dynamics, Autumn pp 59-80.

TIMMINS, N. (1988) Cash. Crisis and Cure Oxford:Newspaper Publishing PLC.

TOLLIDAY, H. (1978), 'Clinical Autonomy' in E.Jacques (ed.). Health Services:Their Nature and Organization and the Role of Patients. Doctors. and the Health Professions, London:Heinemann.

TREMBLAY, M.A. (1982), 'The Key Informant Technique:A Non-Ethnographic Application, in BURGESS. R.G. (ed.).

TRIST, E.L., and BAMFORTH, K.W. (1951), 'Some Social and Psychological Consequences of the Long-Wall Method of Coal Getting', Human Relations, 4, pp 1-38.

TURNER, R. (1974), Ethnomethodology,Harmondsworth:Penguin.
TURNER, B.A. (1983), 'The Use of Grounded Theory for the Qualitative Analysis of Organizational Behaviour', Journal of Management Studies, 20. 3. pp 333-348

TURNER, B.A. (1988), 'Connoisseurship in the Study of Organizational Cultures', in BRYMAN, A. (ed.).

VAN DE VEN, A. and ASTLEY, G. (1983), 'Central Perspectives and Debates in Organization Theory', Administrative Science Quarterly, 28:2, pp 245-73.

VAN MAANEN, J. (ed.) (1983), Qualitative Methodology, Beverly Hills:Sage

VAN MAANEN, J. and BARLEY, S.R. (1985), Cultural Organizations:Fragments of a Theory, in FROST, P.J., et al (eds.).

WATKIN, B. (1978), The National Health Service:The First Phase - 1948-1974 and After, London:Allen and Unwin.

WATSON, T.J. (1977), The Personnel Managers, London:Routledge & Kegan Paul

WATSON, T.J. (1980), Sociology, Work and Industry, (1st edition), London:Routledge & Kegan.

WATSON, T.J. (1982) 'Group Ideologies and Organizational Change', Journal of Management Studies, Vol.19 No 3. pp 259-275.

WATSON, T.J. (1986), Management, Organization and Employment Strategy, London: Routledge and Kegan Paul

WATSON, T.J. (1987), Sociology, Work and Industry, (2nd edn.). London: Routledge and Kegan Paul

WEBB, E.J., CAMPBELL, D.T., SCHWARTZ, R.D. AND SECHREST, L. (1966), Unobtrusive Measures:Nonreactive Research in the Social Sciences, (Chicago:Rand McNally).

WEBER, M. (1968), Economy and Society (G. Roth and C. Wittach, trans.). Berkeley:University of California Press.
WEICK, K.E. (1979), 'Cognitive Processes in Organizations', in Cummings, L.L and Staw, B.M. (eds.).

WEICK, K.E. (1985), 'The Significance of Corporate Culture' in FROST, P. (ed.).

WESTLEY, F.R. and JAEGER, A.M. (1985), An Examination of Organization Culture:How It Is Linked to Performance, Working Paper, No 85/01, Faculty of Management McGill University.

WICKINGS, I. (1983), 'Consultants Face the Figures', Health and Social Service Journal, (December 8th), pp. 1466-1468

WILKINS, A.L. (1983), 'The Culture Audit: A Tool for Understanding Organizations', Organizational Dynamics, Autumn, pp 24-38.

WILKINS, A.L., and OUCHI, W.G. (1983), 'Efficient Cultures:Exploring the Relationship Between Culture and Organizational Performance', Administrative Science Quarterly, 1983, 28, pp 468-481.

WILLCOCKS, A.J. (1967), The Creation of the National Health Service, London:Routledge and Kegan Paul.

WILLIAMS, D. (1985) 'Patterns of Communication', Health and Social Service Journal, (June 13), pp 736-737.

WILLIAMS, R. (1981), Culture, Glasgow:Fontana.

YIN, R.K. (1984), Case Study Research:Design and Methods, Beverly Hills:Sage.

YINGER, J.M. (1970), 'Contraculture and Subculture', in Arnold, D.O. (ed.)

YOUNG, K. (1977), 'Values in the Policy Process', Policy and Politics, Vol. 5, pp. 1-22.

ZELDITCH Jr, M. (1982), 'Some Methodological Problems of Field Studies', in BURGESS, R.G. (ed.).

ZIMMERMAN. D.H. (1973), 'The Practicalities of Rule Use', in Salaman and Thompson (eds).

The Management Of Change in The N.H.S.

A Research Study By Mr Terry McNulty
Dept of Business and Management Studies
Trent Polytechnic
Chaucer Building
Goldsmith St
Nottingham
TELE: 418248 ext 2561

As part of my doctoral research on the implementation of management change in the NHS at district and unit levels I am focusing on Kingstown Health Authority. This follows a number of meetings to discuss research access with district and individual units.

Prior to my joining the research group in Trent Business School I was employed by Kingstown Health Authority and worked for 16 months as part of the clerical team at Kingstown HQ. In my research work I am following up my interest in the management problems of the NHS which I developed during this time.

I hope that this document will give you some idea of the nature and aims of my research and will encourage you to assist me in my endeavours.

THE NATURE AND AIMS OF THE STUDY

The research aims to assess from a 'cultural perspective' the attempts to achieve managerial change throughout the District. Due to the use of a cultural perspective the project will focus on the impact that the 'softer' aspects of organizational life have on its smooth running and effectiveness. This involves looking at things like individuals' perceptions and beliefs and group cultures.

In the past in both academic literature and practice the major focus of attempts to improve managerial effectiveness has been on the 'harder' aspects of organizational life such as organizational structure, and systems. As a result, little attention has been paid to the more cultural aspects of the organization i.e the presence of groups of people with varying beliefs, styles and perceptions based on the variation of occupational/professional, social, geographical backgrounds. Ultimately, it is the people within the organization that determine the success of changes and this acceptance depends on their beliefs and perceptions of what is good or bad, right and wrong. Hence, by analysing the organizational culture I will be looking at the way people think and act in the organization. An understanding of the organizational culture, how it forms, the function it serves and how it changes, is essential to any appreciation of attempts to achieve the managerial change of the type currently being attempted in the N.H.S.

Since the implementation of general management there has bee much talk from both inside and outside the Health service of changing the organizational culture. However, despite this, ther has been no evaluation of the basic characteristics of the NHS culture. It is my intention to analyse the cultural elements at managerial level throughout Kingstown Health Authority and asses the part they play in the implementation of strategic intentions.

I would like to stress TWO things about the study

-- it is not a 'Griffiths' study per se, as the issues being studied are clearly ones that have had a major impact on the management of health care provision and delivery long before the introduction of general management.

-- it is not a study of the effectiveness of the District Health Authority, units within it or individual managers.

IT IS A STUDY INTO THE CULTURE, PERCEPTIONS AND BELIEFS HELD BY MANAGERS AND MANAGEMENT TEAMS THROUGHOUT THE DISTRICT.

Clearly,the NHS is a very complex organization and Health Authority is a large organization to study. Because of this, it is intended that the study will cover three main areas

of management.

1. The senior managers at Unit Management Team level and advisory level throughout the units plus a selection of managers at middle management levels.

2. A selection of wards in particular units in order to analyse the "cultural" aspects of hospital life and to look at attempts to get general management at the point of delivery in the Hospital.

3. At primary health care team level- to analyse the move to general management outside the hospital.

TIME-SPAN OF PROJECT

The project has a life-span of three years in total. This began in October 1985 and will end in October 1988. The project plan is broadly this;

Oct 85 - Oct 86 -- Formulation of study aims/objectives and negotiation of access with the district health authority.

Oct 86 - Jan 88 -- fieldwork consisting of personal interviews, questionnaire distribution, meeting attendance, and study of local and national documentation.

Jan 88 - May 88 -- 1st draft conclusions (distribution inside the polytechnic)

June 88 - Oct 88 -- Presentation of thesis for examination.

HEALTH AUTHORITY INVOLVEMENT AND RESEARCH METHODS

Currently, plans are being finalised with the individual units to start the fieldwork. Clearly the success of the research is determined greatly by the co-operation of units and in particular of individual managers. The co-operation received so far has been tremendous and it is hoped that this remains the case. The value of good co-operation cannot be underplayed. The level of co-operation will partly determine the methods of research that are adopted. However, the main line of research will be by personal interviews with individual managers. The focus in the interview will be on areas such as;

-- Past Career
-- Your role as a manager with particular emphasis on the perceptions of demands, constraints, and choices you have as a manager.
-- Perceptions on cultural aspects such as ;
The organization's basic role,

The relationship between the organization and the social/political environment within which it exists,

The basis and nature of decision-making in the organization,

The basic outlook and orientation of the organization

The basis of internal relationships between managers and groups of staff

The presence of organizational stories, rituals and othe cultural features,

The similarities and differences between the NHS and oth public and private sector organizations, both in terms of its management and the function it performs.

In conducting a personal interview it is intended (subject to interviewee permission) to use a tape recorder. In doing so, complete confidentiality and anonymity is assured. It is expect that an interview will last 1-2 hours.

Other forms of co-operation desired from managers are;

-- Permission to approach other members of staff for an interview,
-- permission to attend meetings that appear vital to the research,
-- Permission to obtain authority documentation,
-- Permission to distribute a questionnaire amongst particular staff groups.

BENEFITS FOR THE UNITS AND AUTHORITY

Among the benefits will be;

-- Publications in National Health Service Journals. Perhaps i will be possible to work with particular individuals in the authority in doing such work.

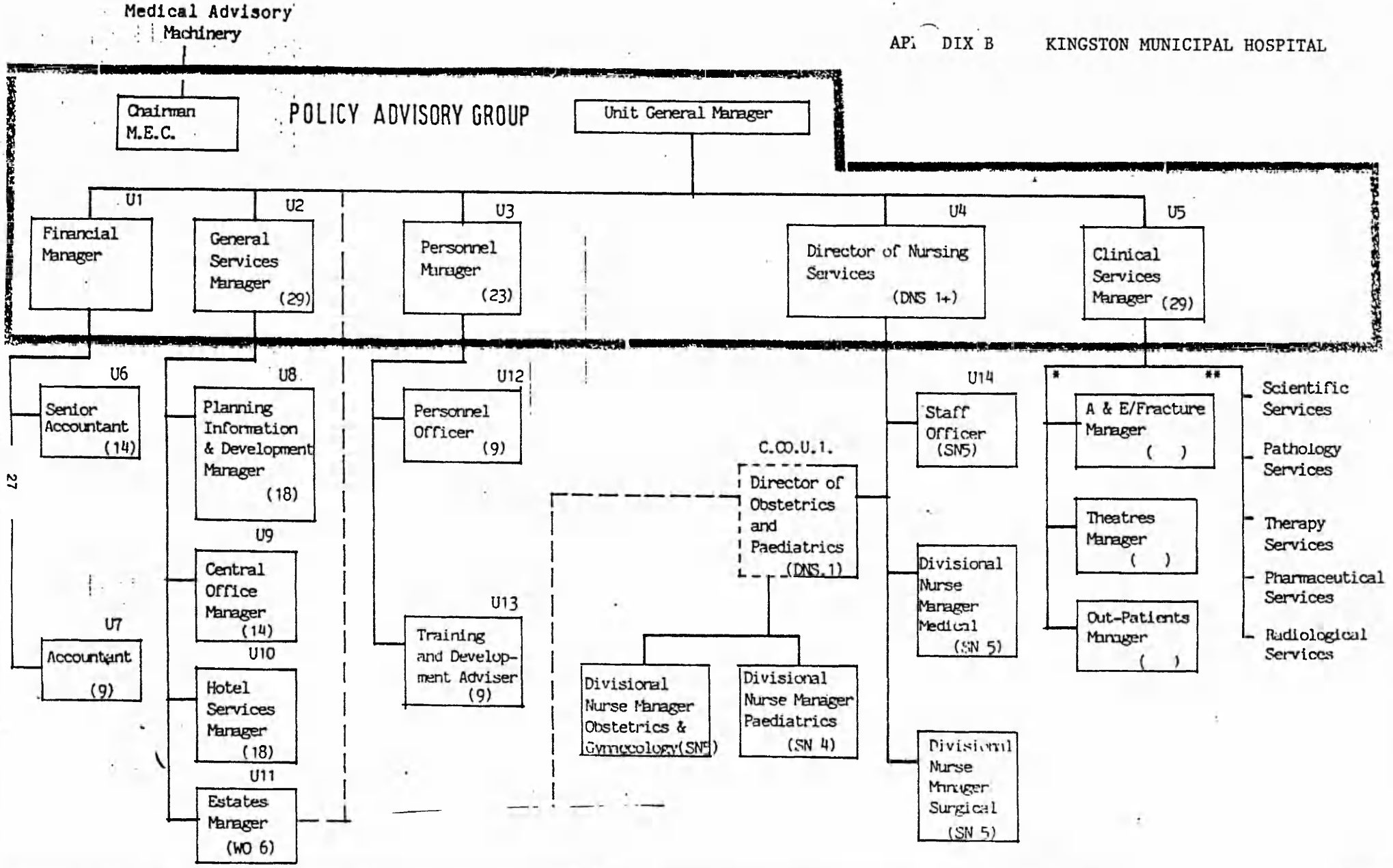
-- Lectures/seminars on the issue of organizational culture in the DHA, and regular discussion of research findings.

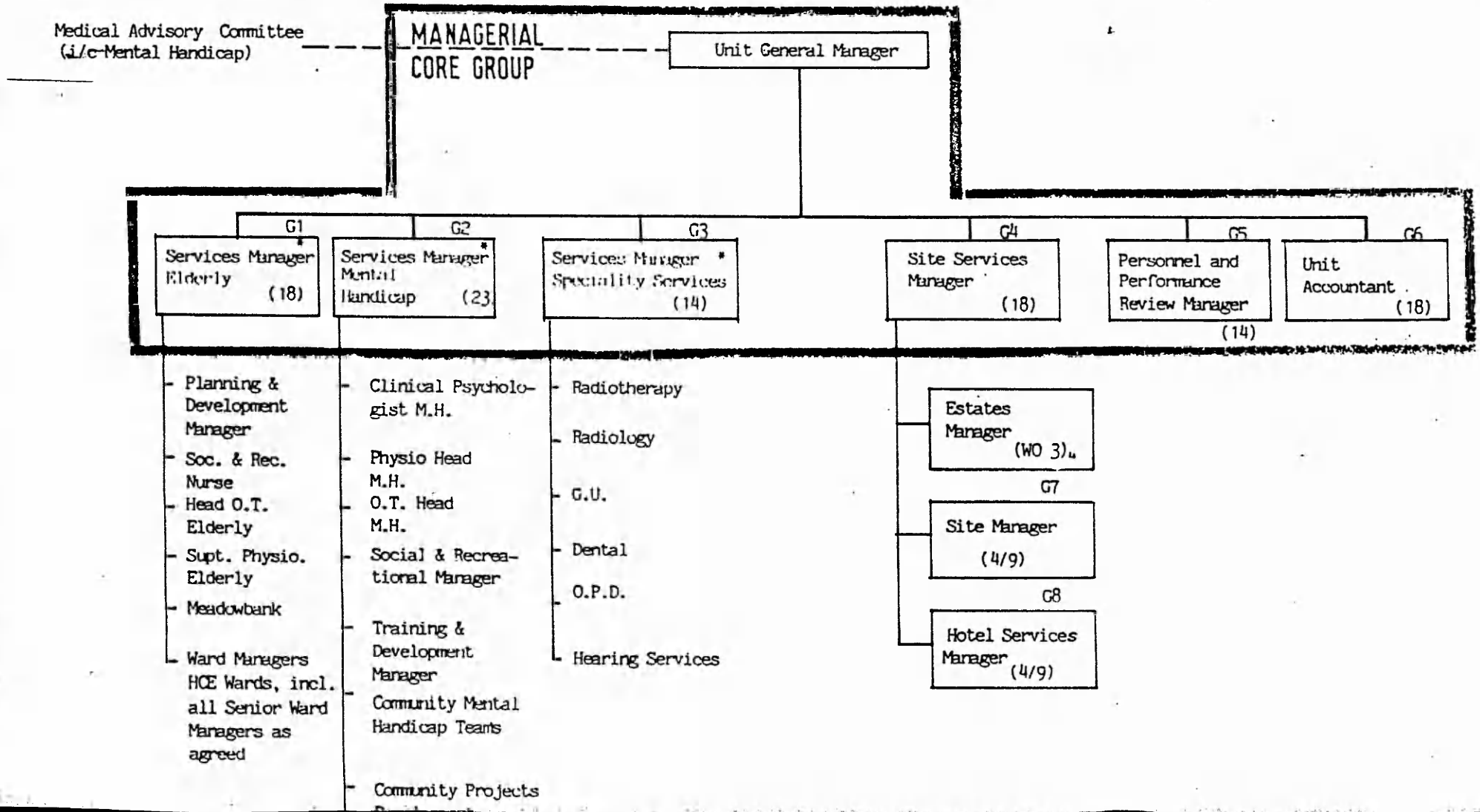
-- An opportunity to allow individuals to talk about their work and "put a mirror up to themselves and the organization" Such a purpose forms the basis of lots of consultancy work.

-- Information that can assist in the future management of Kingstown Health Authority and provide a greater understanding the complexities of management in the N.H.S.

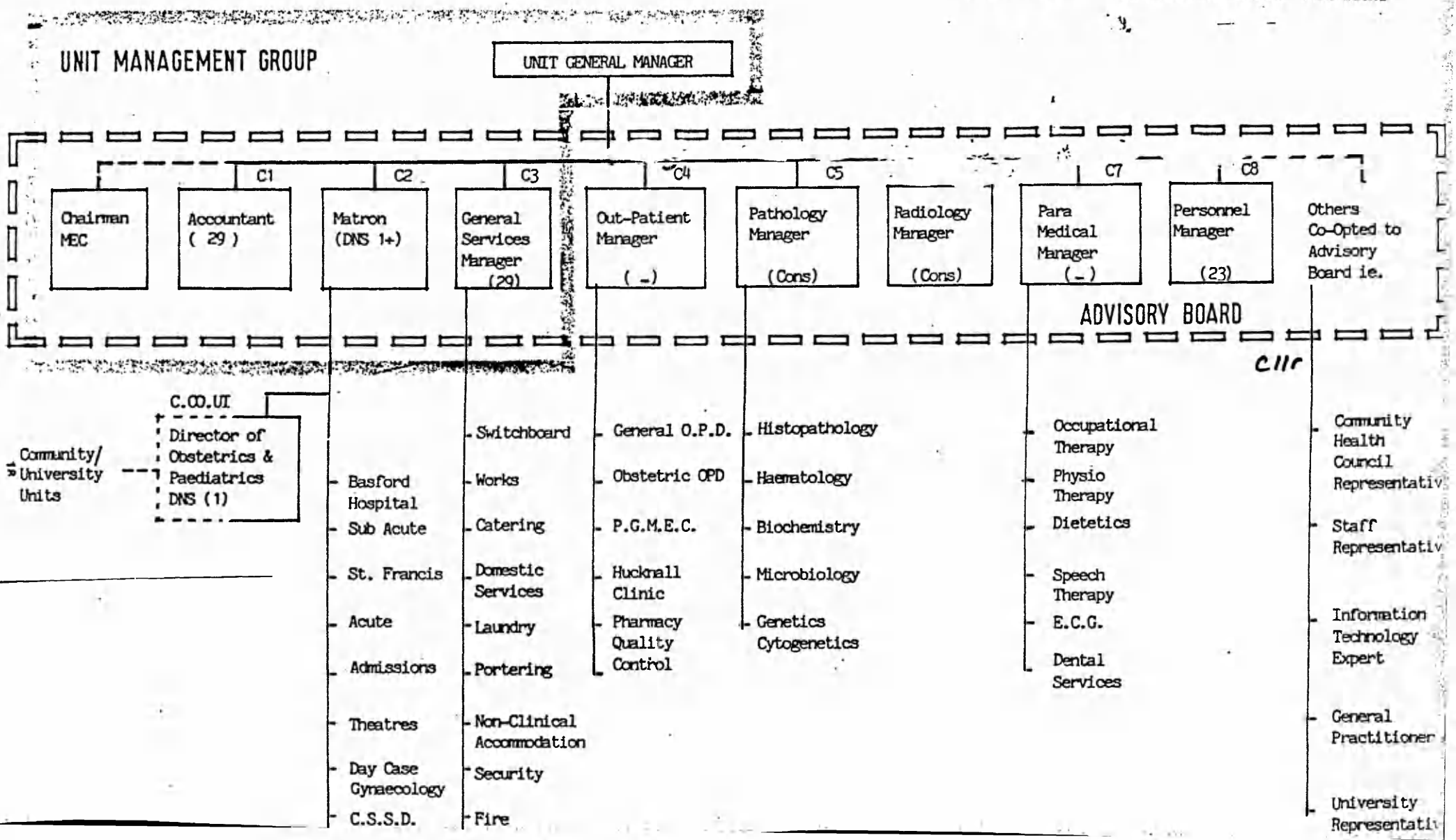
T.McNulty -- Sept 1986

APPENDIX B KINGSTON MUNICIPAL HOSPITAL




Medical Advisory Committee (i/c Mental Handicap)
MANAGERIAL CORE GROUP
Unit General Manager
G1
Services Manager Elderly (18)
G2
Services Manager Mental Handicap (23)
G3
Services Manager Speciality Services (14)
G4
Site Services Manager (18)
G5
Personnel and Performance Review Manager (14)
G6
Unit Accountant (18)
Planning & Development Manager
Soc. & Rec. Nurse
Head O.T. Elderly
Supt. Physio. Elderly
Meadowbank
Ward Managers HCE Wards, incl. all Senior Ward Managers as agreed
Clinical Psychologist M.H.
Physio Head M.H.
O.T. Head M.H.
Social & Recreational Manager
Training & Development Manager
Community Mental Handicap Teams
Community Projects
Radiotherapy
Radiology
G.U.
Dental
O.P.D.
Hearing Services
Estates Manager (WO 3)
G7
Site Manager (4/9)
G8
Hotel Services Manager (4/9)

APPENDIX D KINGSTOWN ROYAL INFIRMARY



APPENDIX E

Issues to be covered by the researcher in interviews.

Feelings about the introduction of general management

Changes in the role and fucntioning of the NHS

The relationship between professionals and managers in the NHS

Pre and post general management experiences of the NHS

Feelings about the concept of managerial culture

Description of the Unit in terms of its history, critical incidents and future direction.

Descriptions of decision-making processes

Frustrations and pleasures of being part of the Unit

Feelings about recent management changes

Social interaction amongst individuals in the Unit

Expectations of managers in the Unit

APPENDIX F

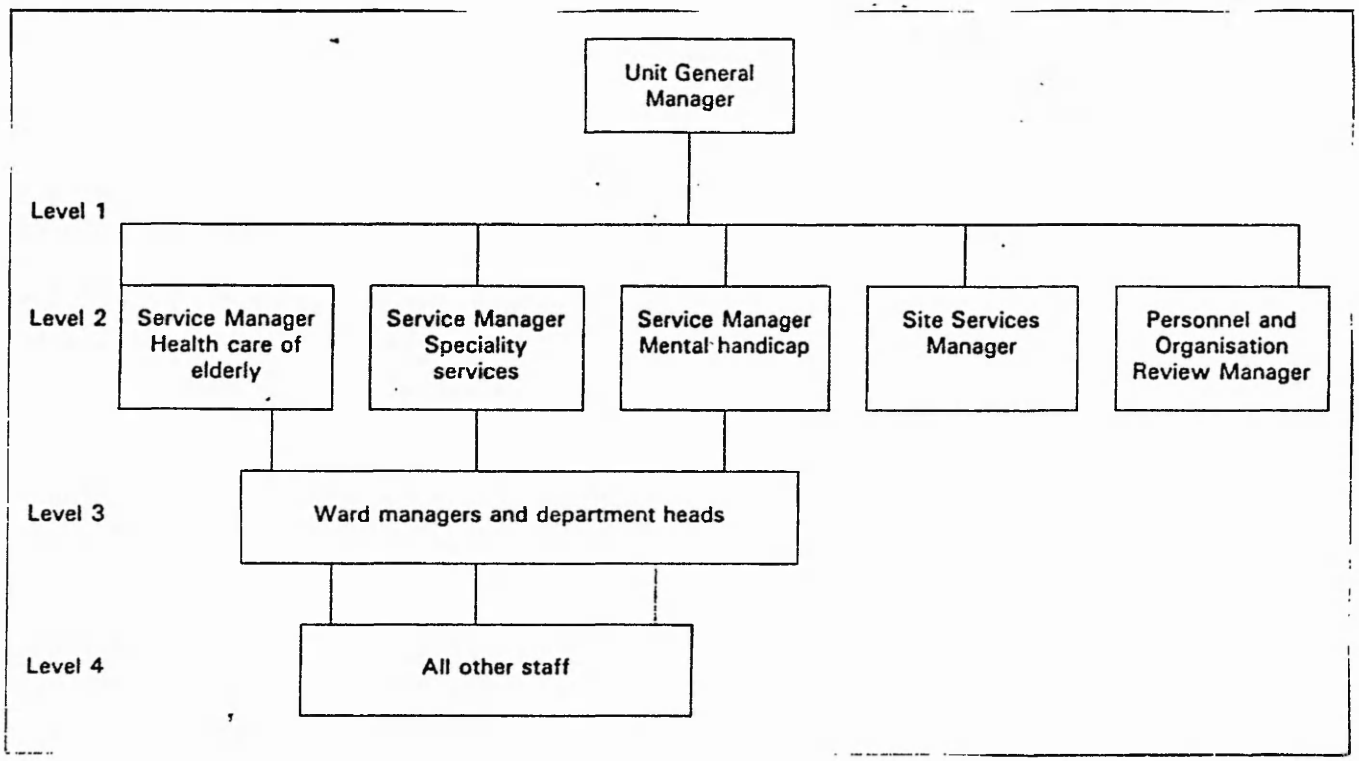
CORE MANAGEMENT TEAM WORKSHOP

~~DAY 1~~ CORPORATE OBJECTIVES

GENE MANA

IDENTIFIED VALUES (NOT IN PRIORITY ORDER)	CONSEQUENT OBJECTIVES
1. COMMUNICATION To Demonstrate - Openness - Honesty - Trust - Visible/Personal	SPOKEN COMMUNICATION - To achi a full briefing framework with sub-structure manager within 3 months. OPEN MEETINGS - To achieve a minimum 10% attendance. VISIBLE COMMUNICATION -To spen not less than 10% of time in unplanned meandering. WRITTEN COMMUNICATION - To ens that every member of staff rec a copy of Unitline.
2. INDIVIDUALITY OF THE CUSTOMER To Demonstrate - Caring - Choice - Dignity - Privacy	CORE GROUP TO AGREE STRATEGY F PROGRESS BY END OF SEPTEMBER CORE GROUP TO SET PERSONAL EXAMPLE Q.E.D. PACKAGE TO BE UTILIZED TASK FORCE OF SERVICE MANAGERS CONSIDER INDIVIDUAL CARE
3. STAFF DEVELOPMENT To Demonstrate - Committment - Innovation	TO INCREASE UNIT TRAINING BUDG BY 50% BY 1 APRIL 1987 TO ACHIEVE THE FOLLOWING LEVEL INCOME GENERATION - £2,000 - £2,000 - £2,000
4. PERFORMANCE REVIEW/APPRAISAL To Demonstrate - Standards - Awareness - Quality	CORE GROUP MEMBERS TO HAVE BEE APPRAISED BY END SEPTEMBER CORE GROUP MANAGERS TO REVIEW WARDS/DEPARTMENTS BY END OCTOBE
5. GENERAL MANAGEMENT To Demonstrate - Progress - Credibility - Clarity - Change	SUBSTRUCTURES TO BE AGREED AND COMMUNICATED BY MID JULY TRAINING NEEDS OF SUB-STRUCTURE MANAGERS TO BE IDENTIFIED BY E JULY
6. PUBLIC IMAGE To Demonstrate - Caring - Efficiency - Dynamics	RECRUITMENT EXHIBITION RADIO PROGRAMMES PUBLIC AWARENESS PROGRAMME FO

APPENDIX G .. KINGSTOWN HOSPITAL



Trent Polytechnic Nottingham

School of Business
Director Professor J O'Neill BSc(Eng) CEng

Department of Business & Management Studies
Head Professor Peter Franklin BA MA

Burton Street Nottingham NG1 4BU
Telephone (0602) 418248 Telex 377534

Research project on Management in the Health Service

I would be very grateful if you could help me in my research, part of which involves considering the views and feelings of people working in health care provision in Kingstown by completing the attached questionnaire.

I am a full-time researcher at Trent Polytechnic and will treat the information which you give me with the strictest confidenciality.

Please return the completed questionnaire in the freepost envelope provided.

Thank you for your co-operation.

Terry McNulty
Research Officer.

Enc.

Trent Polytechnic Nottingham

School of Business
Director Professor J O'Neill BSc(Eng) CEng

Department of Business & Management Studies
Head Professor Peter Franklin BA MA

Burton Street Nottingham NG1 4BU
Telephone (0602) 418248 Telex 377534

HEALTH ORGANIZATION CULTURE INVENTORY

This questionnaire is an attempt at getting to YOUR feelings and perceptions of wha it is like to work in a particular "unit" of Kingstown Health Authority.

REMEMBER IT IS YOUR VIEW THAT IS REQUIRED

Instructions

*** All information given is treated with the strictest confidentiality.

-- Please indicate by ticking the appropriate box, which "unit" you belong to.

Kingstown Hospital Unit ☐
Kingstown Royal Infirmary ☐
Community Unit ☐
Mental Illness Unit ☐
Kingstown Municipal Hospital Unit ☐
District HQ ☐

-- Please indicate the nature of your post, by ticking as many boxes as you feel appropriate.

Medical ☐ Profession allied to medicine ☐ Administration ☐
Nursing ☐ Management ☐ Other ☐

-- If you have ticked the "Management box" do you perceive yourself as:

First line management ☐ Middle Management ☐ Senior Management. ☐

Instructions for answering the questions

-- Please read the statements and respond according to; how well it describes your unit as it was BEFORE the introduction of general management and how it is NOW.

Have you joined this unit since the introduction of GM YES ☐ NO ☐
Has your role changed since the introduction of GM YES ☐ NO ☐

SHOULD YOU HAVE ONLY BEEN PART OF THE UNIT SINCE THE INTRODUCTION OF GENERAL MANAGE PLEASE ANSWER IN THE SAME MANNER USING WHAT PEOPLE HAVE SAID ABOUT THE PAST AND ANY GENERAL IMPRESSIONS YOU MAY HAVE BEEN GIVEN.....

PTO

			Strongly Agree	Agree	Neither	Disagree	Strong Disagr
1.	Decisions are made according to professional expertise	Pre GM Now					
2.	Bad goes unpunished good work unrewarded	Pre GM Now					
3.	Political games are characteristic of this unit	Pre GM Now					
4.	This is the best unit to work for	Pre GM Now					
5	This unit is good at responding to changes in clients' needs	Pre GM Now					
6.	There's no thanks for the work people do	Pre GM Now					
7.	Individual intuition is the basis of decisions	Pre GM Now					
8.	People do not mix well with each other	Pre GM Now					
9.	Accountability and responsibility are clear issues	Pre GM Now					
1	People just want to put the past behind them here	Pre GM Now					
11.	Individuals and groups put their interests before the patient	Pre GM Now					
12.	Quickness of action when needed is a feature of this unit	Pre GM Now					
13.	There is a unique character about this unit	Pre GM Now					
14.	The management structure is clear and logical	Pre GM Now					
15.	The rewards are there if you strive for them	Pre GM Now					

			Strongly Agree	Agree	Neither	Disagree	Strong Disagr
16.	There is no shared purpose among individuals	Pre GM Now					
17.	People keep themselves to themselves here	Pre GM Now					
18.	The organizational structure is often a hindrance to action	Pre GM Now					
19.	For this unit, the old days are the good old days	Pre GM Now					
20.	Facts and figures are the basis of decisions	Pre GM Now					
21.	There is a lack of incentive for people working here	Pre GM Now					
22.	Dedication to patient care is the main motivation for staff	Pre GM Now					
23.	Different people pursue different purposes in this unit	Pre GM Now					
24.	People feel trusted by superiors in their work	Pre GM Now					
25.	Staff are motivated by self interest	Pre GM Now					
26.	If you want to change something, you have to get the agreement of lots of committees	Pre GM Now					
27.	You can rely on people in this unit	Pre GM Now					
28.	Management has clearly established the goals and objectives	Pre GM Now					
29.	The future is challenging and exciting	Pre GM Now					
30.	We suffer from paralysis by analysis	Pre GM Now					